TULARE COUNTY

LEAVE OF ABSENCE REQUEST FORM

Employee Name_____ Date of Request_____

Department Probation Position Title_____ EE ID _____

Contact Phone Number While on Leave:_____

In order to be considered for a leave of absence, the requested information on this form must be provided and approval received from the Department Head prior to the requested leave commencing, unless an emergency exists. All requests will be evaluated for eligibility with applicable leave provisions and if your request meets the employment standards for leave protection, provisions of the leave acts will commence the date of your request. Employees requesting a medical leave of absence may be expected to use accrued sick leave benefits before a leave without pay may begin. A Department Head may require vacation leave balances to be used before leave without pay begins. Compensatory Time Off (CTO) usage may only occur with employee approval. (Note: Not all bargaining units/employee classifications earn CTO.) Vacation usage, while on a workers compensation leave, may only occur with employee approval.

An employee intending to take family or medical leave because of an expected birth or placement, or because of a planned medical treatment, must submit an application for leave at least thirty (30) days before the leave is to begin. If leave is to begin within thirty (30) days, an employee must give notice to his or her immediate supervisor as soon as the necessity for the leave arises.

If you have a current CTO balance, do you authorize use of CTO during your medical leave of absence? Yes_____ No_____

I request Leave for the following reason (check one):

_____ **A.** The birth of a child. Estimated DOB: _____

_____ **B**. Bonding. Childs DOB: _____

_____ **C.** The placement of a child for adoption or foster care (Must submit verification of adoption/date of placement)

_____ **D.** In order to care for an immediate family member because such family member has a serious health condition. Relationship: _____ **(Must submit "Physician Certification".)**

_____ **E.** Care for an adult child who is incapable of self care. **(Must submit "Physician Certification".)**

_____ **F.** Employee's own serious health condition that makes the employee unable to perform the functions of his/her position. **(Must submit "Physician Certification".)**

_____ **G.** Military Leave of Absence. **(Attach a copy of your orders)**

_____ **H.** To assist a child, spouse, or parent who is a member of the National Guard or Reserves with a "qualifying exigency" related to active duty or a call of active-duty status in support of a contingency operation. Relationship: _____ **(Must submit "Certification" of Qualifying Exigency)**

_____ **I.** To care for a child, spouse, parent or "next of kin" servicemember of the United States Armed Forces who has a serious injury or illness incurred in the line of duty while on active duty (up to 26 weeks of leave). **(Must submit "Certification" from Department of Defense or Department of Veteran Affairs.)**

_____ **J.** To care for a designated person. This person will be my designated person for the next 12 months starting the date of leave commencement. Name of Designated Person: _____ **(Must submit "Physician Certification".)**

_____ **K.** Other: _____
(ie. Personal Leave, Organ Donor Leave, Domestic Violence Leave, School Leave, etc.)

Leave Information:
Date leave is to begin: _____ Expected Return to Work Date:_____

_____**A.** Consecutive Leave _____**B.** Intermittent or Reduced Leave Schedule (Specify schedule) _____

I understand that my restoration to employment is subject to the following conditions: 1) As a condition of restoration, I must provide a written certification from my health care provider that I am able to resume working. 2) For FMLA, CFRA and PDL covered leaves every attempt will be made to restore me to my original position. If my original position is unavailable, I will be placed in an equivalent position with equivalent pay and benefits. These conditions apply to returns from leaves of absence.

Employees are not permitted to work, including accessing County information or email accounts, while on leave of absence, except under terms and conditions specifically authorized by your department head or his/her "designee." Failure to comply with this directive may result in discipline up to and including dismissal.

Date_____ Employee's Signature_____

For further information, contact departmental coordinator: Sophia Renteria (Name) Probation HR (Department) 559-608-9016 (Phone Number)

LEAVE OF ABSENCE INTEGRATION SELECTION FORM

DATE: _____ LEAVE START DATE:_____

EMPLOYEE: _____ EE ID:_____

FROM: _____

You have recently requested or are currently on a Leave of Absence. In order to indicate the use of your paid time accruals while you are out on leave and to indicate if you will be integrating your accruals with temporary income replacement, such as State Disability Insurance (SDI) or Paid Family Leave (PFL), you will need to complete this form. The options available to you for the use of your accrued paid time while integrating will vary depending upon the type of leave you are on and if your leave has been qualified and designated under leave time protection, such as FMLA, CFRA, PDL, HWA, or Workers' Compensation.

In some instances you may have the option to not use your accruals during your leave of absence. Please note that when you are not using your accruals while you are out on leave you will be considered in an "unpaid" status. Electing to go "unpaid" (or "off payroll") may impact you in different ways, including, but not limited to the following:

- Your County Benefit Length of Service Date will be adjusted one pay period for every pay period you are "unpaid" and for every pay period in which you are paid less than 40 hours.
- Your TCERA retirement contributions will be suspended and an adjustment may be made to your County Service Time.
- If you are enrolled in Tulare County Employee Health Benefits, TCDSA Insurance plans, or TCPA Insurance plans:
    - You have the option to suspend your coverage while on leave.
    - If leave IS NOT time protected, your coverage will be suspended. You will be offered COBRA and will be responsible for 100% of the insurance premium cost.
    - If leave IS time protected, the County will apply the Flexible Benefit Amount towards your insurance premium to maintain coverage; However, you will be responsible to pay the difference in premium that exceeds your Benefit Amount. Non-payment of premium will result in suspension of your health coverage.
- If you are enrolled in a Flexible Spending Account, voluntary insurance plan through Chimienti & Associates, OR Deferred Compensation through Empower Retirement, you will need to make payment arrangements directly with the Providers in order to continue these benefits.
- It is important to contact the Benefits Unit –HRD at (559) 636-4911 prior to your leave to make arrangements for continued health insurance coverage and premium payments.

If I elect to go "unpaid/off payroll", I have read and understand the impacts to my Benefit Length of Service Date, my County Service Time, and the above mentioned Employee Health Plan I am enrolled in. I represent that I have carefully considered any other consequences of being "unpaid/off payroll" including those that are not listed above. I agree it is entirely my decision to be "unpaid/off payroll" and as a result, I am solely responsible for any consequences resulting from this decision. I acknowledge that the County is not liable for any such consequences. I further understand that once I make my selections for the use of my paid time accruals, I cannot change my selections for the duration of my leave.

_____

Employee Print Name

_____ _____

Employee Signature Date

BASED UPON THE TYPE OF LEAVE YOU ARE TAKING, PLEASE MAKE YOUR SELECTIONS ON THE FOLLOWING PAGE AS TO THE PAID TIME ACCRUALS YOU WILL BE UTILIZING WHILE ON YOUR LEAVE. FOR SOME LEAVES, YOU MAY HAVE THE OPTION TO GO "UNPAID/OFF PAYROLL."

Integration Selection

ALL LEAVES OTHER THAN BONDING:

1. I will be applying to receive : ☐ SDI ☐ PFL ☐ None (skip to #3)

2. If you **are applying** for SDI or PFL, which accruals do you designate to utilize for integration? *Check all that apply.(Please note that if you do not qualify for leave time protection, or have exhausted your leave time protection you will be required to use applicable accruals)*

   a. Employee's Serious Health Condition:
      ☐ Sick ☐ Vacation ☐ None ("unpaid/off payroll")
      ☐ CTO ☐ Personal Holiday
   b. Family Member's Serious health Condition:
      ☐ Sick ☐ Vacation ☐ None ("unpaid/off payroll")
      ☐ CTO ☐ Personal Holiday
   c. Pregnancy Disability Leave:
      ☐ Sick ☐ Vacation ☐ None ("unpaid/off payroll")
      ☐ CTO ☐ Personal Holiday

3. If you **are NOT applying for SDI/PFL or if FMLA/CFRA/PDL is exhausted/you are ineligible**, which accruals do you designate to utilize for integration? *Check all that apply. If box is checked, you are required to use that leave. If both Sick and Vacation are checked, sick accruals will be used first, then vacation.*

   a. Employee's Serious Health Condition:
      ☒ Sick ☒ Vacation
      ☐ CTO ☐ Personal Holiday
   b. Family Member's Serious health Condition:
      ☐ Sick ☒ Vacation
      ☐ CTO ☐ Personal Holiday
   c. Pregnancy Disability Leave:
      ☒ Sick ☐ Vacation
      ☐ CTO ☐ Personal Holiday

BABY BONDING LEAVES ONLY:

1. I will be applying to receive : ☐ PFL ☐ None (skip to #3)
2. If you **are applying for PFL**, which accruals do you designate to utilize for integration? *Check all that apply.*
   ☐ Vacation ☐ CTO
   ☐ Personal Holiday ☐ None ("unpaid/off payroll")
3. If you **are NOT applying for PFL**, which accruals do you designate to utilize for integration? *Check all that apply. If box is checked, you are required to use that leave.*
   ☒ Vacation ☐ CTO
   ☐ Personal Holiday

For questions regarding this Form, contact: _____Phone number_____

TULARE COUNTY

MEDICAL CERTIFICATION – EMPLOYEE'S FAMILY MEMBER'S SERIOUS HEALTH CONDITION

SECTION I: For Completion by the EMPLOYER

Employer name and contact: Tulare County Probation- HR Dept. / Sophia Renteria (559) 608-9016

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your family member or his/her medical provider. The State and Federal Leave laws permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for time pro leave to care for a covered family member with a serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of leave time protections. 29 U.S.C.§§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in denial of your leave request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this for to your employer. 29 C.F.R. § 825.305.

