

EMPLOYEE INSTRUCTIONS FOR A LEAVE OF ABSENCE

WHAT IS A LEAVE OF ABSENCE?

A LEAVE OF ABSENCE IS ANY PERIOD OF TIME, PAID OR UNPAID, WHEN YOU WILL NOT BE AT WORK ON A CONTINUOUS OR INTERMITTENT BASIS DUE TO YOUR OWN SERIOUS HEALTH CONDITION OR TO CARE FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION.

YOU MAY BE ELIGIBLE FOR CERTAIN TYPES OF JOB PROTECTION AND/OR PAY WHILE OUT ON A LEAVE OF ABSENCE. THESE INCLUDE FAMILY MEDICAL LEAVE ACT (FMLA), CALIFORNIA FAMILY RIGHTS ACT (CFRA), PREGNANCY DISABILITY ACT (PDA), PARENTAL LEAVE AND FAMILY CARE (PLFC), AND/OR EXTENDED ILLNESS (EI). FOR MORE INFORMATION ABOUT LEAVE PROTECTION, PLEASE REFER TO YOUR BARGAINING AGREEMENTS AND THE DISTRICT WEBSITE AT WWW.SBCCD.ORG.

WHEN IS A LEAVE OF ABSENCE REQUIRED?

A LEAVE OF ABSENCE MAY BE REQUIRED FOR VARIOUS REASONS:

- YOUR OWN MEDICAL DISABILITY THAT WILL RESULT IN A CONTINUOUS ABSENCE OF **MORE THAN FIVE DAYS** (CSEA, CONFIDENTIAL, MANAGEMENT) OR **FIVE OR MORE DAYS** (CTA). IF YOU ARE ABSENT FOR LESS THAN THE ABOVE PERIOD, YOU ARE NOT REQUIRED TO REQUEST A LEAVE OF ABSENCE OR PROVIDE PROOF OF YOUR ILLNESS.
- YOUR OWN MEDICAL DISABILITY THAT WILL REQUIRE INTERMITTENT ABSENCES FOR LONGER THAN ONE WEEK
- THE NEED TO CARE FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION EITHER CONTINUOUSLY OR ON AN INTERMITTENT BASIS

WHEN DO I REQUEST A LEAVE OF ABSENCE?

- IF YOU WILL BE OUT FOR A **PLANNED EVENT** (SURGERY, PREGNANCY), YOU MUST REQUEST THE LEAVE OF ABSENCE AT LEAST 30 DAYS IN ADVANCE OR IMMEDIATELY UPON YOUR KNOWLEDGE OF THE NEED FOR A LEAVE.
- IF THE LEAVE IS **NOT PLANNED**, YOU MUST IMMEDIATELY REQUEST THE LEAVE UPON YOUR KNOWLEDGE OF THE NEED FOR A LEAVE.

WHAT FORMS ARE REQUIRED TO REQUEST A LEAVE?

1. LEAVE OF ABSENCE APPLICATION

- THIS FORM IS COMPLETED BY YOU. A COPY SHOULD BE GIVEN TO YOUR SUPERVISOR AND THE ORIGINAL SHOULD BE SENT TO THE HUMAN RESOURCES OFFICE.

2. CERTIFICATE OF HEALTH CARE PROVIDER

- THE TOP SECTION OF THIS FORM IS COMPLETED BY YOU. YOU MUST SIGN THE FORM TO AUTHORIZE THE DOCTOR TO RELEASE THE REQUESTED INFORMATION TO THE DISTRICT. THE REST OF THE FORM MUST BE COMPLETED BY THE APPROPRIATE DOCTOR. YOU MUST ALSO PROVIDE A COPY OF YOUR JOB DESCRIPTION TO YOUR DOCTOR, IF THE LEAVE IS FOR YOUR OWN MEDICAL CONDITION.
- THIS FORM SHOULD ONLY BE GIVEN TO HUMAN RESOURCES. YOUR MEDICAL INFORMATION IS NEVER REQUIRED TO BE GIVEN TO YOUR SUPERVISOR.

