Clear Print

CALIFORNIA STATE UNIVERSITY
FULLERTON
Human Resources, Diversity & Inclusion http://hr.fullerton.edu

REQUEST FOR FORMAL LEAVE OF ABSENCE

A. EMPLOYEE INFORMATON

◯ Faculty ◯ Staff/Management

Employee ID	First Name	Last Name	Department	Date Initiated

Contact Information While on Leave:

Address	City	State	Zip	Phone Number
		CA		

B. LEAVE OF ABSENCE INFORMATION *(please complete all sections)*

Action	*Leave Type*	*Leave Time Base*	*Leave Credits*
☐ New ☐ Change* Leave Ext. Date: _____ Early Return Date: _____ ☐ Cancel* *Attach copy of original leave form	☐ Medical* ☐ *FML Self* ☐ *FML Family* Relationship: _____ ☐ *Military (attach orders)* ☐ *Organ Donor Program** ☐ Pregnancy Disability** ☐ Parental** Faculty: ☐ 30 paid days ☐ 40% paid reduction ☐ Personal (Unpaid) ☐ Professional (Unpaid) (Attach description of activity) *Medical certification required **Attach evidence of due date/birth/adoption	☐ Full ☐ Partial *(For partial, provide the number of hours or WTU absent per week: _____)* ☐ Intermittent *(Employees not taking consecutive leave, attach a work schedule)*	Will you be using leave credits? ☐ Yes ☐ No Please check all credits that will be used: ☐ Sick ☐ Vacation ☐ Personal Holiday ☐ CTO

Dates for Leave *(Please specify month, day, and year)*	***Non-Industrial Disability Insurance (NDI)***	
Date From:	Will you be applying for NDI?	☐ Yes ☐ No
Date Through and Including:	*If yes, you must exhaust your sick leave balance. If you choose to use your vacation, you must exhaust your balance. Do you elect to use your vacation credits?*	☐ Yes ☐ No
Expected Return to Work Date:	Will you be applying for Catastrophic Leave?	☐ Yes ☐ No
	If yes, you must exhaust all leave, credits.	

C. EMPLOYEE CERTIFICATION AND ACKNOWLEDGEMENT OF LEAVE DATES

This is to certify that the information provided here is accurate to the best of my knowledge

_____ _____

Employee's Signature Date

D. RECOMMENDATIONS *(as appropriate per division)*

Position	*Printed Name*	*Signature*	*Recommended?* *if not recommended, please attach justification*
Chair / Director:			☐ Yes ☐ No
Dean / Administrator:			☐ Yes ☐ No
Vice President / President: *(if applicable)*			☐ Yes ☐ No

FORWARD COMPLETED FORM TO PAYROLL, BENEFITS & RETIREMENT SERVICES (CP770) FOR PROCESSING

FOR HUMAN RESOURCES USE ONLY:

Vice President HRDI:			☐ Yes ☐ No

Employee Details:

Employee Class: _____ Hire Date: _____

SCO Position #: _____ FTE: _____

Empl Rcd: _____ CBID: _____

Review Details:

☐ Approved ☐ Denied Type: _____

Reviewed by: _____

Forwarded To: _____

Date Forwarded: _____

Comments: _____

STATE OF CALIFORNIA **DEPARTMENT OF FAIR EMPLOYMENT AND HOUSING**

"NOTICE B"

FAMILY CARE AND MEDICAL LEAVE AND PREGNANCY DISABILITY LEAVE

• Under the California Family Rights Act of 1993 (CFRA), if you have more than 12 months of service with your employer and have worked at least 1,250 hours in the 12-month period before the date you want to begin your leave, you may have a right to an unpaid family care or medical leave (CFRA leave). This leave may be up to 12 workweeks in a 12-month period for the birth, adoption, or foster care placement of your child or for your own serious health condition or that of your child, parent or spouse.

• Even if you are not eligible for CFRA leave, if disabled by pregnancy, childbirth or related medical conditions, you are entitled to take pregnancy disability leave (PDL) of up to four months, or the working days in one-third of a year or 17⅓ weeks, depending on your period(s) of actual disability. Time off needed for prenatal or postnatal care; doctor-ordered bed rest; gestational diabetes; pregnancy-induced hypertension; preeclampsia; childbirth; postpartum depression; loss or end of pregnancy; or recovery from childbirth or loss or end of pregnancy would all be covered by your PDL.
• Your employer also has an obligation to reasonably accommodate your medical needs (such as allowing more frequent breaks) and to transfer you to a less strenuous or hazardous position if it is medically advisable because of your pregnancy.

