REQUEST FOR LEAVE OF ABSENCE

SAN DIEGO COMMUNITY COLLEGE DISTRICT

***INSTRUCTIONS:* PLEASE PREPARE ONE COPY AND SUBMIT TO YOUR SUPERVISOR AND/OR MANAGER FOR CONSIDERATION.**

***IMPORTANT:* NOT ALL LEAVES ARE AVAILABLE TO ALL EMPLOYEES**

REFER TO APPROPRIATE BARGAINING AGREEMENT/HANDBOOK FOR INSTRUCTIONS AND REGULATIONS

EMPLOYEE NAME: (LAST, FIRST, MIDDLE)	BARGAINING UNIT	EMPLOYEE ID #	CLASSIFIED ☐ / ACADEMIC ☐

LOCATION NO.	LOCATION NAME:	POSITION TITLE:

START DATE	END DATE	NO. OF DAYS	NO. OF HOURS	TIME (FROM – TO)

Type of Leave [check appropriate box] and provide details as indicated. Only the employee should complete the form.

Any changes should be initialed by the employee.

☐ **Vacation**

Change to previously submitted request? ☐Y ☐N

Previous Dates:

☐ **Sick Leave**** *(may need verification from physician)* ☐ **Faculty Monthly** ☐ **Faculty Hourly**

☐ **Family Necessity Leave**** Care for unit member's sick child, parent, spouse or domestic partner. Leave, per calendar year, taken from Accrued, Full Salary Sick Leave only.

☐ **Personal Necessity Leave** ** (*may qualify for FMLA depending on circumstances*) Leave, per fiscal year, taken from Accrued, Full Salary Sick Leave only.

Comments/Reasons:

Relationship: ____________

Reason (*if required by agreement*) ____________

☐ **Comp Time**

Available balance ________ Remaining Balance ________ *(for office use only)*

SHORT-TERM LEAVE (NOT TO EXCEED 30 CALENDAR DAYS)

(paid, unless otherwise indicated)

☐ **Personal Business w/Pay**

☐ **Personal Business w/out Pay**** (*may qualify for FMLA depending on circumstances*)

☐ **Adoption/Paternity/Parental Leave** ** ☐ w/pay (One day paid leave) ☐ w/out pay (not to exceed 30 days)

☐ **Bereavement Leave** -- (indicate # of travel miles ________)

☐ **Short-Term Military Leave** (not to exceed 30 workdays)

☐ **Court Appearance** (other than litigant)

☐ **Jury Duty**

Comments/Reasons:

Relationship: ____________

Attach Orders

Attach supporting documents

LONG-TERM LEAVE (In excess of 30 CALENDAR DAYS)

(unpaid unless otherwise indicated)

☐ **Health Leaves - including leave due to pregnancy****

☐ **Family/Parental** ** *(not qualifying for FMLA/CFRA)*

☐ **Professional Study Leave**

☐ **Service to Other Public Agencies & Institutions**

☐ **Long-Term Military Leave** - more than 30 workdays per college year (First 30 days paid)

☐ **Other (specify reason)** - at Chancellor's discretion

Comments/Reasons:

Relationship: ____________

Attach Materials Outlined in Agreement

Attach Orders

Specify reasons: ____________

OTHER LEAVE OF ABSENCE

☐ **On The Job Injury/Industrial Accident *****(requires physician's signature below)***

☐ **Employee Organization Leave**

☐ **Union-Paid Release Time**

☐ **District Off-site Activity (**District interviews, workshops, staff development meetings*)*

Date of Injury: ____________

Name of Organization: ____________

Identify Union: ____________

Identify District Activity: ____________

GENERAL INFORMATION – FMLA/CFRA

Family Medical Leave Act (FMLA)/California Family Rights Act (CFRA) **

- Birth of a child/Care of newborn **Date of Birth** ____________
- Care for employee's parent, child, spouse or domestic partner
- Adoption, placement or Foster care (with employee) **Date of Adoption** ____________
- Serious health condition of employee *(Note: CFRA does not include pregnancy or related medical conditions within definition of serious health condition.)*

