San Bernardino Community College District

OFFICE OF HUMAN RESOURCES
114 S. DEL ROSA DRIVE; SAN BERNARDINO CA 92408
PHONE 909-382-4040 FAX 909-382-0173

EMPLOYEE LEAVE OF ABSENCE REQUEST FORM

Please complete and return to your HR representative 30 days prior to requested leave start date.

SECTION I- TO BE COMPLETED BY THE EMPLOYEE

Employee Name	Phone #	Campus
Job Title	Department	Supervisor

Request Type
☐ Initial Application
☐ Amendment to LOA that began on _____

Reason for Leave of Absence (check one):
☐ Care for Injured/Ill Family Member
☐ Own Injury/Illness (not work-related)
☐ Work-Related Injury
☐ Qualifying Exigency Leave
☐ Military _____
☐ Pregnancy/Disability
☐ Care for Newborn/Placed Child
Date of Birth/Placement _____
☐ Other (specify): _____

Type of Leave Requested	Requested Start Date	Anticipated Return Date
☐ Consecutive ☐ Intermittent		

If intermittent leave is requested, please state specific intermittent or reduced schedule requested.

For leaves due to your own or a Family Member's Serious Health Condition, a Medical Certification form is required. Please contact HR to obtain the form.

☐ A completed Medical Certification form is attached.
☐ I will submit a Medical Certification form within 15 days to Human Resources.

A leave of absence is normally leave without pay. Paid leave (accrued sick leave or vacation) may be substituted for all or a portion of the unpaid leave in according with appropriate policies/contracts.

☐ I wish to use paid leave as indicated below: (attach additional sheets if necessary)

	(MM/DD/YYYY)	(MM/DD/YYYY)
_____Hours of accrued sick	Begins on _____	and ends on _____
_____Hours of accrued vacation	Begins on _____	and ends on _____

I have read and understand the above information. I acknowledge that it is my responsibility to furnish the required medical certification within 15 calendar days and to communicate with Human Resources regarding my leave status.

_____ _____
Employee's Signature Date

SECTION II- To BE COMPLETED BY THE COLLEGE

Pay Status During Leave

	(MM/DD/YYYY)	(MM/DD/YYYY)
_____Sick leave hours to be applied	Begins on _____	and ends on _____
_____Extend sick leave hours to be applied	Begins on _____	and ends on _____
_____Vacation hours to be applied	Begins on _____	and ends on _____

Human Resources Signature	Date