VILLAGE OF HESPERIA – VACATION / LEAVE REQUEST FORM

I. Employee Information

Name:

Employee #:

Phone:

Dept. Name:

Dept. #:

II. Paid Leave and/or Unpaid Leave of Less than 30 days

Start Date:

Anticipated Return Date:

Reason for Time Away	Allocation of Leave Hours	
	Type of Leave	# Days/Hours
	Paid	
	Unpaid	
	Vacation	
	Sick	
	Total Time Away	

Employee Signature/Date: _____

Supervisor's Decision: [ ] Approved
[ ] Denied
Reason:_____

Supervisor's Signature/Date:_____ Clerk's Signature/ Date:_____

III. Unpaid Leave of Absence of 30 Consecutive Days or More

(Original form sent to Clerks Office; copy filed in Employee File; copy given to Employee ;)

Reason for Leave	Start Date: Anticipated Return Date:

Employee Signature/Date:

Supervisor's Decision: [ ] Approved
[ ] Denied Reason:

Supervisor's Signature/Date: :_____Clerk's Signature/
Date:_____

IV. RETURN TO WORK FROM ANY UNPAID LOA, FMLA, SHORT TERM DISABILITY, OR LONG TERM DISABILITY (Send original to Clerks Office.)

Name: _____ Social Security #:
_____

Dept Name: _____ Dept #: _____

Supervisor: [ ] Employee returned to work after unpaid LOA, STD, or LTD in excess of 30 days.
Return Employee to active status as of the following date: _____/_____/_____.

Return to: [ ] staff: scheduled hours of #_____hrs/wk
[ ] academic: ___% FT
[ ] new rate of pay _____

Supervisor's Signature/Date: :_____Clerk's Signature/
Date:_____

LOA (Leave of Absence) FMLA (Family and Medical Leave Act) FT (Full Time)

V. Family Medical Leave Act

(Original form sent to Human Resources; Copy kept in department)

Employee: Clarify eligibility and type of leave by reading Section VI: ELIGIBILITY FOR FMLA AND TYPES OF LEAVE COVERED, below and check next to the appropriate reason for the leave.

[ ] Check here if this is the initial request Start date of FMLA: _____

I will go out: [ ] LOA [ ] Intermittent

[ ] Reduced Time (_____hrs/week or _____% FT)

My signature below indicates that all information on this form is correct and I have read my rights and responsibilities as stated on the reverse side of this form.

Employee's Signature/Date:_____

Supervisor: [ ] Approved. I will reduce hours or place the employee on unpaid Leave of Absence as indicated above, if appropriate. I will complete Part V when the employee returns to work or regularly scheduled hours. New rate of Pay $_____

[ ] Denied Reason:

Supervisor'sSignature/Date:_____Clerk'sSignature/Date:_____

VI. Eligibility For FMLA And Type Of Leave Covered

You are eligible for FMLA Leave if you have worked for the Village of Hesperia for one year AND have worked at least 1,000 hours within that year. Family/Medical Leave may be taken to care for yourself or qualified relationships during periods of serious illness. If you are going out on FMLA, review the list below and check next to the reason which best describes the leave you will be taking. If leave is related to the birth or placement of a child in your custody, please provide a birth or placement date.

[ ] Birth, adoption, or initiation of foster care of child. Valid only for one year after birth or placement. (DCF and Federal)

Child's date of birth: _____/_____/_____ or

Date child placed in your care: ____/____/_____

[ ] Initiation of guardianship of Child which began on _____/____/_____. (DCF only)

~~Federal FMLA leave to care for dependent children is limited to children under the age of 18 or, in the case of certain disabilities, under the age of 25.~~

[ ] Care of one's own parent, child (biological, adopted, foster, guardian), or spouse with a serious health condition requiring medical treatment. (DCF and Federal)

[ ] Care of a family member ***other than one's own parent, child or spouse*** related by blood, custody guardianship or marriage, or committed live-in relationship for an illness requiring continuing care by a health care provider or a continuing regimen of treatment. (DCF only)

[ ] Unable to perform the functions of the position due to your own serious illness requiring continuing care by a health care provider or a continuing regimen of treatment. (DCM and Federal).

Contact Human Resources Department for further clarification on Family/Medical Leave.

Your responsibilities include:

Complete a Medical Certification Form - you must complete a Medical Certification Form as soon as possible or within 15 days. Approval of your leave may be delayed until this form is submitted.

Pay your premiums to continue benefits - you are responsible for paying your share of your health and other insurance premiums while you are on leave. Contact the Faculty and Staff Benefits Office.

Before you return:

If you're going out for your own illness - you may be requested to complete a Return to Work Medical Certification Form before you will be permitted to return to work.

If you do not return to work:

If you cannot return due to medical condition - you must present another Medical Certification Form from the appropriate health care provider stating that, as of the date that your leave expired, you are either unable to perform the functions of your position or that you are needed to care for your relation.

Employee's Signature/Date: