



County of Ventura Human Resources

Leave of Absence Request Steps

1. Complete LOA Request Form and Payroll Form
2. Review Terms and Conditions
3. Review, Sign, and Submit

EMPLOYEE INFORMATION

Name (Last, First)		EID	
Personal Phone		Personal Email	
Preferred Way of Contact	☐ Phone ☐ Email	Work Phone	
Agency		Department	
Supervisor Name		Supervisor Email	

SECTION I – DATES of REQUEST

I request ☐ Leave of Absence ☐ Extension of Leave ☐ Change in Reason for Leave					
Last Day Worked		Date Leave Starts		Date Leave Ends	
Request Type ☐ Continuous ☐ Intermittent ☐ Reduced Schedule					

SECTION II – REASON for LEAVE

☐ Your own serious health condition			
Is the injury work related ☐ Yes ☐ No	Injury Date		
☐ Pregnancy	Estimated Due Date		
☐ Bonding			
☐ Newborn ☐ Adoption ☐ Foster Placement	Date Born/Acquired		
☐ You are needed to care for family member/designated person due to a serious health condition			
Name		Relation to you	
☐ You are needed to care for your family member who is a covered servicemember with a serious injury or illness			
Name		Relation to you	
☐ A qualifying exigency arising out of the fact that your family member is on covered active duty or has been notified of an impending call or order to covered active duty status.			
Name		Relation to you	
☐ Military Service Leave (attach Military Service Notification & Orders)	☐ Emergency Rescue Personnel Leave		
☐ Donor Leave			
☐ Bone Marrow Donation			
☐ Organ Donation			
☐ Other Reason or Requests (e.g., Personal, Educational, Organizational) Explain:			

I certify the information given above is true and correct to the best of my knowledge. I agree to notify my supervisor, agency human resources, and/or designee of any changes to my leave circumstances and provide updated medical certification as required. Should my leave be approved, I will adhere to all its terms and conditions. Non-compliance with this agreement may result in a comprehensive review under applicable rules and regulations, potentially leading to disciplinary action.

Employee Signature		Date	
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County of Ventura
TERMS AND CONDITIONS
READ THE TERMS CAREFULLY BEFORE SIGNING

Name (Last, First) :		EE ID:	
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I understand that:

1. 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 by provisions of the Federal Family Medical Leave Act, the California Family Rights Act, the California Pregnancy Disability Leave rights, applicable collective bargaining agreements, Article 22, Section 2203 of the County of Ventura Personnel Rules and Regulations, and the County Administrative Policy Manual.
2. I may be required to make premium payments directly to the County or its third-party administrator 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 pays any premiums on my behalf, I agree to repay the County directly or through wage/salary deduction.
3. The failure to return to work on the day following the "Date Leave Ends" 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 day following the "Date Leave Ends" 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 County of Ventura Personnel Rules and Regulations.
4. 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 BOTH, my supervisor and leave of absence coordinator 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 Reimbursement for Overpayment and Underpayment policy which prevents me from using leave hours that result in pay that is greater than my biweekly base rate resulting in an overpayment and/or using less than the required amount of bank hours in conjunction with disability resulting in an underpayment. I understand that the appropriate use of my leave bank hours must be because of and consistent with the leave granted and that I have provided my department with payroll instructions during my leave of absence.
6. My dependent(s) eligibility for health care coverage is contingent on my submitting the proper forms within 60 days of (1) acquiring a new dependent (birth, marriage, placement for adoption, permanent legal custody), (2) a current dependent losing eligibility (divorce, dependent child turns age 26, death), even when the event occurs during my leave of absence.
7. I must comply with the 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 of absence and failure to comply may jeopardize my participation.
8. 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.

Initial _____