LEAVE FORMS AND YOUR JOB DESCRIPTION CAN BE FOUND ON THE DISTRICT WEBSITE AT WWW.SBCCD.ORG OR BY CONTACTING THE HUMAN RESOURCES OFFICE.

HOW WILL I KNOW IF MY LEAVE IS APPROVED?

YOU WILL RECEIVE A LETTER FROM HUMAN RESOURCES IDENTIFYING EITHER YOUR APPROVAL, OR REQUESTING ADDITIONAL INFORMATION. IF YOU HAVE ANY QUESTIONS ABOUT THE STATUS OF YOUR LEAVE, PLEASE CALL THE HUMAN RESOURCES OFFICE AT 909-382-4040.

HOW AM I PAID WHILE ON LEAVE?

PAY WHILE ON LEAVE IS BASED ON MANY FACTORS INCLUDING YOUR BARGAINING AGREEMENT. YOU SHOULD CONTACT PAYROLL IF YOU HAVE SPECIFIC QUESTIONS ABOUT YOUR PAY OR YOUR AVAILABLE SICK AND/OR VACATION HOURS/DAYS. GENERAL INFORMATION CAN BE FOUND ON THE DISTRICT WEBSITE AT WWW.SBCCD.ORG.

KEEP HUMAN RESOURCES AND YOUR SUPERVISOR INFORMED

IT IS YOUR RESPONSIBILITY TO PROVIDE UPDATED DOCUMENTATION TO HUMAN RESOURCES IF THE NEED FOR YOUR LEAVE CHANGES. IF YOU NEED TO EXTEND YOUR LEAVE, YOU SHOULD COMPLETE A NEW LEAVE OF ABSENCE APPLICATION AND PROVIDE UPDATED MEDICAL INFORMATION.

DO I NEED TO DO ANYTHING TO RETURN TO WORK?

THE DISTRICT REQUIRES THAT YOU PROVIDE A RETURN TO WORK NOTE, DATED WITHIN ONE WEEK OF YOUR INTENDED RETURN DATE. THE NOTE MUST BE PROVIDED TO HUMAN RESOURCES AT LEAST **TWO BUSINESS DAYS PRIOR** TO YOUR INTENDED RETURN DATE. THE NOTE MUST CLEARLY INDICATE IF YOU CAN RETURN TO WORK WITH OR WITHOUT RESTRICTIONS OTHERWISE YOU WILL NOT BE ALLOWED TO RETURN TO WORK.

IF YOU ARE GIVEN **WORK RESTRICTIONS** BY YOUR PHYSICIAN, THEY SHOULD CLEARLY STATE WHAT YOUR LIMITATIONS ARE, INCLUDING ANY RECOMMENDED CHANGE IN YOUR NORMAL SCHEDULE. BE CERTAIN YOU UNDERSTAND THESE LIMITATIONS AND THEY ARE CLEARLY WRITTEN ON YOUR RETURN TO WORK NOTE. THE DISTRICT AND YOUR SUPERVISOR WILL DETERMINE IF YOUR TEMPORARY RESTRICTIONS CAN BE ACCOMMODATED. IF YOUR RESTRICTIONS CANNOT BE ACCOMMODATED, YOU MUST REMAIN OFF WORK.

WHERE CAN I FIND ADDITIONAL INFORMATION ABOUT THE LEAVE PROCESS?

YOUR LEAVE ENTITLEMENT IS GOVERNED BY DISTRICT POLICY AS WELL AS THE BARGAINING AGREEMENTS. IN ADDITION TO THE POLICIES, THERE ARE HELPFUL CHARTS ON THE DISTRICT WEBSITE TO ASSIST YOU IN UNDERSTANDING YOUR RIGHTS WHILE ON DIFFERENT TYPES OF LEAVES. PLEASE VISIT WWW.SBCCD.ORG FOR MORE INFORMATION.

IF YOU HAVE ANY QUESTIONS, CONTACT HUMAN RESOURCES AT 909-382-4040

LEAVE OF ABSENCE APPLICATION

INSTRUCTIONS: PLEASE COMPLETE **ALL** SECTIONS ON THIS FORM. TYPE OR PRINT IN INK. COMPLETE THIS FORM EACH TIME THAT YOU A) REQUEST A LEAVE; B) WISH TO EXTEND THE DATE OF YOUR LEAVE; OR C) CHANGE FROM ONE TYPE OF LEAVE TO ANOTHER. ONCE THIS APPLICATION IS COMPLETED, PLEASE SEND THE ORIGINAL TO HUMAN RESOURCES AND GIVE A COPY OF THE APPLICATION TO YOUR SUPERVISOR.

