Ensure the most current form is submitted.  Refer to EMACS Forms/Procedures website.

# LEAVE REQUEST FOR EXTENDED SICK AND SPECIAL LEAVE

**Employees must contact MetLife no later than the 4th day of leave to initiate the leave process.[1]**

*Must print in Black or Blue ink ONLY*

*Check box if applying for* **STD** ☐

| Employee ID | Rcd No. | Last Name, First Name | |
|---|---|---|---|
| | | | |
| **Job Title** | | **Department** | **Department ID** |
| | | | |

***To Be Completed By Employee*** (*Supervisor may complete in employee's absence*)

| Home Address | City | State | Zip Code |
|---|---|---|---|
| | | | |
| **Mailing Address (if different than Home)** | **City** | **State** | **Zip Code** |
| | | | |

| Telephone Numbers: | Home | Work | Alternate |
|---|---|---|---|
| | | | |

| Type of Request | Reasons for Leave |
|---|---|
| New<br>Continuation<br>Revision | ☐ Own serious health condition (non-work related)<br>☐ Occupational injury/illness<br>☐ Indicate due date if pregnant :<br>☐ Care for child/spouse/domestic partner/parent for a serious health condition[2]<br>☐ Birth, placement or adoption of a child's other parent is a county employee, indicate name and employee ID:<br>☐ Care for other family member, including legal guardianship, for serious health condition<br>☐ Military leave, educational leave, or other leave not specified above |

[1]Please refer to the MetLife's Frequently Asked Question about Reporting Absences and Filing for Short Term Disability Benefits

| Leave Type[2] | | | Leave Begin Date | Leave End Date | Check If Applicable |
|---|---|---|---|---|---|
| ☐ Sick Leave With Pay | or | ☐ Sick Leave Without Pay | | | Reduced Schedule<br>Intermittent Leave |
| ☐ Leave With Pay | or | ☐ Leave Without Pay | | | Reduced Schedule<br>Intermittent Leave |
| ☐ Leave With Right To Return To Position | or | ☐ Leave Without Right To Return To Position | | | |
| Military Leave (attach active duty orders) | | | | | |
| Occupational Injury/ Illness | (Pending Risk Management's approval and requires an Employer's Report of Occupationally Injury or Illness) | | | | Reduced Schedule<br>Intermittent Leave |
| Other - Explain: | | | | | Reduced Schedule<br>Intermittent Leave |

| | Print & Sign | Date |
|---|---|---|
| Employee[3] | | |
| Supervisor/Title | | |
| Appointing Authority or Designee | | |
| Human Resources Officer[4] | | |

This document/form incorporates use of e-signatures in accordance with the San Bernardino County Policy #03-12 and Standard Practice 1.

[2] At no time will the Employee receive more than 100% of pay from County paid leave, Short Term Disability or any other state leave program.

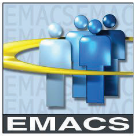
[3] If employees is unable to sign , write SNA and indicate date copy sent to employee's mailing address

[4] Required for Leave WIth/Without Right to Return, Medical Leave of Absence, educational leave

*DISTRIBUTION:*
*Original-EBSD-Leaves Team (0440)*
*Leave With Right-EBSD-Leaves Team (0440)*
*Leave Without Right-EBSD-Leaves Team (0440)*
*Medical Leave of Absence-EBSD-Leaves Team (0440) 1st Copy - Department*
*2nd Copy - Supervisor*
*3rd Copy - Employee*

**Office Use Only**

| Payroll Specialist Name | | Approved | Approved Pending Cert. | |
|---|---|---|---|---|
| | | | | |
| **Mail Code** | **Reviewed By** | **Date** | **Keyed By** | **Date** |
| | | | | |



Ensure the most current form is submitted. Refer to EMACS Forms/Procedures website.

# LEAVE INTEGRATION REQUEST

## (STD, SDI and WORKERS' COMPENSATION)

Clear Form Fields

*Notice: This form must immediately be submitted for processing based on the distribution choice below.*
*Integration choice will begin based on the date this form is received.*
**NO FUTURE OR RETRO PROCESSING WILL BE MADE**

*Must print in Black or Blue ink ONLY*

| Employee ID | Rcd No. | Last Name, First Name | Department ID |
|---|---|---|---|
| | | | |

| Type of Request | Type of Integration | Type of Benefit Payments | Department Name |
|---|---|---|---|
| ☐ New Request<br>☐ Revised | Full<br>☐ No Integration | Short Term Disability (STD)<br>☐ Workers' Compensation | |
| **Date of Injury/ Start of Leave** | ☐ Partial Integration - List number of hours per **pay period:** ____ | ☐ State Disability Insurance (SDI) | **Union Code** |

## Requested Order of Use

Default Order of Use - Check box if requesting to use leave in the order listed.
Requested Order of Use - Check box if requesting an order other than default, enter the requested order of leave to be used.
Sick Only - Check box if requesting to use sick leave only.
**Note**: Leaves will be used until exhausted, then the next designated leave will be used. Sick Leave must be used first in accordance with the MOU.

