Clear Form

COUNTY OF SANTA CRUZ
EMPLOYEE REQUEST FOR LEAVE WITHOUT PAY OVER 160 CONSECUTIVE HOURS
(Submit to Supervisor First)

Department _____ **Employee Name** _____

Employee Address _____

All foreseeable requests for time off must be submitted 30 days in advance.
An employee who is absent from duty for more than three working days without an approved leave is considered to have automatically resigned.

	FROM		THROUGH	
FAMILY CARE OR MEDICAL LEAVE:	Date _____	Hour _____am/pm	Date _____	Hour _____am/pm
OTHER MEDICAL LEAVE:	Date _____	Hour _____am/pm	Date _____	Hour _____am/pm
PERSONAL/EDUCATIONAL LEAVE:	Date _____	Hour _____am/pm	Date _____	Hour _____am/pm

IF PAID LEAVE IS USED IN ADDITION TO LEAVE WITHOUT PAY, SHOW THE PERIOD OF PAID LEAVE BELOW:

FROM: Date _____ Hour _____am/pm **THROUGH:** Date _____ Hour _____am/pm LEAVE TYPE _____

PERIOD OF PAID LEAVE:

FROM: Date _____ Hour _____am/pm **THROUGH:** Date _____ Hour _____am/pm LEAVE TYPE _____

LEAVE OF ABSENCE WITHOUT PAY IN EXCESS OF 160 CONSECUTIVE HOURS (Prorated for Part-time Employees):

1. Attach appropriate documentation (see below) and submit to supervisor at least 30 days prior to the beginning of the leave, when foreseeable.
2. Employees MUST contact Risk Management In advance of leave concerning eligibility for continuation of employee and dependent Insurance coverage and long term disability coverage during the leave of absence.
3. A leave of absence without pay in excess of 160 working hours for a full-time employee and prorated for a part-time employee (80 hours for a half-time employee; 120 bours for a three-quarter time employee, etc.) requires the prior approval of the County Personnel Director in addition to departmental approval.
4. If there are conditions placed upon the granting of a leave of absence without pay, they must be noted below and initialed by both the requesting employee end the appointing authority.
5. The maximum of any period of leave of absence without pay is one year. The one year maximum applies to any type of leave or combination of types.
6. AN EMPLOYEE WHO FAILS TO RETURN UPON THE EXPIRATION OF AN APPROVED LEAVE OF ABSENCE WITHOUT PAY IS DEEMED TO HAVE AUTOMATICALLY RESIGNED.

CHECK LEAVE TYPE BELOW:

☐ **FAMILY CARE OR MEDICAL LEAVE OF ABSENCE WITHOUT PAY:**

A. Obtain (from supervisor) and read the notice on Employee Obligations under Family & Medical Leave Act.
B. Attach a completed PER1081B for medical leave for yourself, of PER1081B for your family member, or proof of birth, adoption or totter placement. A completed PER1086 is also required to return from medical leave and must be submitted to the department at least one week prior to the expiration of the leave.
C. All compensatory time and sick leave (for periods of your own Illness) must be used before any leave without pay can be granted.

☐ **OTHER MEDICAL LEAVE OF ABSENCE WITHOUT PAY:**

D. Attach a completed PER1081A. A completed PER1086 is also required to return from any Other Medical leave and must be submitted to the department at least one week prior to the expiration of the leave.
E. All compensatory time and sick leave must be used before any leave without pay can be granted.

☐ **PERSONAL/EDUCATIONAL LEAVE OF ABSENCE WITHOUT PAY:**

F. Attach a written statement indicating the reasons for your request.
G. All compensatory time must be used before any leave of absence without pay can be granted.
H. A department may require an employee to use all annual leave, vacation, or administrative leave before granting a Personal/Educational leave without pay.

CONDITIONS FOR GRANTING THE EMPLOYEE LEAVE OF ABSENCE WITROUT PAY (Must be initialed by employee and appointing authority)

☐ Please check this box If additional sheets stating conditions are attached.

DO YOU INTEND TO RETURN TO WORK UPON THE EXPIRATION OF YOUR APPROVED LEAVE OF ABSENCE?

☐ YES, I INTEND TO RETURN TO WORK FOLLOWING MY LEAVE.

☐ NO, I DO NOT INTEND TO RETURN TO WORK FOLLOWING MY LEAVE.

Employee Signature _____ **Date** _____ **Departmental Approval** _____ **Date** _____

Personnel Signature _____ **Date** _____ **Risk Mgt. Approval** _____ **Date** _____

Distribution: To be distributed by Personnel after all approvals are received.
ORIG - Personnel YELLOW - Department, PINK — Employee copy (will be mailed to home address).

PER1083 (New 7/2022) (Forms/PER/1083)