DEPARTMENT OF HUMAN RESOURCES
Risk Management Division
675 Texas Street, Suite 1800
Fairfield, CA 94533
FAX: 707-784-1988
EMAIL: riskmanagement2@solanocounty.com

SOLANO COUNTY

LEAVE OF ABSENCE REQUEST FORM

****Risk Management may not be able to process incomplete forms****

Purpose: To request **1)** leave of absence; or **2)** extension of leave; or **3)** report an employee's absence.

Instructions:

A. Requesting a Leave of Absence OR Extension of Leave:

- **Section 1**: Employee completes, prints and signs form. Attaches Certification of Health Care Provider/Doctor's Note, if available, and forwards a hard copy to Supervisor.
- **Section 1.a**: To be completed and signed by Supervisor. Complete Section 3 if employee has exhausted FMLA. Forwards page 1, 2 and 3 of the form and any documentation, if available to Departmental Payroll Clerk.
- **Section 2**: To be completed by Departmental Payroll Clerk.
  - If Employee meets FMLA Eligibility Requirements of: (a) worked for the County for at least 12 months and (b) worked for a minimum of 1250 hours in the 12 months immediately preceding the start of leave, and selects *box 1, 2, 3, 4, 5(a, b and c), 6, 7 or 8*, form is sent to Risk Management.
  - If Employee meets FMLA Eligibility Requirements and selects *box 5d, 9, 10, or 11* **OR** if Employee does **NOT** meet FMLA Criteria, a copy of the form is faxed or e-mailed to Risk Management and original form is returned to Supervisor to complete Section 3.
- **Section 3**: If not already completed, Supervisor/Manager/Dept. Head or Designee completes this section.
  - Supervisor approves or denies the leave of absence request form and forwards it to Manager.
  - If forwarded to Manager, he/she approves or denies it and forwards to Department Head.
  - Department Head or Designee approves or denies form.
  - Completed form is sent to Risk Management via FAX: 707-784-1988 or EMAIL: riskmanagement2@solanocounty.com.

B. Reporting an Employee Absence *when absence is or known to be greater than 3* full consecutive days:

- **Section 1 and 1.a.:** Supervisor completes, prints and signs form. Attaches Certification of Health Care Provider/Doctor's Note, if available and forwards to Departmental Payroll Clerk. If employee has exhausted FMLA, Section 3 must be completed.
- **Section 2:** To be completed by Departmental Payroll Clerk
  - If Employee meets FMLA Criteria listed above and supervisor/manager selects *box 1, 2, 3, 4, 5 (a, b and c), 6, 7 or 8,* form is sent to Risk Management.
    - ***If employee has leave accruals, mail copy to employee with cover letter within 48 hours of receipt of LOA form for employee to review, sign Section 1, and return within 10 calendar days of the letter. Once received, send a copy to Supervisor, Risk Management and Auditor/Controller's payroll.***
  - If Employee meets FMLA Eligibility Requirements and selects *box 5d, 9, 10, or 11* **OR** if Employee does **NOT** meet FMLA Criteria listed above, a copy of the form is faxed or e-mailed to Risk Management and original form is returned to Supervisor to complete Section 3.
- **Section 3:** If not already completed, Supervisor/Manager/Dept. Head or Designee completes this section
  - Supervisor approves or denies leave of absence and forwards form to Manager.
  - If forwarded to Manager, he/she approves or denies it and forwards to Department Head.
  - Department Head or Designee approves or denies form.
  - Completed form is sent to Risk Management via FAX: 707-784-1988 or EMAIL: riskmanagement2@solanocounty.com.

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SECTION 1: To be completed by employee requesting a leave of absence **OR** by Supervisor *after* the 3rd full consecutive day of employee absence OR by Supervisor upon notice the employee will be absent more than three consecutive days.

Employee Name/Job Title: ____________________

Employee. I.D. # ________ **FTE%:** ________ **Department/Division:** ____________________

Spouse Employed by County? ☐ **Yes** ☐ **No** **If yes:** ____________________
(Name)

Mailing Address: ____________________
(Number, Street, City, Zip Code)

Home Phone or Cell # ____________________ **Home E-mail:** ____________________

Supervisor's Name:____________________ **Supervisor's Phone #**: ____________________

Check applicable box:
☐ Initial Application **or** ☐ Extension of an existing LOA that began on ____________________
Month - Day – Year

First Full Day of Absence/Leave request beginning: ________________ **through and including:** ________________
Month - Day - Year / Month – Day – Year

Is this leave request for intermittent leave? ☐ Yes ☐ No

Leave requested for the following reason: *Check applicable box(es) 1-11*

1-☐ Work-Related Injury/Illness* *2-*☐ Medical condition for myself/Reasonable Accommodation*

3-☐ Pregnancy/birth*, adoption, or foster care placement - Estimated Due date ____________ *4-*☐ Baby Bonding**

5-☐ Family Illness*: a) child ☐ under 18 **or** ☐ over 18 – b)☐ parent – c) ☐ spouse – d) ☐other________________ (Check one)

6-☐ Military Qualifying Exigency/Caregiver under FMLA* *7-*☐ Organ Tissue Donation*

8-☐ Bone Marrow Donation* *9-*☐ Exhaustion of or Ineligible for FMLA/CFRA

10-☐ Course of Study *11-*☐Other: ____________________

Will you be applying for State Disability Insurance (SDI) or Paid Family Leave (PFL) through the State EDD office?
☐ Yes *If yes, select one*: ☐SDI or ☐ PFL (**A** copy of EDD payment stubs must be submitted to payroll) ☐ No