**If a box is not checked, the default order will be used**

| Type of Leave | ☐ Default Order of Use | Requested Order of Use | ☐ Sick Only |
|---|---|---|---|
| Sick | 1 | 1 | 1 |
| MOU Mandated Leave ____ | 2 | 2 | |
| Vacation | 3 | | |
| Holiday | 4 | | |
| Compensatory Time | 5 | | |
| Annual | 6 | | |
| Administrative | 7 | | |
| Attorney | 8 | | |
| Other ____ | 9 | | |
| Medical Emergency Leave (MEL)<br>*Must be integrated with STD* | Medical Emergency Leave (MEL) donations will be integrated with STD when leave accruals have been exhausted. | | |

I understand that all leave benefits will be administered in accordance with the MOU and County/Special Districts Policy. I have received a copy of the Leave Integration Guidelines (page 3). I authorize my supervisor, department payroll specialist and/or Central Payroll to code or modify my paid time to be consistent with this Leave Integration Request. I understand that the maximum amount of pay that I am allowed to receive while out on leave and integrating with another benefit (disability or Workers' Compensation payments) shall not exceed 100% of my base salary.

| Employee Signature * | Telephone | Date |
|---|---|---|
| | | |

***I have been given authorization and direction on completing this form on behalf of the above employee - REQUIRED if form is completed by someone other than the employee***

| * *Appointee (Print & Sign)* | *Telephone* | *Date* |
|---|---|---|
| | | |
| **Appointing Authority or Designee (Print & Sign)** | | **Date** |
| | | |
| **Payroll Specialist (Print & Sign)** | **Telephone** | **Date** |
| | | |

*DISTRIBUTION: Original - STD - EBSD - Leaves Team (0440)*
*- SDI / Workers' Compensation - Central Payroll (0032)*
*Copy - Department, Supervisor and Employee*

This document/form incorporates use of e-signatures in accordance with the San Bernardino County Policy #03-12 and Standard Practice 1.

# Leave Integration Guidelines

Integration of available leave balances with any Short-Term Disability (STD) Benefit Payments, State Disability Insurance (SDI) Benefit Payments, Workers' Compensation Benefit Payments, and/or regular/transitional work hours shall not exceed 100% of your normal base salary. In the event that any combination of these payments exceeds 100% of your normal base salary, the County will recover the overpayment from future pay warrants per MOU guidelines.

Medical Emergency Leave (MEL) will not be considered "eligible leave" for certain purposes such as the accumulation of leave accruals, eligibility for step advancement or retirement credit per the MOU. However, the use of MEL will count towards the minimum requirement for the receipt of Benefit Plan Dollars and/or premium subsidies. If you are using MEL, you must contact your payroll specialist to determine exactly how your benefits and accruals will be affected.

It is your responsibility to provide your supervisor and department payroll specialist any and all information regarding changes in your leave status, copies of all off-work orders and your anticipated return to work date. You should check with your Appointing Authority for specific department policies and procedures.

Each pay period your paid time will be coded with the anticipated number of leave hours required to integrate with your additional benefit payment and any time worked so that you may receive 100% of your normal biweekly base salary or the amount specified according to your election.

Receipt of Benefit Plan Dollars and/or premium subsidies, leave accruals, retirement credit and eligibility for step advancements will be administered in accordance with the appropriate MOU, contract or salary ordinance provisions governing your terms of employment.

The Leave Integration Request will be honored for the current pay period as long as it is submitted in time to meet payroll deadlines.

In addition to this form, it is your responsibility to complete any additional paperwork required for your STD, SDI, MEL and/or Workers' Compensation Benefits. Delay in submitting the required forms may also result in the loss or delay of benefits.

Short-Term Disability payments are taxable income; however, taxes are not automatically withheld. If you wish to have taxes withheld from your disability payments, submit a DE-4S to request state income taxes and a W-4S to request federal income taxes. Mail or fax these forms directly to the County Short-Term Disability provider as listed in the Employee Benefits Guide or per the "STD and FMLA Filing a Request Instructions and Form". You will receive a W-2 at the end of the year from this provider.

# PRELIMINARY FMLA DESIGNATION NOTIFICATION

This is to inform you that your extended and/or intermittent leave will be preliminarily designated as FMLA (Family Medical Leave Act) and/or CFRA (California Family Rights Act) Leave in accordance with federal and state laws. These laws are there to protect your job and employer paid benefits while you are out on a qualified leave of absence.

As indicated on this *Leave Request for Extended Sick and Special Leave* form, you are requesting an extended leave for your own serious health condition, the serious health condition of your child, spouse, domestic partner, or parent, for the birth or adoption of a child or to care for a family member with a serious injury or illness who is a member of the Regular Armed Forces, the National Guard or Reserves, and the illness or injury incurred in the line of duty. Leave for any of these reasons qualifies as FMLA and/or CFRA Leave.

A "serious health condition" for a family member requires either:

- Hospitalization; or
- Any period of incapacity of more than three calendar days that involves continuing treatment by a health care provider; or
- Any health condition that if left untreated would result in a period of incapacity of at least three days (including chronic conditions); or
- For prenatal care
- Written documentation confirming the covering service member's injury/illness was incurred in the line of duty on active duty and the covered service member is undergoing treatment for such injury or illness by a health care provider.

The definition of a "serious health condition" is the same for an employee with the addition that it must prevent the employee from performing the functions of his/her position.

If the reason for your leave meets the above criteria ***and*** you meet the eligibility requirements, your leave will be counted as FMLA and/or CFRA. ***This does not impact how or if you are paid during your leave. You are still required to complete the necessary paperwork to receive sick pay and/or disability, if eligible.*** A formal notification will be sent to you indicating the dates covered, what entitlement your leave counts against, your eligibility, and if there is any additional information required.

For more information, please refer to the *FMLA and Pregnancy Supplemental Brochures*. If you have any further questions, call your departmental payroll specialist.