

REQUEST FOR LEAVE OF ABSENCE (PAGE 1 OF 2)

COMPLETE AND FORWARD TO YOUR SUPERVISOR/PERSONNEL REP AS SOON AS YOU ARE AWARE YOU MAY NEED LEAVE.

EMPLOYEE INFORMATION (FILL OUT ALL FIELDS!)

NAME:		DATE:
HOME ADDRESS:		CITY:
HOME/CELL PHONE:		ZIP:
DIVISION:	<input type="checkbox"/> F/T or <input type="checkbox"/> P/T	HOME EMAIL:
JOB TITLE:		EMPLOYEE ID #
DATE OF HIRE:	DAYS OFF:	SUPERVISOR:
DATES OF LEAVE REQUEST: FIRST DAY		LAST DAY
		STRAIGHT <input type="checkbox"/> INTERMITTENT <input type="checkbox"/>

REASON FOR LEAVE:

PREGNANCY/PRENATAL CARE/CHILD BIRTH

CARE/BONDING FOR YOUR NEWBORN CHILD AFTER BIRTH, PLACEMENT FOR ADOPTION OR FOSTER CARE. DOB: _____

YOUR OWN SERIOUS HEALTH CONDITION

CARE FOR: CHILD SPOUSE PARENT PARENT IN LAW OTHER (please specify) _____
 Family Member Name _____ Age (if child) _____
 Address _____ City, State, Zip _____

MILITARY QUALIFYING EXIGENCY – SERVICEMEMBER'S RELATIONSHIP TO YOU _____
 Family Member Name _____ Full Address _____

MILITARY CAREGIVER LEAVE – SERVICEMEMBER'S RELATIONSHIP TO YOU _____
 Family Member Name _____ Age (if child) _____ Full Address _____

TYPE OF LEAVE REQUESTED:

FAMILY MEDICAL LEAVE REQUEST and/or FAMILY LEAVE ACT (FMLA/FLA)
 Do you wish this leave to run concurrent with any paid benefits time? NO YES - Sick Comp Admin Vac
 Will you be requesting Disability Pool? NO YES If YES, you must submit the request form located in Policy 5.08 (III)

Will you be applying for FLI (STATE PAID FAMILY LEAVE INSURANCE)? NO YES
Unlike Federal Family Medical Leave (FMLA) and State Family Leave (FLA), State Family Leave Insurance (FLI) is a monetary benefit only – it is not a leave entitlement program. Your job is protected only when you utilize FMLA and FLA approved leave and FLI is running concurrently. If you exhaust all FMLA/FLA time, no rights to job reinstatement exist.
 If a waiting week applies, do you wish it to be unpaid? YES NO - If NO, indicate the type of time: Sick Comp Admin Vac

REGULAR MEDICAL LEAVE OF ABSENCE (FMLA NOT APPLICABLE): WITH PAY -or- WITHOUT PAY
 If you are required to pay the full monthly premium, please indicate whether you wish to have the benefits continued. YES NO

PHYSICIAN/HEALTH CARE PROVIDER NAME: _____ **PHONE:** _____

UNPAID PERSONAL (NON-MEDICAL) LEAVE OF ABSENCE
 Per Policy 5.08 (IX), please provide reason for leave: _____
 If you are required to pay the full monthly premium, please indicate whether you wish to have the benefits continued. YES NO

NJ SAFE ACT: Do you wish this leave to run concurrent with any paid benefits time? NO YES - Sick Comp Admin Vac

EMPLOYEE CERTIFICATION (PLEASE READ):

- I certify that the purpose of my leave is correctly stated above. I understand that falsely stating the purpose of my leave is grounds for disciplinary action up to and including termination of my employment. An employee who fraudulently obtains FMLA leave from an employer is not protected by the FMLA's job restoration or maintenance of health benefits provisions.
- I certify that I will not engage in other employment during any time period when I am absent and claiming the use of medical leave or FMLA and/or FLA protected leave, unless that is fully disclosed to my department, as my County employment is primary (See P.S. 5.08 (II) FMLA/FLA Policy).
- I understand that my FMLA and FLA time will run concurrently if my leave falls under both definitions – regardless of whether paid time is used, leave is unpaid, or FLI benefits are claimed. I understand that I am responsible for continuing to pay the bi-weekly cost share if I am on a leave of absence in an unpaid status, and if I do not pay my cost shares during my leave, the cost share will be paid back to the County upon return from leave through payroll deduction. Depending on the length and type of my leave, I may be responsible for the monthly premiums. If I do not pay the monthly premium, my benefits will be terminated. See P.S. 5.08 (IV) Unpaid Medical Leave and (IX) Unpaid Personal Leave.
- I hereby certify that the statements on the accompanying medical certification are accurate. If I have not yet submitted my medical certification, I hereby certify that I will review the certification my doctor provides and if anything contained therein is known to me to be false, I may be subject to penalties, up to and including termination of employment.

EMPLOYEE SIGNATURE: _____ DATE: _____

(REQUEST WILL NOT BE PROCESSED IF NOT SIGNED & DATED)

REQUEST FOR LEAVE OF ABSENCE (PAGE 2 OF 2)

EMPLOYEE NAME: _____ **DATE:** _____

FOR FMLA/FLA LEAVES OF ABSENCE, HUMAN RESOURCES WILL APPROVE OR DENY REQUESTS.
FOR ALL OTHER LEAVES, PLEASE INDICATE APPROVAL/DENIAL. IN ALL CASES, PLEASE SIGN AND FORWARD TO NEXT LEVEL.

SUPERVISOR SIGNATURE: _____ DATE RECEIVED: _____

DIVISION/OFFICE DIRECTOR:

Approved Denied

DIRECTOR'S COMMENTS:

SIGNATURE: _____ DATE: _____

DEPARTMENT HEAD:

Approved Denied

DEPARTMENT HEAD'S COMMENTS:

SIGNATURE: _____ DATE: _____

DIVISION OF HUMAN RESOURCES:

Approved Denied

COMMENTS REGARDING STATUS OF LEAVE REQUEST:

SIGNATURE: _____ DATE: _____

COUNTY ADMINISTRATOR:

Approved Denied

SIGNATURE: _____ DATE: _____

For Office Use Only:

Date Rec.:		
NOE Date:	DN Date:	
Ann. Date:	Hrs. Remain.:	