COUNTY OF VENTURA
LEAVE OF ABSENCE REQUEST

Employee (Print name): _____ Employee ID #: _____

☐ Request for **NEW** leave of absence from: _____ *(first day off after last date of work)*

to: _____ *(first day due back at work)*

☐ Request for **EXTENSION** of current leave to: _____ *(first day due back at work)*

REASON FOR REQUEST: (check one below)

☐ Non work-related Employee illness or injury (Including alleged work illness or injury)

☐ Approved work-related Employee Illness or injury (including 4850, Temporary Total or Partial Disability Benefits)

☐ Pregnancy Disability Leave/maternity Expected due date: _____

☐ Illness or injury of immediate family member (check one below)

☐ Spouse ☐ Child ☐ Parent Name _____

☐ Bonding (check one) ☐ Newborn ☐ Adoption ☐ Foster Care Placement Date Acquired/Born _____

Do you have a spouse employed by the County? ☐ No ☐ Yes Employee ID #_____

☐ Servicemember Family Leave (check one below & attach military orders and/or certification)

☐ Due to qualifying exigency of spouse/child/parent ☐ Due to serious injury or illness of spouse/child/parent/next of kin

☐ Military Service (attach Military Service Notification)

☐ Other Reason (including personal, educational, and death of family member)

Explain: _____

During this leave or extension: ☐ I request **PAID** leave, or ☐ I request **UNPAID** leave (attach request form)

Will you receive disability benefits during this leave? ☐ Yes ☐ No (attach waiver form)

I affirm that I have read, understand and agree to the terms of the Authorization as stated above and the reverse side of this form. I have been given a copy of the Family Medical Leave Act (FMLA), California Family Rights Act (CFRA) and if applicable the (PDL) California Pregnancy Disability Leave Notice to Employees.

I fully understand that during an unpaid leave, I remain responsible for any healthcare premium costs which exceed the flexible credit allowance paid by the County. If I fail to make payments on a timely basis, coverage will be cancelled until I return from leave and deductions resume.

Employee Signature: _____ Request Date: _____

DEPARTMENT USE ONLY

FMLA (Family Medical Leave Act) & CFRA (California Family Rights Act) ELIGIBILITY INFORMATION:

1. Has the employee worked 1,250 hours for the County within the past 12 months? ☐ No ☐ Yes How many hours _____

   If yes, has the employee worked for the County for a total of at least 12 months, including previous periods of employment? ☐ No ☐ Yes Hire date _____

2. Has the employee been on FMLA/CFRA Leave during the current calendar year? ☐ No ☐ Yes Number of pay periods ____

3. Does the Leave requested now qualify under FMLA/CFRA guidelines? ☐ No ☐ Yes

4. What type of FMLA/CFRA leave is requested? ☐ REGULAR ☐ INTERMITTENT

5. What date & method was the Leave of Absence Handbook provided? ☐ Given ☐ Mailed Date_____

ELIGIBILITY APPROVED: (check all that apply) ☐ **FMLA** ☐ **CFRA** ☐ **PDL**

Approved/Denied By: _____ Date: _____

If you need assistance in completing this form, please ask your department LOA Coordinator, Personnel Representative or Payroll Representative

READ THE TERMS BELOW CAREFULLY BEFORE SIGNING ON THE REVERSE SIDE

For more information on the County's Leave of Absence Program, review the Employee Leave of Absence Handbook provided to you

1. I understand that I am bound by all the terms and conditions of the County's Leave of Absence Program and that the County has the right to grant or deny any request for a leave of absence or an extension thereof, subject to provisions of the Federal Family Medical Leave Act, the State Family Rights Act, the State Pregnancy Disability Leave rights, applicable collective bargaining agreements, Article 22, Section 2203 of the Ventura County Personnel Rules and Regulations, and the County Administrative Policy Manual.

2. I **I understand that (to the extent that benefit premiums are not covered by County contributions) I may be required to make premium payments directly to the County while on leave of absence. If I fail to make payments on a timely basis, coverage under that benefit will be canceled until I return from leave and deductions resume. If the County mistakenly pay premiums on my behalf, I agree to repay the County directly or through wage/salary deduction.**

3. I understand that the failure to return to work on the "first day due back at work" may be considered inexcusable absence without leave and subject me to disciplinary action**. I also understand that if I am absent from work without authorization for three (3) days or two (2) consecutive twenty-four hour work shifts beginning with the "first day due back at work" I have entered on the front of this form, the County may deem that I have voluntarily abandoned my job under Article 22, Section 2203, of the Ventura County Personnel Rules and Regulations. I understand that there will be no further notice to me prior to the taking of either of these two (2) actions by the County.**

4. I understand that failure to provide a complete and sufficient medical certification may result in a denial of my leave of absence request. I further understand that I may be required to provide periodic reports on my status and intent to return to work. I agree to notify my department of my availability to return to full or restricted duty if I am released by my doctor prior to the end of an approved medical leave of absence.

5. I agree to comply with the County's Integration policy to which employees may use leave bank hours in conjunction with disability benefits that result in the employee's full biweekly base pay. The policy prevents employees from using leave bank hours that result in pay that is greater than their biweekly base rate. I understand that the appropriate use of your leave bank hours must be because of and consistent with the leave granted and that I have provided my department with request for pay instructions during my paid leave of absence.

6. I understand and agree that if I fail to return to work at the end of the approved leave period, I will repay any health insurance premiums paid by the County during the portion of my unpaid leave which is subject to the provisions of the Family Medical Leave Act (I understand that repayment may not be required under "circumstances beyond my control"). I authorize the Auditor-Controller to allocate any accrued wages/salary due to me upon termination towards the amount necessary to recover health care plan premiums paid by the County and further agree to reimburse the County of Ventura for any remaining amounts due after the allocation of all available accrued wages/salary, within 30 days of the date my employment terminates.

7. I understand that my dependent(s) eligibility for health care coverage is contingent on my submitting the proper forms within 31 days of (1) acquiring a new dependent (birth, marriage, placement for adoption, permanent legal custody), (2) a current dependent losing eligibility (divorce, loss of student status, 25th birthday), even when the event occurs during my leave of absence.

8. I understand that I must comply with health plan & Flexible Benefits Program Open Enrollment rules even if I am on leave of absence. Any applicable forms must be completed and submitted during the open enrollment period, not when I return from leave and failure to comply may jeopardize my participation.

9. I agree to notify my department of any change of address and/or phone number. I understand and agree that all communications from the County of Ventura will be sent to the address I have on file and that I am responsible for acknowledging information sent to the address on file.