

COUNTY OF IMPERIAL REQUEST FOR LEAVE OF ABSENCE

Name:	Social Security #:	Date:
Job Title:	Department:	Employee #:
Home Address		Home/Mobile Telephone

Initial Request Extension Request

Date Leave of Absence Begins:	Date Leave of Absence Ends:	Expected Return to Work Date:	Total Number of Days:
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Leave Requested is: <input type="checkbox"/> With Pay* <input type="checkbox"/> Without Pay** <small>** Contact HR to arrange insurance premium payments during leave (760-482-4488)</small>	If leave is with pay, use hours as follows: <table style="width: 100%; border: none;"> <tr> <td style="text-align: center;"><u>Accrued Sick Leave</u></td> <td style="text-align: center;"><u>Accrued Vacation</u></td> <td style="text-align: center;"><u>Accrued Comp Time</u></td> <td style="text-align: center;"><u>Accrued Admin Leave</u></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/> ___ Hrs pay period</td> <td style="text-align: center;"><input type="checkbox"/> ___ Hrs pay period</td> <td style="text-align: center;"><input type="checkbox"/> ___ Hrs pay period</td> <td style="text-align: center;"><input type="checkbox"/> ___ Hrs pay period</td> </tr> <tr> <td style="text-align: center;">Period Starting _____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">Period Ending _____</td> <td style="text-align: center;">_____</td> </tr> </table>	<u>Accrued Sick Leave</u>	<u>Accrued Vacation</u>	<u>Accrued Comp Time</u>	<u>Accrued Admin Leave</u>	<input type="checkbox"/> ___ Hrs pay period	<input type="checkbox"/> ___ Hrs pay period	<input type="checkbox"/> ___ Hrs pay period	<input type="checkbox"/> ___ Hrs pay period	Period Starting _____	_____	Period Ending _____	_____
<u>Accrued Sick Leave</u>	<u>Accrued Vacation</u>	<u>Accrued Comp Time</u>	<u>Accrued Admin Leave</u>										
<input type="checkbox"/> ___ Hrs pay period	<input type="checkbox"/> ___ Hrs pay period	<input type="checkbox"/> ___ Hrs pay period	<input type="checkbox"/> ___ Hrs pay period										
Period Starting _____	_____	Period Ending _____	_____										

Type of Leave:			
<input type="checkbox"/> 1. Illness/Injury -Not Work Related	<input type="checkbox"/> 4. Pregnancy Disability	<input type="checkbox"/> 7. Military	<input type="checkbox"/> 10. Personal
<input type="checkbox"/> 2. Illness/Injury – Work Related	<input type="checkbox"/> 5. Newborn Bonding	<input type="checkbox"/> 8. Bereavement	<input type="checkbox"/> 11. Other : _____
<input type="checkbox"/> 3. Care for Ill Parent/Spouse/Child/ Domestic Partner	<input type="checkbox"/> 6. Adoption/Foster Child Bonding	<input type="checkbox"/> 9. Educational	_____

Provide Details of Request (Including requested intermittent or reduced work schedule):

I voluntarily request a leave of absence for the reason(s) stated above. I understand my rate of pay will be subject to any general increases or decreases in wage rates that become effective during my absence from work; that I am not to accept any other employment of any kind; that my return to work will be subject to employment conditions existing at the time of such return.

I _____ (employee's initials) understand that the leave reasons numbers 1 to 6 will be designated as FMLA/CFRA leave if I meet the criteria (medical certification may be required), and that my FMLA/CFRA leave will begin on the first day of the qualifying leave. I further understand that it is my responsibility to make arrangements with the Benefits Unit of the Human Resources Department for payment of group insurance premiums during this leave period, if necessary.

Signature: _____ Date: _____

Department Head:

<input type="checkbox"/> Approved <input type="checkbox"/> Not Approved	Signature: _____ Date: _____
<input type="checkbox"/> Approved with the following restrictions _____	

Director of Human Resources:

<input type="checkbox"/> Approved <input type="checkbox"/> Not Approved	Signature: _____ Date: _____
<input type="checkbox"/> Approved with the following restrictions _____	