PLEASE NOTE: ANY SUPPORTING MEDICAL DOCUMENTATION SHOULD ONLY BE GIVEN TO HUMAN RESOURCES.

1. EMPLOYEE INFORMATION

EMPLOYEE NAME: _____ HOME/CELL PHONE NUMBER: _____

STREET ADDRESS: _____ CITY: _____ ZIP: _____

2. PURPOSE OF LEAVE REQUEST

THIS APPLICATION IS FOR: INITIAL LEAVE EXTENSION OF LEAVE

I WISH TO APPLY FOR THE FOLLOWING TYPE OF LEAVE:

- EMPLOYEE'S MEDICAL DISABILITY – NON-PREGNANCY RELATED
- EMPLOYEE'S MEDICAL DISABILITY – PREGNANCY RELATED
- FAMILY CARE LEAVE – SERIOUS HEALTH CONDITION OF FAMILY MEMBER
- FAMILY CARE LEAVE – BONDING WITH NEWBORN OR NEWLY PLACED CHILD

3. REQUIREMENTS OF LEAVE

EMPLOYEE'S OWN MEDICAL DISABILITY

- ATTACH A COMPLETED "CERTIFICATE OF HEALTHCARE PROVIDER" CERTIFYING YOUR MEDICAL DISABILITY. (FORMS ARE AVAILABLE FROM HUMAN RESOURCES)

FAMILY CARE LEAVE

- ATTACH A COMPLETED "CERTIFICATE OF HEALTHCARE PROVIDER" CERTIFYING THE FAMILY MEMBER'S SERIOUS HEALTH CONDITION. (FORMS ARE AVAILABLE FROM HUMAN RESOURCES)
- ATTACH PROOF OF THE FAMILY MEMBER'S RELATIONSHIP TO YOU.

4. DATES AND SCHEDULE OF LEAVE REQUEST

REQUESTED LEAVE BEGIN DATE:	_____	REQUESTED LEAVE END DATE:	_____
IF REQUESTING REDUCED OR INTERMITTENT SCHEDULE, PLEASE DESCRIBE.			

5. SIGNATURE

I UNDERSTAND THAT EACH LEAVE APPLICATION OR LEAVE EXTENSION MUST BE VERIFIED BY HUMAN RESOURCES. I UNDERSTAND THAT TO BE APPROVED FOR A LEAVE, I MUST PROVIDE DOCUMENTATION REQUIRED FOR THE TYPE OF LEAVE REQUESTED. I UNDERSTAND THAT I MUST RETURN TO WORK ON THE FIRST BUSINESS DAY AFTER MY LEAVE ENDS.

SIGNATURE _____

DATE _____



CERTIFICATE OF HEALTH CARE PROVIDER

INSTRUCTIONS FOR EMPLOYEE: PLEASE FILL OUT THE EMPLOYEE PORTION, THEN FORWARD TO YOUR OR YOUR FAMILY MEMBER'S HEALTHCARE PROVIDER TO COMPLETE AND SIGN. THIS FORM MUST BE SUBMITTED NO LATER THAN 30 DAYS PRIOR TO YOUR REQUESTED LEAVE DATE, OR IMMEDIATELY FOR UNFORESEEABLE LEAVES.