GENERAL INFORMATION – FMLA/PDL

Family Medical Leave Act (FMLA)/Pregnancy Disability Leave (PDL)**

- Pregnancy that makes absence from work medically necessary

****NOTIFICATION: THIS LEAVE CONSTITUTES NOTIFICATION FOR FMLA AND/OR CFRA QUALIFYING EVENTS, PROVIDED THE EMPLOYEE IS QUALIFIED. PLEASE BE ADVISED THAT THE LEAVE WILL RUN CONCURRENTLY WITH ANY AVAILABLE FMLA AND/OR CFRA LEAVE. SEE REVERSE FOR QUALIFYING REQUIREMENTS.**

EMPLOYEE'S SIGNATURE ____________ DATE ________ MANAGER'S/SUPERVISOR'S SIGNATURE ____________ DATE ________

(*Please read the notice on page two of this form)*

(For Long-term Unpaid Leave of Absence for "Other") CHANCELLOR'S SIGNATURE ____________ DATE ________

Physician's Certification: I certify that the above named person was unable to work during the above period.

PHYSICIAN'S SIGNATURE ____________ LICENSE NO. ____________ DATE ________

Distribution: ORIGINAL: TIMEKEEPER PHOTOCOPY: SUPERVISOR PHOTOCOPY: EMPLOYEE

NOTICE TO EMPLOYEES REQUESTING FAMILY AND/OR MEDICAL LEAVE OF THEIR SPECIFIC RIGHTS AND OBLIGATIONS

[Refer to your appropriate bargaining agreement/handbook for more detailed instructions.]

1. In order to qualify for Family Medical Leave Act and/or the California Family Rights Act you must (a) have been employed by the District for at least 12 months and have worked a minimum of 1250 hours of service during the 12-month period immediately preceding the commencement of the leave. **NOTE:** The District has adopted the "rolling 12 month period" for determining eligibility. This means that the District will measure back 12 months from the date of the qualifying event.

2. Any District-approved leave of absence that you take, paid or unpaid, that is FMLA/CFRA qualifying will run concurrently with the leave provided under your annual 12-week federal Family Medical Leave Act ("FMLA") entitlement and your annual California Family Rights Act ("CFRA") entitlement. Hereinafter this notice shall refer to both leaves as FMLA. EXCEPTION: Female employees are allowed up to 28 weeks (FMLA/CFRA 12 weeks plus PDL 16 weeks) for reasons of pregnancy, childbirth or related medical conditions. Unit members wishing to take FMLA/PDL must provide the District with at least thirty (30) days advance notice before the leave begins if the need for leave is foreseeable.

3. If you are requesting federal FMLA leave due to your own serious health condition or a serious health condition of a family member, you must provide a medical certification regarding the nature of the illness with submission of this form.

4. You are required to provide re-certification of the serious health condition every 30 days or, under certain circumstances, before 30 days. Failure to provide a medical certification may result in denial of your leave or the continuation of your leave until the certification is provided.

5. Medical certification need not identify the serious health condition but shall contain: (a) date, if known, on which the serious health condition began; (b) probable duration of the condition; (c) an estimate of the amount of time which the health care provider believes the employee needs to care for individual requiring care; and, (d) a statement that the serious health condition warrants the participation of the employee to provide care during a period of treatment or supervision of the child, parent or spouse. If the medical certification of the serious health condition is for the employee, the certification shall also include whether the employee is able to work at all or is unable to perform any one or more of the essential functions of his or her position.

6. You may be required to provide a fitness-for-duty certification before you will be restored to employment.

7. You may be required by the SDCCD to substitute accrued vacation or other paid leave in place of your FMLA leave if you are eligible for the paid leave according to your bargaining agreement. Such paid leave will be counted against your FMLA entitlement.

8. You are entitled to restoration after FMLA leave to the same or equivalent job upon return from leave. However, after your FMLA leave has been exhausted, if you continue on some other form of unpaid leave, you may not be entitled to be restored to your position.

9. If applicable, you will be required to continue paying your share of your regular health insurance premiums to maintain your health benefits during FMLA unpaid leave. The Benefits Office at the inception of your FMLA will bill you. If your health insurance is District paid, you will continue to be covered during FMLA unpaid leave.

10. You may be liable for the payment of health insurance premiums paid by the SDCCD during your FMLA leave if you fail to return to work after taking FMLA leave. If payment is required the Benefits Office will bill you.