CITY OF OXNARD CALIFORNIA

CITY OF OXNARD
LEAVE OF ABSENCE REQUEST FORM

Employee (print name):_____ Employee ID number:_____

Phone number:_____Email:_____

Union:_____Department:_____

☐ Request for **NEW** leave of absence from_____to_____
first day off after last day of work *first day back at work*

Requesting: ☐ Consecutive ☐ Intermittent leave of absence

REASON FOR REQUEST: (check one below)

☐ Your own serious health condition ☐ Workers Compensation Leave? ☐ YES ☐ NO

☐ Because you are needed to care for your ☐ spouse ☐ child ☐ parent due to his/her serious health condition.

☐ The birth of a child, or placement of a child with you for adoption or foster care, DUE DATE

Bonding (check one) ☐ Newborn ☐ Adoption ☐ Foster Care Placement ☐ Date Acquired/Born:

☐ Service members Family Leave (checks one below and attach military orders and/or certification)
- ☐ Due to qualifying exigency of spouse/child/parent
- ☐ Due to serious injury/illness of spouse/child/parent/next of kin

☐ Other reason (including personal, educational, death of a family member, etc.)

Explain:_____

I affirm that I have read, understand and agree to the terms of the Authorization as stated above and the reverse side of this form. I have been given a copy of the Family Medical Leave Act (FMLA), California Family Rights Act (CFRA) and if applicable the (PDL) California Pregnancy Disability Leave Notice to Employees. In order to determine whether leave is covered under the FMLA, the City of Oxnard requests that the leave be supported by a certification. If the certification is incomplete or insufficient, the city will state in writing what additional information is necessary to make the certification complete and sufficient.

Annual leave pay may be substituted for all or a portion of the unpaid leave in accordance with appropriate policies/contracts. While on leave I understand that I am responsible for payment of my customary portion of benefit premiums or other payroll deductions. If I fail to make payments on a timely basis, coverage will be cancelled until I return from leave and deductions resume.

Employee Signature:_____Date:_____

Printed name of Supervisor:_____ Signature_____ Date:_____

Printed name of Department Director:_____ Signature:_____Date:_____

******signatures above does not constitute leave request as being approved***

HUMAN RESOURCES USE ONLY

FMLA (Family Medical Leave Act) & CFRA (California Family Rights Act) ELIGIBILITY INFORMATION:

1. Has the employee worked 1,250 hours for the City within the past 12 months? ☐ No ☐ Yes How many hours_____

   If yes, has the employee worked for the City for a total of at least 12 months, including previous periods of employment? ☐ No ☐ Yes Hire date_____

2. Has the employee been on FMLA/CFRA Leave during the current calendar year? ☐ No ☐ Yes Number of pay periods_____

3. Does the Leave requested now qualify under FMLA/CFRA guidelines? ☐ No ☐ Yes

4. What type of FMLA/CFRA Leave is requested? ☐ Regular ☐ Intermittent

5. What date & method was the Leave of Absence Handbook provided? ☐ Given ☐ Mailed Date_____

ELIGIBILITY APPROVED: (check all that apply) ☐ FMLA ☐ CFRA ☐ PDL

☐ **APPROVED** ☐ **DENIED**

Human Resources Representative Signature:_____ Date:_____

READ THE TERMS BELOW CAREFULLY BEFORE SIGNING ON THE REVERSE SIDE

1. I understand that I am bound by all the terms and conditions of the City's Personnel Policies and that the City has the right to grant or deny any request for a leave of absence or an extension thereof, subject to provisions of the Federal Family Medical Leave Act, the State Family Rights Act, the State Pregnancy Disability Leave rights, applicable collective bargaining agreements. I must give at least 30 days advance notice. Requesting leave less than 30 days in advance, I must give notice as soon as reasonably possible (generally either the day you learn of the need or the next work day).

2. I understand and agree that if I fail to return to work at the end of the approved leave period, I will repay any health insurance premiums paid by the City during the portion of my unpaid leave which is subject to the provisions of the Family Medical Leave Act (I understand that repayment may not be required under "circumstances beyond my control").

3. I understand that I may be required to make premium payments directly to the City 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 City mistakenly pays premiums on my behalf, I agree to repay the City directly or through wage/salary deduction.

4. I understand that the failure to return to work on the "first day due back at work" may be considered inexcusable absence without leave and subject to disciplinary action. I also understand that if I am absent from work without authorization for three (3) consecutive work days beginning with the "first day due back at work" I have entered on the front of this form, the City may deem that I have voluntarily abandoned my job under section 8.7, of the City of Oxnard Personnel Rules and Regulations.

5. I understand that failure to provide a complete and sufficient medical certification or requested documentation 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 my department 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.

6. Employees will be prohibited from using leave bank hours that result in pay that is greater than their biweekly base rate. I understand that the appropriate use of your leave bank hours must be because of, and consistent with, the leave granted and that I have provided my department with request for pay instructions during my paid leave of absence. During a leave of absence, no overtime will be permitted.

7. I understand that my dependent(s) eligibility for health care coverage is contingent on my submitting the proper forms within 31 days of (1) acquiring a new dependent (birth, marriage, placement for adoption, permanent legal custody), (2) a current dependent losing eligibility (divorce, loss of student status, 26th birthday), even when the event occurs during my leave of absence.

8. I understand that I must comply with health plan, Flexible Benefits Program, and Open Enrollment rules even if I am on leave of absence. Any applicable forms must be completed and submitted during the open enrollment period, failure to comply may jeopardize my participation.

9. I agree to notify my department of any change of address and/or phone number. I understand and agree that all communications from the City of Oxnard will be sent to the address I have on file and that I am responsible for acknowledging information sent to the address on file.

10. Paid leaves, holidays, fringe benefits, and other similar benefits do not accrue during the period of unpaid absence, nor is the City required to maintain contributions toward group insurance or retirement coverage, except as provided otherwise by law or the Personnel Rules. Any leave of absence exceeding five (5) working days shall extend the probationary period equal to the corresponding amount of leave.