City of Carson
REQUEST FOR LEAVE OF ABSENCE

NAME: _____ DEPARTMENT: _____

POSITION: _____ ID#: _____ PHONE: _____

HOME ADDRESS: _____ CITY: _____ ZIP: _____

SUPERVISOR'S NAME: _____ HIRE DATE: _____

REASON FOR LEAVE REQUESTED:

☐ Continuous period of leave for Employee's own serious health condition that makes the employee unable to perform the functions of his/her position. (Must attach completed Physician Medical Certification - Employee form.)

☐ Continuous period of leave to care for (Check one): ☐CHILD ☐SPOUSE ☐PARENT ☐DESIGNATED PERSON. (Must attach completed Physician Medical Certification - Family Member/Designated Person form.)

☐ Intermittent period of leave for a serious health condition of ☐ Self ☐ Family member ☐ Designated Person. (Must attach Physician Medical Certification - Employee form for employee OR Family Member/Designated Person form.)

☐ Birth or adoption of a child and/or to care for such child. (Requires proof of birth or adoption.)

☐ Military (Attach copy of military leave orders/paperwork.)

☐ Military Caregiver Leave. Circle one: CHILD – SPOUSE – PARENT – NEXT OF KIN (Attach Physician Medical Certification – Military Family Leave form, Invitational Travel Order, or Invitational Travel Authorization.)

☐ Qualifying Exigency Leave. * Circle one: CHILD – SPOUSE – PARENT (Attach copy of active-duty orders and certification providing facts related to qualifying exigency for which leave is sought.)

☐ Personal Leave - Reason: _____

DATE LEAVE IS TO BEGIN: _____ DATE LEAVE IS TO END: _____

*Approval of leave will run concurrent with Family Medical Leave Act (FMLA) and California Family Rights Act (CFRA) if employee qualifies.

PLEASE READ CAREFULLY:

1. **If you would like your union representative notified that you are applying for disability benefits through Cigna please initial _____.**
2. **If you are unable to return to work on the scheduled date, you must submit a request to extend the leave of absence two working days prior to the leave ending date.**
3. **For an unpaid leave of absence over a certain number of days, you will not continue to receive benefits which accrue with service time (i.e., vacation, sick leave, seniority) during that time. If you choose to use your accrued time there will be no change in your accrual of time related benefits. You must contact the Human Resources Department to be advised on how your insurance and time related benefits may be impacted.**

I have read and understand the instructions and procedures regarding leaves of absence and that I am attesting that all information contained herein is truthful to the best of my knowledge. I further understand if I provide misinformation I may be disciplined, up to and including termination. I am aware that any selections made cannot be changed retroactively.

Employee Signature: _____ Date you provided notice of leave to your supervisor (May be written or verbal): _____

Department Acknowledgement

Comments: _____

_____ _____ _____

Supervisor Date

_____

_____ _____ _____

Department Director Date

DEPARTMENTS: PLEASE TIME & DATE STAMP FORM UPON RECEIPT FROM EMPLOYEE