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	

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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_____