APPLICATION FOR LEAVE

Directions: In order to request leave, an employee shall complete this form and forward it to his/her supervisor.

EMPLOYEE SECTION (Part A)

Name: **Date of Request:** ______________________________

Department: ________________________ **Bureau/Division:** ______________________________

Leave Beginning Date: __________________ **Time:** ______

Leave Ending Date: __________________ **Time:** ______ **Total Hours Requested:** ______

Leave Type Requested (Check all that apply & fill in hours requested. All leave must be taken in minimum of fifteen (15) minute increments.):

☐ **Civil:** _________ ☐ **Compensatory:** _________ ☐ **Conference/Convention:** _________

☐ **Educational:** _____ ☐ **Funeral (Immediate Family):** _____ ☐ **Funeral (Other):** _____________

☐ **Holiday (for floating, shift or accumulated)** ________ ☐ **Injury:** _____ ☐ **LWOP:**

☐ **Military with Pay:** ____ ☐ **Military without Pay:** ______ ☐ **Shared Leave:** ___________

☐ **Sick (Self) :** ________ ☐ **Sick (Immediate Family) :** ______ ☐ **Vacation:** _____

☐ **Other (specify) :**____ **Hrs:** ___________

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Signature of Employee: ____ **Date:** _______________

(I certify that the information in the Section A is correct & true.)

REVIEWER'S SECTION (Part B)

Is this leave for a Family & Medical Leave Act (FMLA) purpose? ☐ **Yes** ☐ **No**

If yes, indicate the amount of each leave type to be applied towards FMLA requirements & complete Parts "C" & "D":

Leave Type: ________________ **Hrs:** ________ **Leave Type:** ____________ **Hrs:** __________

Leave Type: ________________ **Hrs:** ________ **Leave Type:** ____________ **Hrs:** __________

☐ **Approved** ☐ **Disapproved (if disapproved explain why) :** ______________________________

Authorizing Signature: ____________________________________ **Date:** _______________

(I certify that I have reviewed this request for FMLA compliance.)

IF THIS REQUEST INVOLVES FMLA, COMPLETE PARTS C& D ON THE BACK OF THIS FORM

FOR FAMILY & MEDICAL LEAVE APPLICATIONS ONLY

For Department/Agency Authorized Representative To Complete

DETERMINATION SECTION (Part C)

It has been determined that the leave type(s) indicated on the front of this form should be applied towards the FMLA allocation which you are entitled to under the U.S. Family & Medical Leave Act (FMLA) of 1993, as outlined in the City's FMLA Administrative Regulation. It has been determined that your request meets the requirements for the granting of leave, given the following conditions (check statements that are applicable):

☐ **Employee Serious Health Condition - A serious health condition exists which prevents you from performing your essential job functions. In order for this request to be processed, you are required to provide the City with a completed "Medical Certification Form," (which is attached) within twenty (20) calendar days.**

☐ **Immediate Family Member Serious Health Condition - A serious health condition involving a member of your immediate family which requires you to care for him/her exists. In order for this request to be processed, you are required to provide the City with a completed "Medical Certification Form," (which is attached) within twenty (20) calendar days.**

☐ **Child Care Provisions - Leave as indicated is for:**
- ☐ **the birth of a child:**
- ☐ **the placement of a child (adoption or foster care).**

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In order for this request to be processed, you are <u>required</u> to provide the City with documentation supporting your use of leave. Failure to provide such documentation with twenty (20) calendar days shall result in disapproval of your leave to be applied under the provisions of FMLA.

NOTE TO DEPARTMENT REPRESENTATIVE: Attach a copy of FMLA Fact Sheet (HR Form #37).

Authorizing Signature: ______________________________ **Date:** ____________________

(To be completed by the departmental payroll clerk & employee if leave without pay is approved)

BENEFITS ELECTION FOR LEAVE WITHOUT PAY (Part D)

If the employee is approved for "leave without pay" for FMLA purposes, the City will continue to pay its portion of the employee's existing health & life insurance coverage based upon its standard formula for paying health & life insurance premiums; conditioned upon the employee's returning to work for the City at the conclusion of the "leave without pay" period, subject to the provisions of the City's FMLA Administrative Regulation. If the employee has health coverage (employee, employee plus one or family) or voluntary dental plan coverage, such coverage may be continued, provided the employee elects at the beginning of the "leave without pay" period to pay these premiums. Payments must be made by separate check or money order for each plan, payable to the City of Richmond & received by the Department of Human Resources, Benefits Division, by the first day of each month due. If Part D is completed, a copy of this form must be submitted to HR, Benefits Section. <u>Nonpayment of premiums will result in a lapse of coverage.</u>

☐ **I do not wish to continue my health insurance coverage.**
☐ **I do not wish to continue my voluntary dental plan coverage.**
☐ **I wish to continue my health insurance coverage at a cost of $ __________ per month.**
☐ **I wish to continue my life insurance coverage at a cost of $ ___________ per month.**
☐ **I wish to continue my voluntary dental insurance coverage at a cost of $ _____________ per month.**

Signature of Employee: ______________________________ **Date:** ____________________

Signature of Payroll Representative: ______________________ **Date**: ____________________