COUNTY of VENTURA

Leave of Absence Request Form

Informational Cover Letter

The County will provide family and medical leave to eligible employees in accordance with the federal Family and Medical Leave Act of 1993 (FMLA), the California Family Rights Act of 1993 (CFRA), Pregnancy Disability Act (PDL) and applicable Memorandums of Agreement (MOA/MR). It is important that employees, supervisors, and managers understand that there is a shared responsibility to comply with the regulations set forth under FMLA, CFRA, and PDL. Employees are expected to adhere to attendance policies in addition to the guidelines set forth in the leave laws. For questions regarding FMLA, CFRA, or PDL, the employee should contact their agency/department Human Resources Representative.

Designation

Once protected leave is designated, it may count against your available leave entitlements. The County requires a valid medical certification form for each requested leave of absence (or simple documentation for bonding leave). Failure to provide requested documentation may result in denial of your protected leave entitlements and a loss of benefits.

Workers' Compensation

Leave because of a work-place injury/workers' compensation may also qualify for protected leave which will run concurrently as long as you remain eligible for and have remaining entitlement balances.

Medical Certification

If your leave is due to a serious or chronic health condition (either your own or a family member's) you must submit a timely, complete and sufficient medical certification within 15 days to obtain or retain the benefit of job-protections. Failure to provide it may result in denial of your request. Subsequent re-certifications may also be required.

*Intermittent Leave	*Reduced Schedule
Intermittent leave is taken in separate periods of time for a single qualifying reason.	A reduced work schedule can be taken by reducing daily or weekly work hours.

*There must be a medical necessity for such change and the employee must make a reasonable effort to schedule their leave to not disrupt the work of the agency/department.

Returning from leave

You will be expected to return to work at the end of your approved leave. If you plan to remain on leave beyond the approved period or circumstances of your leave changes you must contact your HR Representative and/or Manager/Supervisor as soon as possible. An updated medical certificate may be required. If you do not return to work following your approved leave, you may be responsible for the employer's share of health care insurance premiums

Important Dates - Employee

30 Days: Request a leave of absence for Foreseeable conditions or as soon as possible if unforeseeable
15 Days: Deadline to submit medical certification to employer.
Chronic Conditions: May request medical certifications every **6 months** or as otherwise available under the law.
Return to Work: If you intend to extend your leave or expect to have any work restrictions upon your return, you are expected to submit supporting medical documentation at least **5 days** before your anticipated return to work date. If no extension is requested, you will be expected to return on your next scheduled workday.

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	

County of Ventura
Leave of Absence Payroll Instruction Form

Employees should refer to the MOA/MR that covers their respective job classification for eligibility to use accrued sick, vacation, annual leave, or comp time hours. Notify your supervisor as soon as possible of an anticipated missed scheduled shift due to illness and/or injury. Return this form in advance of your leave of absence.

Employee:	Employee ID:
Biweekly Scheduled Work Hours:	Last Day Worked (estimated):
Pay Revision Request? ☐ Yes ☐ No *Applies only to revision	Requested Effective Date: *Applies only to revision

Pay Integration (Wage Replacement Benefits and Accruals)

Employees may be eligible for some type of disability insurance benefits or wage loss due to illness or injury. Disability plans do not pay an employee's full salary during periods of disability and most plans have a Benefit Waiting Period (BWP) before any benefit is payable. To ensure proper integration with disability benefits, send a copy of your first benefit award statement to your payroll/department representative.

PAY INTEGRATION - During this Leave of Absence, I request the following pay status			
☐	Integration with disability benefits up to 100% of base biweekly compensation (Optional if receiving TTD)		
During this Leave of Absence, I expect to receive benefits			
☐	State Disability Insurance	☐	Paid Family Leave
☐	Voluntary Short-Term Disability (MetLife)	☐	Union Disability Plan (PORAC, other)
☐	Long Term Disability (County of Ventura group plan)		
☐	Wage Supplement Plan (Check One) ☐ HIGH or ☐ LOW option	☐	Temporary Total Disability (TTD) or Temporary Partial Disability (TPD) benefits

Please contact your payroll/department representative immediately if your disability benefit(s) amount increases, decreases, or is terminated/exhausted. The County's Reimbursement for Overpayment and Underpayment policy prevents employees from using leave hours that result in pay that is greater than their 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.

Pref. #		Current sick leave	Use all hours, as needed	Hours to be used:
Pref. #		Current vacation/annual leave	Use all hours, as needed	Hours to be used:
Pref. #		Current comp bank	Use all hours, as needed	Hours to be used:
Pref. #		Floating Holiday	Use all hours, as needed	Hours to be used:

FULL PAY - During this Leave of Absence, I request the following pay status **Would require disability waiver for support*				
☐	Leave bank hours equal to total biweekly scheduled work hours			
Pref. #		Current sick leave	Use all hours, as needed	Hours to be used:
Pref. #		Current vacation/annual leave	Use all hours, as needed	Hours to be used:
Pref. #		Current comp bank	Use all hours, as needed	Hours to be used:
Pref. #		Floating Holiday	Use all hours, as needed	Hours to be used:

UNPAID - During this Leave of Absence, I request	
☐	Leave without pay (LWOP) equal to total biweekly scheduled work hours (Fully unpaid)
A leave without pay indicates the employee may be responsible for paying their share of insurance. Employees are not entitled to receive cash back from the flexible credit allowance during an unpaid leave. Please refer to the MOA/MR that covers the employee's job classification that allows for MOA/MR benefit contribution for their approved type of leave.	

I understand medical documentation supporting this leave request may be required. If this leave is without pay, I understand I may be responsible for paying insurance premium(s). I have read this document in its entirety, and I agree to comply with the County's Reimbursement for overpayment and Underpayment policy I further acknowledge that any over utilization of my leave bank balances may result in an overpayment, and I agree to repay the County of Ventura directly or through wage/salary deduction(s). These payroll instructions will remain in effect unless my leave status changes or I file revised payroll instructions. The final determination will be made based on the circumstances and in accordance with applicable policies and regulations.

Employee Signature		Date	

County of Ventura
Leave of Absence Payroll Instruction Form
TERMS AND CONDITIONS
READ THE TERMS CAREFULLY BEFORE SIGNING

Name (Last, First) :		EE ID:	

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_____