TULARE COUNTY

LEAVE OF ABSENCE REQUEST FORM

Employee Name_____ Date of Request_____

Department_____ Position Title_____ EE ID _____

Contact Phone Number While on Leave:_____

In order to be considered for a leave of absence, the requested information on this form must be provided and approval received from the Department Head prior to the requested leave commencing, unless an emergency exists. All requests will be evaluated for eligibility with applicable Family Care leave provisions and if your request meets the employment standards for Family Care leave, provisions of the leave acts will commence the date of your request. Employees requesting a medical leave of absence will be expected to use accrued sick leave benefits before a leave without pay may begin. A Department Head may require vacation leave balances to be used before leave without pay begins. Compensatory Time Off (CTO) usage may only occur with employee approval. (Note: Not all bargaining units/employee classifications earn CTO.) Vacation usage, while on a workers compensation leave, may only occur with employee approval.

An employee intending to take family or medical leave because of an expected birth or placement, or because of a planned medical treatment, must submit an application for leave at least thirty (30) days before the leave is to begin. If leave is to begin within thirty (30) days, an employee must give notice to his or her immediate supervisor as soon as the necessity for the leave arises.

If you have a current CTO balance, do you authorize use of CTO during your medical leave of absence? Yes_____ No_____

I request Leave for the following reason (check one):

_____ **A.** The birth of a child. Estimated DOB: _____

_____ **B**. Bonding. Childs DOB: _____

_____ **C.** The placement of a child for adoption or foster care (Must submit verification of adoption/date of placement)

_____ **D.** In order to care for an immediate family member because such family member has a serious health condition. Relationship: _____ **(Must submit "Physician Certification".)**

_____ **E.** Care for an adult child who is incapable of self care. **(Must submit "Physician Certification".)**

_____ **F.** Employee's own serious health condition that makes the employee unable to perform the functions of his/her position. **(Must submit "Physician Certification".)**

_____ **G.** Military Leave of Absence. **(Attach a copy of your orders)**

_____ **H.** To assist a child, spouse, or parent who is a member of the National Guard or Reserves with a "qualifying exigency" related to active duty or a call of active duty status in support of a contingency operation. Relationship: _____ **(Must submit "Certification" of Qualifying Exigency)**

_____ **I.** To care for a child, spouse, parent or "next of kin" servicemember of the United States Armed Forces who has a serious injury or illness incurred in the line of duty while on active duty (up to 26 weeks of leave). **(Must submit "Certification" from Department of Defense or Department of Veteran Affairs.)**

_____ **J.** Other: _____
(ie. Personal Leave, Organ Donor Leave, Domestic Violence Leave, School Leave, etc.)

Leave Information:
Date leave is to begin: _____ Expected Return to Work Date:_____

_____**A.** Consecutive Leave _____**B.** Intermittent or Reduced Leave Schedule (Specify schedule) _____

I understand that my restoration to employment is subject to the following conditions: 1) As a condition of restoration, I must provide a written certification from my health care provider that I am able to resume working. 2) For FMLA covered leaves every attempt will be made to restore me to my original position. If my original position is unavailable, I will be placed in an equivalent position with equivalent pay and benefits. These conditions apply to returns from leaves of absence.

Employees are not permitted to work, including accessing County information or email accounts, while on leave of absence, except under terms and conditions specifically authorized by your department head or his/her "designee." Failure to comply with this directive may result in discipline up to and including dismissal.

Date_____ Employee's Signature_____

For further information, contact departmental coordinator: _____
Name Department Phone Number