Employee's Name:_____ Contact Phone While on Leave:_____

Employee's Department:_____ Title:_____

Name of family member for whom you will provide care:_____
First Middle Last

Relationship of family member to you:_____

If family member is your son or daughter, date of birth:_____

Describe care you will provide to your family member and estimate leave needed to provide care:

_____

_____

_____

_____ _____
Employee Signature Date

SECTION III: For completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave to care for your patient. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a conditions, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you in; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine protected leave coverage. Limit your responses to the condition for with the patient needs leave. Do not provide information about genetic tests, as defined in 29 C.F.R § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e). Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address:_____

Type of practice / Medical Specialty:_____

Telephone: ( )_____ Fax: ( )_____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Probable duration of conditions: _____

   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? _____No_____Yes If so, dates of admission:_____

   Date(s) you treated the patient for conditions:_____

   Was medication, other than over-the-counter medication, prescribed?_____No_____Yes

   Will the patient need to have treatment visits at least twice per year due to the condition?_____No_____Yes

   Was the patient referred toother health care provider(s) for evaluation or treatment (e.g., physical therapist)? _____No_____Yes If so, state the nature of such treatments and expected duration of treatment:

   _____

   _____

2. Is the medical condition pregnancy? _____No_____Yes If so, expected delivery date: _____
3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

   _____

   _____

   _____

   _____

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? _____No_____Yes

   Estimate the beginning and ending dates for the period of incapacity: _____

   During this time, will the patient need care?_____No_____Yes

   Explain the care needed by the patient and why such care is medically necessary:

   _____

   _____

   _____

   _____

5. Will the patient require follow-up treatments, including any time for recovery?_____No_____Yes

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:_____

   _____

   _____

Explain the care needed by the patient, and why such care is medically necessary: _____

_____

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery?

   _____No_____Yes

   Estimate the hours the patient needs care on an intermittent basis, if any:

   _____hour(s) per day:_____days per week from_____through_____

   Explain the care needed by the patient, and why such care is medically necessary:

   _____

   _____

   _____

   _____

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities?_____No_____Yes

   Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

   Frequency:_____times per_____week(s)_____month(s)

   Duration:_____hours or_____day(s) per episode

   Does the patient need care during these flare-ups?_____No_____Yes

   Explain the care needed by the patient, and why such care is medically necessary: _____

   _____

   _____

   _____

   _____

   ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

   _____

   _____

   _____

   _____

   _____

Signature of Health Care Provider:_____Date:_____

Health Care Provider Address: _____

Health Care Provider Telephone:_____FAX:_____

Please return this form to Sophia Renteria / Probation HR Dept. **(Name/Department)**

Phone/FAX: (559) 608-9026/ Fax (559) 713-3750

Serious Health Conditions
Define by the Family Medical Leave Act

_____***Hospital Care***

Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

_____***Absence Plus Treatment***

(a) A period of incapacity of more than three consecutive, full calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:

(1) Treatment two or more times within 30 days of the first day of incapacity, unless extenuating circumstances exist, by a health care provider, by a nurse, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or

(2) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment (e.g., prescription medication or therapy with specialized equipment but not over-the-counter medications or salves, bed rest, fluid intake, or exercise.) under the supervision of the health care provider. The in-person treatment visit must take place within seven days of the first day of incapacity. *****

NOTE: As the accepted practice of the County, the leave process is triggered by an absence of 40 hours or more. While the Absence Plus Treatment scenario is FMLA qualified and only three days in duration, the County practice of using 40+ hours as a benchmark to start the LOA process will continue to be followed. However; there may be cases in which an employee will qualify for FMLA under Absence Plus Treatment with out meeting the 40+ hours as stated in the personnel rule. In these cases, FMLA should be designated to comply with the Act.

_____***Pregnancy***

Any period of incapacity due to pregnancy, or for prenatal care.

_____***Chronic Conditions Requiring Treatments***

A chronic condition which:

(a) Requires periodic visits (defined as at least twice a year) for treatment by a health care provider, or by a nurse;

(b) Continues over an extended period of time (including recurring episodes of a single underlying condition); and

(c) May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

_____***Permanent/Long-term Conditions Requiring Supervision***

A period of incapacity which is permanent or long term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

_____***Multiple Treatments (Non-Chronic Conditions)***

Any period of absence to receive multiple treatments (including any period of recovery there from) by a health care provider or by a provider of healthcare services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three full consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).