



Leave of Absence Request Form

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) agreement. 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, you must contact your HR Representative and/or Manager/Supervisor. If the circumstances of your leave change, please notify your manager and LOA Coordinator 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 liable for the employer's share of health care insurance premiums [29 CFR 825.301 (B)(1)].

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

EMPLOYEE INFORMATION

Name (Last, First)		EID	
Personal Phone	Personal Email		
Preferred Way of Contact	<input type="checkbox"/> Phone <input type="checkbox"/> 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
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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
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You are needed to care for your family member who is a **covered servicemember** with a serious injury or illness

Name	Relation to you
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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
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Military Service Leave (attach Military Service Notice) 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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