• If you are CFRA-eligible, you have certain rights to take BOTH PDL and a separate CFRA leave for reason of the birth of your child. Both leaves guarantee reinstatement to the same or a comparable position at the end of the leave, subject to any defense allowed under the law. If possible, you must provide at least 30 days advance notice for foreseeable events (such as the expected birth of a child or a planned medical treatment for yourself or a family member). For events that are unforeseeable, you must to notify your employer, at least verbally, as soon as you learn of the need for the leave.

• Failure to comply with these notice rules is grounds for, and may result in, deferral of the requested leave until you comply with this notice policy.

• Your employer may require medical certification from your health care provider before allowing you a leave for:

- your pregnancy;
- your own serious health condition; or
- to care for your child, parent, or spouse who has a serious health condition.

• See your employer for a copy of a medical certification form to give to your health care provider to complete.

• When medically necessary, leave may be taken on an intermittent or a reduced work schedule. If you are taking a leave for the birth, adoption or foster care placement of a child, the basic minimum duration of the leave is two weeks and you must conclude the leave within one year of the birth or placement for adoption or foster care.

• Taking a family care or pregnancy disability leave may impact certain of your benefits and your seniority date. Contact your employer for more information regarding your eligibility for a leave and/or the impact of the leave on your seniority and benefits.

This notice is a summary of your rights and obligations under the Fair Employment and Housing Act (FEHA). The FEHA prohibits employers from denying, interfering with, or restraining your exercise of these rights. For more information about your rights and obligations, contact your employer, visit the Department of Fair Employment and Housing's Web site at www.dfeh.ca.gov, or contact the Department at (800) 884-1684. The text of the FEHA and the regulations interpreting it are available on the Department's Web site.

☐ I have read and understand my rights explained in the above notice

CALIFORNIA DEPARTMENT OF FAIR EMPLOYMENT AND HOUSING

CERTIFICATION OF HEALTH CARE PROVIDER FOR PREGNANCY DISABILITY LEAVE, TRANSFER AND/OR REASONABLE ACCOMMODATION

Employee's Name:

_____

Please certify that, because of this patient's pregnancy, childbirth, or a related medical condition (including, but not limited to, recovery from pregnancy, childbirth, loss or end of pregnancy, or post-partum depression), this patient needs (check all appropriate category boxes):

☐ Time off for medical appointments.
Specify when and for what duration:

_____

_____

☐ A disability leave. [Because of a patient's pregnancy, childbirth or a related medical condition, she cannot perform one or more of the essential functions of her job or cannot perform any of these functions without undue risk to herself, to her pregnancy's successful completion, or to other persons.]

Beginning (Estimate): _____

Ending (Estimate): _____

☐ Intermittent leave. Specify medically advisable intermittent leave schedule:

_____

_____

☐ Reduced work schedule. [Specify medically advisable reduced work schedule.]

_____

_____

Beginning (Estimate): _____

Ending (Estimate): _____

☐ Transfer to a less strenuous or hazardous position or to be assigned to less strenuous or hazardous duties [specify what would be a medically advisable position/duties].

_____

_____

Beginning (Estimate): _____

Ending (Estimate): _____

☐ Reasonable accommodation(s). [Specify medically advisable needed accommodation(s). These could include, but are not limited to, modifying lifting requirements, or providing more frequent breaks, or providing a stool or chair.]

_____

_____

Beginning (Estimate): _____

Ending (Estimate): _____

☐ Name, license number and medical/health care specialty [printed] of health care provider.

_____

_____

_____

Signature of health care provider:

_____

Date:

_____

Authority Cited: Government Code sections 12935, subd. (a), and 12945.

Reference: Government Code sections 12940, 12945; FMLA, 29 U.S.C. §2601, et seq. and FMLA regulations, 29 C.F.R. § 825.

Certification of Health Care Provider for Employee's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

Print Clear

OMB Control Number: 1235-0003
Expires: 5/31/2018

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R § 1635.9, if the Generic Information Nondiscrimination Act applies.

Employer name and contact: California State University, Fullerton - Human Resources (657) 278-2425

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions: _____

Check if job description is attached: ☐

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: _____

First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 C.F.R § 1635.3(f), generic services, as defined in 29 C.F.R § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R § 1635.3(b). Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: _____ Fax: _____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

Probable duration of condition: _____

Mark below as applicable:

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

☐ No ☐ Yes If so, dates of admission:

_____

Date(s) you treated the patient for condition:

_____

Will the patient need to have treatment visits at least twice per year due to the condition? ☐ No ☐ Yes

Was medication, other than over-the-counter medication, prescribed? ☐ No ☐ Yes

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g. physical therapist)?