EMPLOYEE	Employee:	
	Patient (if other than employee):	Relation to employee:
	Begin date of requested leave:	End date of requested leave:
	If intermittent or reduced schedule is requested, please indicate requested schedule:	
	If leave is for my own serious health condition, I authorize my health care provider to provide diagnosis. (Your answer will not affect approval of leave, but will be used for identifying available rights and protection)	

Yes No

Signature: _____ Date: _____

HEALTH CARE PROVIDER: PLEASE FILL OUT THE FOLLOWING INFORMATION

HEALTH CARE PROVIDER	IF LEAVE IS DUE TO EMPLOYEE'S SERIOUS HEALTH CONDITION	
	Does this employee have a serious health condition? (See reverse side for definition)	
	If authorized above, what is employee's diagnosis?	
	When did the serious health condition begin?	
	Please review the attached job description. Is this employee able to perform the functions of his or her job?	
	If intermittent leave or a reduced work schedule is being considered, is it medically necessary?	
	* If yes, please describe the recommended schedule:	
	What is the begin date of the leave?	What is the anticipated return to work date?
	IF LEAVE IS DUE TO SERIOUS HEALTH CONDITION OF EMPLOYEE'S FAMILY MEMBER	
	Does employee's family member have a serious health condition? (See reverse side for definition)	
When did the serious health condition begin?		
Is the employee's presence necessary or would it be beneficial to the patient? (This may include psychological comfort and/or arranging for third-party care for the family member.)		
If intermittent leave or a reduced work schedule is being considered, is it medically necessary?		
* If yes, please describe the recommended schedule:		
What is the begin date of the leave?	What is the anticipated return to work date?	
HEALTH CARE PROVIDER INFORMATION		
Name of Health Care Provider:		
Specialty:		
Address of Health Care Provider:		
_____ *Signature of Health Care Provider	_____ Date	
Place stamp here		
<small>* Department of Labor regulations for the Family and Medical Leave Act doctor of medicine or osteopathy, podiatrist, dentist, chiropractor, clinical psychologist, optometrist, nurse practitioner, nurse-midwife, or clinical social worker who is authorized to practice by the State and performing within the scope of their practice as defined by State law, or a Christian Science practitioner.</small>		

Dear Health Care Provider:

Our employee has requested leave under the provisions of Federal and/or California Family and Medical Leave statutes for:

- his or her own serious health condition; or
- for the purpose of caring for your patient (who is a parent, child, or spouse of our employee).

In order for the District to determine whether this leave qualifies for family and medical leave under District policy and Federal and/or State law, **please complete the brief Certificate of Health Care Provider on the reverse side of this letter and return via fax to:**

Cheryl Burge
Human Resources/San Bernardino Community College District
Fax: 909-382-0173

Or via mail to:

Benefits/Human Resources
San Bernardino Community College District
114 S. Del Rosa Dr.
San Bernardino, CA 92408

Do not release the employee's diagnosis unless authorized by the employee (see "Employee Section" of this form for authorization).

If you have any questions, please phone 909-382-4040. Thank you for your assistance.

A serious health condition is

any illness, injury, impairment or physical or mental condition that involves:

- any period of incapacity or treatment in connection with or consequent to an overnight stay in a hospital, hospice, or residential medical care facility; or
- continuing treatment by a health care provider for one or more of the following:
 - any period of incapacity for more than three consecutive calendar days that also involves treatment two or more times or treatment on at least one occasion which results in a regimen of continuing treatment under the supervision of a health care provider.
 - any period of incapacity due to pregnancy, for prenatal care.
 - any period of incapacity due to a chronic serious health condition that:
 - requires periodic visits for treatment;
 - continues over an extended period of time; and
 - may cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.)
 - any period of incapacity which is long-term due to a condition for which treatment may not be effective (e.g., Alzheimer's disease).
 - any period of absence required to receive multiple treatments (including the period of recovery) either for restorative surgery after an accident or other injury, or for a chronic condition such as cancer or kidney disease.

A serious health condition is not

- allergies, stress, or substance abuse unless inpatient hospital care is required, or the patient is incapacitated for more than three calendar days and is under the continuing care of a health care provider, or the patient has a serious long-term health condition; or
- voluntary treatment or surgery unless inpatient hospital care is required.

Department of Labor regulations for the Family and Medical Leave Act define a "health care provider" as: a doctor of medicine or osteopathy, podiatrist, dentist, chiropractor, clinical psychologist, optometrist, nurse practitioner, nurse-midwife, or clinical social worker who is authorized to practice by the State and performing within the scope of their practice as defined by State law, or a Christian Science practitioner. A health care provider also is any provider from whom the University or the employee's group health plan will accept certification of a serious health condition to substantiate a claim for benefits.