

LEAVE OF ABSENCE REQUEST FORM

Submission Instructions for Employees:

1. **Complete this form** and review it with your Immediate Supervisor for awareness.
2. **Submit directly to Human Resources** via the secure portal or email to hrLeave@swccd.edu.
3. **Medical Details:** Do not attach medical diagnoses to this form if it is being routed through your department. Send all medical certifications directly to Human Resources (hrLeave@swccd.edu).

SECTION I: EMPLOYEE INFORMATION

Name: _____ Employee ID: _____ Date of Hire: _____

Position Title: _____ Department: _____

Supervisor Name: _____ Supervisor Title: _____

Classification: Faculty (SCEA) Classified (CSEA) Administrator (SCCDAA) Confidential/Unrep

Type of Assignment: 10-Month 11-Month 12-Month Part-Time/Adjunct

SECTION II: TYPE OF LEAVE REQUESTED

Check all that apply. Note: Many leaves run concurrently.

Medical & Family Care:

Employee's Own Serious Health Condition (Includes Pregnancy Disability)

Family Care: To care for a family member with a serious health condition.

Relationship: Spouse/Partner Child Parent Grandparent/Sibling Designated Person

Parental/Bonding Leave: (Birth, Adoption, or Foster Care Placement)

District-Specific & CBA Leaves:

Military Leave: (Attach copies of orders)

Unpaid Personal Leave: (Requires Superintendent/President approval)

SECTION III: LEAVE DATES & SCHEDULE

Requested Start Date: _____ Estimated End Date: _____

Type of Schedule:

Continuous: Full-time absence for the duration of the dates above.

Intermittent: Reduced schedule or periodic absences. (Please describe):

SECTION IV: PAY COORDINATION (STAYING IN PAID STATUS)

I request to use my accrued paid leave banks (per CBA guidelines):

Sick Leave (Accrued)

Vacation / Compensatory Time (Classified/Admin Only)

Banked Leave (Faculty Only)

Differential/Half-Pay (Once all sick banks are exhausted; in accordance with relevant CBA language)

Unpaid Leave (Once all full-pay banks are exhausted)

[CSEA Article 12](#)

[SCCDAA Article 10](#)

[SCEA Article 5](#)

SECTION V: EMPLOYEE ACKNOWLEDGMENT

- I understand that for medical leaves exceeding five (5) days, I must provide a Medical Certification to Human Resources.
- I understand that I must notify my supervisor of any changes to my return-to-work date.
- I will follow departmental procedures for requesting time off. For intermittent leaves: I will inform my supervisor and select the appropriate accrual category in Colleague Self-Service to report any absences to be counted toward applicable leave.
- I understand some protected leave is an UNPAID leave unless I have accrued sick leave, vacation, or other paid leaves available for use per my collective bargaining agreement. I further understand that my paid leaves will be used in conjunction with FMLA/CFRA leave, as applicable, so that I will remain in paid status. At such time, all applicable accrued paid leaves or the allowable number of days for any particular paid leave such as Personal Necessity has been exhausted, I will be on an unpaid leave.

- I will be financially responsible for my share of monthly medical insurance and other benefit plan premiums, if any, and if in an unpaid status, I will submit payment to SWCCD by the 15th of the month, prior to the month of coverage for the coverages I wish to continue.
- I understand that I may be required to reimburse SWCCD for the employer paid portion of my health insurance if I do not return to work following FMLA/CFRA leave for a reason other than: (1) the continuation, recurrence, or onset of a serious health condition which would entitle me to another FMLA/CFRA leave; or (2) other circumstances beyond my control.
- I understand that any time on an unpaid leave of absence will not count towards earned service credit under my respective retirement plan (STRS or PERS).
- Contact the Employee Benefits Department at SWCbenefits@swccd.edu if you have any questions regarding your benefits.

Employee Signature: _____ **Date:** _____

Supervisor Signature: _____ **Date:** _____

VP/Director/Dean Signature: _____ **Date:** _____

SECTION VI: DISTRICT ACTION (HR USE ONLY)

Sick Leave Hours: _____

Comp Time: _____

Vacation Hours: _____

Catastrophic Leave: Eligible Not Eligible

FMLA/CFRA Eligibility: Eligible Not Eligible

Reason:

PDL Entitlement: Applicable N/A

Parental/Bonding Leave: Eligible Not Eligible

Designation: Approved Denied Pending Documentation

HR Representative Title: _____

HR Representative Signature: _____ **Date:** _____

Comments:

