

**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 immediate family member who has a serious health condition. Circle one: CHILD – SPOUSE – PARENT. * (Must attach completed Physician Medical Certification - Family Member form.)
- Intermittent period of leave for a serious health condition of Self OR Family member.* (Must attach Physician Medical Certification - Employee form for employee OR Family Member form for family member.)
- 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 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.
2. I request to use my accrued sick leave ____, vacation ____, and/or comp time ____ during my leave (Until short-term disability benefits begin, if applicable).
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 health 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 _____ Supervisor _____ Department Director	Date _____ Date _____	Comments: _____ _____ _____
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DEPARTMENTS: PLEASE TIME & DATE STAMP FORM UPON RECEIPT FROM EMPLOYEE