Leave Integration

a) While on a leave of absence which qualifies under Family Medical Leave Act (FMLA), or Pregnancy Disability Leave (PDL), or Discretionary leave all applicable accrued leave will be integrated during my leave of absence.

b) While on a leave of absence which qualifies under the California Family Rights Act (CFRA), and receiving State Disability Insurance (SDI) or Paid Family Leave (PFL), the County will integrate all applicable accrued leave during my leave of absence, *unless* I opt to not use my accruals by electing the box below:

☐ **Option** : I elect **NOT** to integrate all applicable accrued leave during my CFRA leave of absence
(*The effective date of this option will be applied upon receipt of request and it will not be retroactive)*

Attach Certification of Health Care Provider/Doctor's Note if available
(Completed certification form must be submitted within 15 calendar days of leave date or County's request)
***** Certificate of live birth***

Per my Memorandum of Understanding (MOU) or Personnel Salary Resolution (PSR), I acknowledge that I must continue to make any normal contribution to the cost of the health insurance premium and I am required to use ALL applicable leave balances before being approved for Non-FMLA leave *and* failure to return at the expiration of a leave of absence or being absent without leave shall be considered an automatic resignation.

Employee Signature: ____________________ **Date**: ________________

SECTION 1.a: To be completed by Supervisor – *If box 5d, 9, 10, or 11 are checked above, Section 3 must be completed.*

Employee's work schedule: Include number of hours worked per day

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Week 1							
Week 2							

Supervisor's Name: ____

Supervisor's Signature: ____ **Date**: ______________

SECTION 2: To be completed by Departmental Payroll Representative

Employee Date of Hire: ___________ Month-Day-Year

Actual hours worked previous 12 months: _______________________ *(The 12 months preceding the day of absence. Include regular and OT worked hours only)*

Accrued Leave Hours As of ______________ (Date): Month-Day-Year Sick ________ Vacation _________ Other ________

Certified by: (Print name) _________________________________ **Work Phone:** ______________ **Date:**___________

FMLA/CFRA Eligibility: Has worked for the County for at least 12 months and worked 1250 hours in the previous 12 months.

☐ **If Yes**, send form to HR/Risk Management via FAX: 707-784-1988 or EMAIL: riskmanagement2@solanocounty.com

If yes, and supervisor is reporting an employee absence and employee has accruals, cover letter and LOA form must be sent to employee within 48 hours of receipt of the LOA form. Employee has 10 calendar days from the letter to sign Section 1 and send it back to departmental payroll clerk. Once received, send copy to supervisor, Risk Management and Auditor/Controller's payroll.

☐ **If No**, send a copy to HR/Risk Management and return to Supervisor to complete Section 3, if not already completed.

NOTE: If leave is due to pregnancy, and employee is not eligible for FMLA, she is eligible for Pregnancy Disability Leave (PDL) and Section 3 is not required.

SECTION 3: TO BE COMPLETED BY SUPERVISOR IF EMPLOYEE **DOES NOT MEET** ELIGIBILITY FOR FMLA **OR** HAS EXHAUSTED FMLA **OR** REQUESTING DISCRETIONARY LEAVE. Once all applicable signatures have been gathered, *send completed form to HR/Risk Management* via FAX: 707-784-1988 or EMAIL: riskmanagement2@solanocounty.com

DEPARTMENTAL RECOMMENDATION*:*

☐ Approved ☐ Denied ____
(Print) Supervisor/Manager (Sign) Date

☐ Approved ☐ Denied ____
(Print) Deputy Director (Sign) Date

☐ Approved ☐ Denied ____
(Print) Department Head or Designee (Sign) Date

If Denied, state reason:

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SECTION 4: HR USE ONLY - DEPARTMENT OF HUMAN RESOURCES APPROVAL IS REQUIRED FOR LEAVE OF ABSENCE IN EXCESS OF THIRTY (30) CALENDAR DAYS OR SUCCESSIVE LEAVE REQUESTS.

Risk Analyst Recommendations and/or comments: ____

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Action: ☐ NOE ☐ Approved Dates:__________ /__________ ☐ Denied ☐ Other: ____________________
Month-Day-Year/ Month-Day-Year

Name of Risk Analyst: ______________________ Signature: ____________________ Date: ____________

Does request require HR Director's approval? ☐ Yes ☐ No

If yes, complete the following:

Request of leave beginning ____________ through and including ____________ Type of Leave ___________
Month-Day-Year Month-Day-Year

Extension of leave beginning ____________ through and including ____________ Type of Leave ___________
Month-Day-Year Month-Day-Year

Extension of leave beginning ____________ through and including ____________ Type of Leave ___________
Month-Day-Year Month-Day-Year

Extension of leave beginning ____________ through and including ____________ Type of Leave ___________
Month-Day-Year Month-Day-Year

Extension of leave beginning ____________ through and including ____________ Type of Leave ___________
Month-Day-Year Month-Day-Year

Extension of leave beginning ____________ through and including ____________ Type of Leave ___________
Month-Day-Year Month-Day-Year

Extension of leave beginning ____________ through and including ____________ Type of Leave ___________
Month-Day-Year Month-Day-Year

Extension of leave beginning ____________ through and including ____________ Type of Leave ___________
Month-Day-Year Month-Day-Year

Extension of leave beginning ____________ through and including ____________ Type of Leave ___________
Month-Day-Year Month-Day-Year

Extension of leave beginning ____________ through and including ____________ Type of Leave ___________
Month-Day-Year Month-Day-Year

Extension of leave beginning ____________ through and including ____________ Type of Leave ___________
Month-Day-Year Month-Day-Year

☐ Approved ☐ Denied ____ Date: ______________
Director of Human Resources

Comments: ____

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