Human Resources & Employee Relations
14000 Fruitvale Avenue
Saratoga, California 95070

OPERATIONAL PROCEDURES FOR A LEAVE OF ABSENCE

COMPLETE THE REQUEST FOR LEAVE OF ABSENCE FORM AND SUBMIT ANY REQUIRED DOCUMENTS THAT ARE APPLICABLE TO YOUR LEAVE.

A. If leave is requested for your own serious health conditions, you must provide a **Physician's Verification Form** (see attached) from a health care provider stating:
   a. the date the condition began.
   b. the probable duration of the condition.
   c. a statement that due to the serious health condition, you are unable to perform one or more of the essential functions of your job.

B. If leave is requested for pregnancy disability, you must provide a **Physician's Verification Form** (see attached) from a health care provider stating:
   a. the date the disability began.
   b. the probable duration of the disability.
   c. a statement that due to the disability, you are unable to perform one or more of the essential functions of your job.

C. If leave is requested for the serious illness of a child, or for a serious health condition of a parent or spouse, you must provide a **Medical Certification Statement** (see attached) from a health care provider specifying all of the following:
   a. the date on which the condition began,
   b. the probable duration of the condition,
   c. an estimate of the amount of time the health care provider believes you will need to care for the individual,
   d. a statement from the health care provider that the serious illness or health condition warrants the participation of a family member.

D. If leave is requested for adoption, you must provide certification from the adoption agency stating the date the adoption began.

E. If leave is requested by an employee to take a reduction in work hours, you must complete the attached Leave of Absence Request Form.

Note: Please check with the Benefits Specialist regarding your benefits before submitting this form.

AFTER YOU HAVE COMPLETED THE LEAVE OF ABSENCE REQUEST FORM AND HAVE ATTACHED ALL APPROPRIATE DOCUMENTS, FORWARD TO YOUR IMMEDIATE SUPERVISOR WHO WILL THEN FORWARD TO HUMAN RESOURCES.

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LEAVE OF ABSENCE REQUEST FORM

NAME: _____ DEPARTMENT: _____

BANNER ID #: _____ CAMPUS: _____

Beginning Date of Leave: _____ Ending Date of Leave: _____

☐ CLASSIFIED ☐ ACADEMIC

→ **Note: All leaves are unpaid unless you choose to apply accrued sick/vacation/bank towards your leave.**

Reason for Leave (Check one): ☐ PAID LEAVE ☐ UNPAID LEAVE

☐ a.) Pregnancy Disability Leave *(attach a copy of the Physician's Verification Form).*

☐ b.) Bonding or adoption of a child, or the receipt of a child to foster care, within one year of such birth or placement *(for adoption, attach a copy of the certificate from the adoption agency).*

☐ c.) The employee's own serious health condition that makes it impossible to perform essential job functions *(attach a copy of the Physician's Verification Form).*

☐ d.) A serious health condition of an employee's eligible child, spouse, parent or member of the immediate household which requires the employee to care for the family member *(attach a copy of the Medical Certification Statement Form).*

☐ e.) Military Leave *(attach a copy of the military orders).*

☐ f.) Other (specify below).

Explanation: Would like to apply sick/vacation hours and or bank (for faculty only) towards unpaid leave to receive full or partial pay (include this verbiage if you mark box for "Paid Leave" or delete if you do not want to use sick/vacation/bank accruals to be paid while on leave and mark "Unpaid Leave")

Note: If the employee's leave of absence constitutes a reduction in FTE, then the employee shall be responsible for paying the percentage (%) of reduction towards their benefits.

Employee must provide the Director of Human Resources fourteen (14) days notice of their intent to return to work. This notice will include a statement from the physician affirming the worker's ability to resume the duties of his / her job description.

I concur with the terms and conditions of the leave and understand that it will be my obligation to return to District employment on the working day following the ending date of the leave or the date as indicated on the medical release form. I am aware that failure to return from leave may be construed as abandonment of the employee's position.

_____ _____
Signature of Employee Date

☐ RECOMMENDED ☐ NOT RECOMMENDED

_____ _____
Signature of Supervisor Date

_____ _____
Signature of Associate Vice Chancellor or Designee Date

Cc: Benefits, Supervisor, Employee

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Use this form when the leave is due to your own serious medical illness.

PHYSICIAN'S VERIFICATION FORM

_____ is not physically able to work in his / her present position
(Patient's Name)

effective _____ through _____ due to the following reason(s):
(Date) (Date)

_____

_____

_____

_____

_____

_____

_____

_____ _____
Print Name of Health Care Provider Signature

_____ _____ _____
Date Phone Number State License Number

Please return this form to the Human Resources Department.

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Use this form only if your leave is to care for a direct family member.

MEDICAL RELEASE

I authorize the release of any medical information necessary to process this request.

Patient's Signature _____ Date _____

MEDICAL CERTIFICATION STATEMENT

Name of Employee: _____

Is this Certification for the ❑ Employee or for the ❑ Ill Family Member?

Name of Ill Family Member (patient): _____

Date Condition Began: _____ Date Condition Ended: _____
(or is expected to end)

Medical facts regarding the condition: _____

Explanation of extent to which employee is unable to perform the functions of his / her job:

Print Name of Health Care Provider _____ Signature _____

Date _____ Phone Number _____ State License Number _____

Please return this form to the Human Resources Department.