EMPLOYEE REQUEST FOR FAMILY/MEDICAL LEAVE

(application shall be made 30 days in advance unless emergency exists)

Employee Name		Date:
Department Name:		
Position Title		Hire Date:

I request a Family/Medical Leave for the following reason (check one):

☐ A. The birth of a child and/or in order to care for such child.

Child's name: _____ Birth date: _____

☐ B. The placement of a child for adoption or foster care.

Child's name: _____ Birth date: _____

For A or B, is your spouse a County employee? Yes ☐ No ☐

If so, will he/she be requesting family leave? Yes ☐ No ☐

Spouse's Name: _____ Department: _____

☐ C. In order to care for an immediate family member because such family member has a serious health condition. Check one: ☐ CHILD ☐ SPOUSE ☐ PARENT ☐ DOMESTIC PARTNER (Must submit "Physician Certification" within 15 calendar days)

☐ D. Care for an adult child who is incapable of self care. (A Child is "incapable of self care" if he/she requires active assistance or supervision to provide daily self care in three or more activities of daily living or instrumental activities of daily living, such as caring for grooming and hygiene, bathing, dressing, eating, cooking, cleaning, shopping, taking public transportation, paying bills, maintaining a residence, using telephones and directories, etc.)

☐ E. Employee's own serious health condition that makes the employee unable to perform the functions of his/her position. (Must also submit "Physician Certification" within 15 calendar days and "Permission to Contact Personal Health Care Provider" forms)

☐ F. 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. Check one: ☐ CHILD ☐ SPOUSE ☐ PARENT (Must submit "Certification of Qualifying Exigency and active duty orders)

☐ G. To care for a child, spouse, parent or "next of kin" service member 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). Check one: ☐ CHILD ☐ SPOUSE ☐ PARENT ☐ NEXT OF KIN (Must submit "Certification" from Department of Defense or Department of Veteran Affairs within 15 days)

METHOD OF LEAVE REQUESTED

☐ A. Consecutive Leave

☐ B. Intermittent or Reduced Leave Schedule (Specify Requested Schedule Below)

Leave Start Date: _____ Expected Duration of Leave: _____

If the duration of my family/medical leave (total of paid and unpaid time) does not exceed 12 weeks (or 26 weeks to care for an injured service member), I will be returned to my same or equivalent position. ***I understand that if my family/medical leave should exceed 12 weeks (or 26 weeks to care for an injured service member), I will be returned to my same or equivalent position, only if available. If my same or equivalent position is not available, I understand that I may be terminated.***

Date: _____

Employee's Signature: _____

Print Name: _____

Please be sure to contact the Human Resources Department, Employee Benefits Division (568-2818) to arrange for payment of your insurance premiums while you are on a leave of absence. *If you do not return to work after your leave is over, the County has the right to recover its share of health plan premiums for the entire leave period, unless you do not return because of the continuation, recurrence or onset of a serious health condition for you or your family member which would entitle you to leave, or because of circumstances beyond your control. Santa Barbara County shall have the right to recover premiums through deduction from any sums due to you (e.g. unpaid wages, vacation pay, etc.).* ***I understand that a failure to return to work at the end of my approved leave of absence may be treated as a resignation unless an extension has been agreed upon and approved by my department head. I further authorize the County of Santa Barbara to deduct any premiums owed from any sums due to me if I cease employment.***

Employee Signature _____

Leave is: ☐ Approved ☐ Denied

_____

Department Head / Supervisor Signature

Please Note: Send copies to Human Resources, Employee Benefits Division & the County Retirement Office.