EMPLOYEE REQUEST FOR FAMILY/MEDICAL LEAVE

Application shall be made 30 days in advance if the need for leave is foreseeable)

Employee Name:		ID#:
Department Name:		
Position Title:		Hire Date:
Personal Email:		Date:

IMPORTANT: While out on a leave the Employee Benefits & Wellness Division would appreciate your personal email address so you can be notified about outstanding leave balances and/or open enrollment details if applicable.

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: _____ Birthdate: _____

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

Child's name: _____ Birthdate: _____

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, INCLUDING AN ADULT CHILD OR THE CHILD OF A DOMESTIC PARTNER ☐ SPOUSE ☐ PARENT ☐ DOMESTIC PARTNER ☐ GRANDPARENT ☐ GRANDCHILD ☐ AND ☐ SIBLING (Must submit "Physician Certification" within 15 calendar days)

☐ **D.** Employee's own serious health condition that makes the employee unable to perform the functions of his/her position. (Must also submit "Certification of Health Care Provider" form within 15 calendar days.

☐ **E.** To assist a child, spouse, or parent who is a member of the Armed Forces of the United State, National Guard or Reserves with a "qualifying exigency" related to active duty or a call of active duty status. **Check one:** ☐ CHILD ☐ SPOUSE ☐ PARENT ☐ DOMESTIC PARTNER (Must submit "Certification of Qualifying Exigency and active duty orders)

☐ F. To care for a child, spouse, parent or "next of kin" servicemember of the United States Armed Forces, National Guard, or Reserves 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" supporting the leave request 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: _____

Date: _____

Employee's Signature: _____

Print Name: _____

Please be sure to contact the Human Resources Department, Employee Benefits Division (805) 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.

Employee Signature _____

Leave is: ☐ Approved ☐ Denied

_____

Department Head / Supervisor Signature

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