☐ No ☐ Yes If so, state the nature of such treatments and expected duration of treatment:

_____

2. Is the medical condition pregnancy? ☐ No ☐ Yes If so, expected delivery date: _____

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

   Is the employee unable to perform any of his/her job functions due to the condition: ☐ No ☐ Yes

   If so, identify the job functions the employee is unable to perform:

   _____

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

   _____

   _____

   _____

   _____

   _____

   _____

   _____

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ☐No ☐Yes

   If so, estimate the beginning and ending dates for the period of incapacity: _____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ☐No ☐Yes

   If so, are the treatments or the reduced number of hours of work medically necessary?

   ☐No ☐Yes

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   _____

   Estimate the part-time or reduced work schedule the employee needs, if any:

   _____hour(s) per day; _____days per week from _____ through _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ☐No ☐Yes

   Is it medically necessary for the employee to be absent from work during the flare-ups? ☐No ☐Yes

   If so, explain:

   _____

   _____

   Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

   Frequency: _____ times per _____ week(s) _____ months(s)

   Duration: _____ hours or _____ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDTIONAL ANSWER.

_____

_____

_____

_____

_____

_____

Signature of Health Care Provider **Date**

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500.Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210.
DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.

Certification of Health Care Provider for Family Member's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

Print Clear

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.

OMB Control Number: 1235-0003 Expires: 5/31/2018

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R § 1635.9, if the Generic Information Nondiscrimination Act applies.

Employer name and contact: California State University, Fullerton - Human Resources (657) 278-2425

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your family member or his/her medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a covered family member with a serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Your name: _____
First Middle Last

Name of family member for whom you will provide care: _____
First Middle Last

Relationship of family member to you: _____

If family member is your son or daughter, date of birth: _____

Describe care you will provide to your family member and estimate leave needed to provide care:

_____

_____

_____

_____ _____
Employee Signature Date

CONTINUED ON NEXT PAGE

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the patient needs leave. Do not provide information about generic tests, as defined in 29 C.F.R § 1635.3(f), or generic services, as defined in 29 C.F.R § 1635.3(e). Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: _____ Fax: _____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

Probable duration of condition: _____

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

☐ No ☐ Yes If so, dates of admission: _____

Date(s) you treated the patient for condition: _____

Was medication, other than over-the-counter medication, prescribed? ☐ No ☐ Yes

Will the patient need to have treatment visits at least twice per year due to the condition? ☐ No ☐ Yes

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g. physical therapist)?

☐ No ☐ Yes If so, state the nature of such treatments and expected duration of treatment:

_____

_____

2. Is the medical condition pregnancy? ☐ No ☐ Yes

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

_____

_____

_____

_____

CONTINUED ON NEXT PAGE

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ☐ No ☐ Yes

   Estimate the beginning and ending dates for the period of incapacity: _____

   During this time, will the patient need care? ☐ No ☐ Yes

   Explain the care needed by the patient and why such care is medically necessary:

   _____

   _____

   _____

   _____

   _____

5. Will the patient require follow-up treatments, including any time for recovery? ☐ No ☐ Yes

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   _____

   Explain the care needed by the patient, and why such care is medically necessary: _____

   _____

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery?

   ☐ No ☐ Yes

   Estimate the hours the patient needs care on an intermittent basis, if any:

   _____ hour(s) per day; _____ days per week from _____ through _____

   Explain the care needed by the patient, and why such care is medically necessary:

   _____

   _____

   _____

   _____

CONTINUED ON NEXT PAGE

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ☐ No ☐ Yes

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per ☐ week(s) ☐ months(s)

Duration: _____ hours or _____ day(s) per episode

Does the patient need care during these flare-ups? ☐ No ☐ Yes

Explain the care needed by the patient, and why such care is medically necessary:

_____

_____

_____

_____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDTIONAL ANSWER.

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Health Care Provider Date

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**

Clear Print

CALIFORNIA STATE UNIVERSITY
FULLERTON
Human Resources, Diversity & Inclusion http://hr.fullerton.edu

REQUEST FOR ADDITIONAL EMPLOYMENT

Name:	College:	Department:	Date:

Faculty's Comments addressing how additional employment affects the approved leave, and how the leave project will be accomplished if applicable (attach copy of approved leave proposal).

Name of organization where additional employment is sought:	Is additional employment with pay? ☐ Yes ☐ No	If yes, amount of remuneration:

List the specific activities for which you will be paid.

