

**City of Torrance
REQUEST FOR LEAVE OF ABSENCE**

NAME: _____ DEPARTMENT: _____

POSITION: _____ ID#: _____ PHONE: _____

HOME ADDRESS: _____ CITY: _____ ZIP: _____

SUPERVISOR'S NAME: _____ HIRE DATE: _____

REASON FOR LEAVE REQUESTED:

Continuous period of leave for Employee's own serious health condition that makes the employee unable to perform the functions of his/her position.* (Must attach completed Physician Medical Certification - Employee form.)

Continuous period of leave to care for immediate family member who has a serious health condition. Circle one: CHILD – SPOUSE – PARENT. * (Must attach completed Physician Medical Certification - Family Member form.)

Intermittent period of leave for a serious health condition of Self OR family member.* (Must attach Physician Medical Certification - Employee form for employee OR Family Member form for family member.)

Birth or adoption of a child and/or to care for such child.* (May require proof of birth or adoption.)

Military (Attach copy of military leave orders/paperwork.)

Military Caregiver Leave.* Circle one: CHILD – SPOUSE – PARENT – NEXT OF KIN (Attach Physician Medical Certification – Military Family Leave form, Invitational Travel Order, or Invitational Travel Authorization.)

Qualifying Exigency Leave. * Circle one: CHILD – SPOUSE – PARENT (Attach copy of active duty orders and certification providing facts related to qualifying exigency for which leave is sought.)

Personal Leave - Reason: _____

DATE LEAVE IS TO BEGIN: ____ / ____ / ____ DATE LEAVE IS TO END: ____ / ____ / ____

*Approval of leave will run concurrent with Family Medical Leave Act (FMLA) and California Family Rights Act (CFRA) if employee qualifies.

PLEASE READ CAREFULLY:

- If you are unable to return to work on the scheduled date, you must submit a request to extend the leave of absence five working days prior to the leave ending date.**
- For an unpaid leave of absence of more than 10 consecutive days, you will not continue to receive benefits which accrue with service time (i.e., vacation, sick leave, seniority) during that time. If you choose to use your accrued time there will be no change in your accrual of time related benefits. You must contact the Human Resources Department to be advised on how your insurance and time related benefits may be impacted.**
- I request to use my accrued sick leave _____, vacation _____, and/or comp time _____ during my leave (Until short-term disability benefits begin, if applicable).**

I have read and understand the instructions and procedures regarding leaves of absence.

Employee Signature: _____ Date you provided notice of leave to your supervisor (May be written or verbal): ____ / ____ / ____

Department Approval: Approved Denied Comments: _____

Department Head Signature Date

City Manager Approval: Approved Denied _____

City Manager/Designee Date

DEPARTMENTS: PLEASE TIME & DATE STAMP FORM UPON RECEIPT FROM EMPLOYEE