

CITY OF CALEXICO
REQUEST FOR LEAVE OF ABSENCE

Name:	Last 4 digits of Social Security #:	Date:
Job Title: DOT <input type="checkbox"/>	Department:	Bargaining Unit:
Immediate Supervisor:	Email Address:	Date of Hire:
Mailing Address:	Daytime/Cell Number: ()	

Initial Request *Extension Request*

Date Leave of Absence Begins:	Date Leave of Absence Ends:	Expected Return to Work Date:
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Leave Requested is: <input type="checkbox"/> With pay <input type="checkbox"/> Partial pay #_hrs per pp <input type="checkbox"/> Without Pay ** Contact HR to arrange insurance premium payments during leave	If leave is with pay, use hours as follows: <u>Accrued Sick Leave</u> <u>Accrued Vacation</u> <u>Accrued Comp Time</u> <u>Accrued Admin Leave</u> _____ Hrs pay period _____ Hrs pay period _____ Hrs pay period _____ Hrs pay period Period Starting _____ Period Ending _____ ** Please attach pay schedule if needed
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Type of Leave: (circle one)

1. Illness/Injury-Not Work Related	4. Pregnancy Disability	7. Military	10. Personal
2. Illness/Injury-Work Related ** Only of claim has been approved or accepted	5. Newborn Bonding	8. Bereavement	11. Other
3. Care for ill Parent/Spouse/Child/ Domestic Partner	6. Adopting/Foster child Bonding	9. Educational	

Provide Details of Request (Including requested intermittent or reduced work schedule):

I voluntarily request a leave of absence for the reason(s) stated above. I understand my rate of pay will be subject to any general increases or decreases in wage rates that become effective during my absence from work; that I am not to accept any other employment of any kind that my return to work will be subject to employment conditions existing at the time of such return.

I (_____) employee's initials) understand that the leave reasons numbers 1 to 6 will be designed as FMLA/CFRA leave if I meet the criteria (medical certification may be required) and that my FMLA/CFRA leave will begin on the first day of the qualifying leave. I further understand that it is my responsibility to make arrangements with the Human Resources Department for payment of group insurance premiums during this leave period, if necessary.

Signature: _____ Date: _____

Department Head

Approve _____ Not Approve _____ Signature _____ Date _____
 Comments: _____

Human Resources Department

Approve _____ Not Approve _____ Signature _____ Date _____
 Comments: _____

Eligible for FMLA/CFRA Yes _____ No _____