If teaching where will you teach?	What courses will you teach?	How many courses will you teach?	Other activities not previously listed:

Amount of time per week:	Name of Supervisor:	Telephone number of Supervisor (with area code):	Is tenure another institution involved? ☐ Yes ☐ No

List all other information that may be pertinent below (attach additional page if necessary); i.e. will employment potentially affect any existing contracts, grants, or agreements with the University or its affiliates.

Faculty Signature:	Date:

Chair's comments (attach additional pages if more space is needed)

Recommend? ☐ Yes ☐ No	Chair's Signature (forward form to Dean):	Date:

Dean's comments (attach additional pages if more space is needed)

Recommend? ☐ Yes ☐ No	Dean's Signature (forward form to Human Resources - CP-700):	Date:

Provost's comments (attach additional pages if more space is needed)

Recommend? ☐ Yes ☐ No	Provist's Signature:	Date:

Guidelines for Sabbaticals can be found at http://www.fullerton.edu/senate/documents/PDF/200/UPS260%20102_Sabbatical_Leaves_effec_10-9-13.pdf
Guidelines for Difference-In-Pay Leaves can be found at http://www.fullerton.edu/senate/documents/PDF/200/UPS260-104.pdf

Clear Print

CALIFORNIA STATE UNIVERSITY
FULLERTON
Human Resources, Diversity & Inclusion http://hr.fullerton.edu

What's Next?

Now that you have read and completed the form(s), and made certain that all fields are accurate, the next step:

Print, sign, obtain all necessary approval signatures and forward completed **forms along with supporting documentation (Certification of Health Care Provider for all medical leaves) to Payroll, Benefits and Retirement Services, CP-770**.

Please note: The Certification of Health Care Provider form must be submitted for all Medical Leaves and Extensions. A note from the attending physician will not be accepted in lieu of the Certification of Health Care Provider form.

Payroll, Benefits and Retirement Services will provide a written notice to you and your department outlining the details of the leave including anticipated return date.

☐ I have read the instructions above

Clear Print

CALIFORNIA STATE UNIVERSITY
FULLERTON
Human Resources, Diversity & Inclusion http://hr.fullerton.edu

PAID AND UNPAID LEAVES OF ABSENCE FOR FACULTY, STAFF AND MANAGEMENT EMPLOYEES

A Leave is an employee originated request and it is the employee's responsibility to initiate the request in a timely manner, unless the employee is unavailable due to illness or injury, in which case, the department should initiate the request. Use this form to request any of the following leave types: Medical, FML Self or FML Family (to care for ill parent, child or spouse/domestic partner), Pregnancy Disability, Parental (Maternity, Paternity or Adoption), Military, Organ Donor, or Leave of Absence Without Pay (Personal or Professional). FERP participants shall be granted one (1) leave of absence without pay for personal illness for all or part of the period of employment, such leaves shall not affect future participation in FERP, and the 5-year FERP period is not extended due to a leave of absence.

FORMAL LEAVE REQUESTS: To request a Full or Partial leaves with or without pay; complete this form even if you have sufficient leave credits and/or want to apply for Non-Industrial Disability (NDI).

INFORMAL LEAVE: Leaves without pay of 5 work days or less may be granted at departmental level. The leave form does not need to be completed. Report absences or time to be docked in Absence Management via the campus portal.

Procedures and timelines

Employee: Complete the Request for Formal Leave of Absence form and submit along with any required supporting documentation to Department Head/Director/Chair 30 days prior to the effective date of the requested leave, if circumstances prevent a 30 days advance notice, notice shall be given as soon as the event necessitating the leave is known. All Medical leaves must have a Certification of Health Care Provider attached. Returning to work - the employee is required to present a physician's release to return to work.

Department Head/Director/Chair: If recommended, forward approved leave form and documentation as appropriate to Vice President or to Human Resources, Diversity and Inclusion (HRDI) within 5 days of receipt.
If not recommended, form is returned to employee with written justification of the denial, and a copy of the leave form and justification must be sent to HRDI.

Dean/Administrator: If recommended, forward approved leave form and documentation as appropriate to Vice President or to Human Resources, Diversity and Inclusion (HRDI) within 5 days of receipt from Department Head/Director/Chair.
If not recommended, form is returned to employee with written justification of the denial, and a copy of the leave form and justification must be sent to HRDI.

Human Resources Diversity and Inclusion (HRDI): Within 5 days of receiving approved formal leave of absence form, and all supporting documents, HRDI will provide written notice to the employee with copies to the department outlining the details of the leave including anticipated return date.
REQUEST FOR EARLY RETURN OR EXTENSIONS: Employee must provide an updated Certification of Health Care Provider to HRDI as soon as the need to change is known. The document(s) will be reviewed and the employee will be notified in writing.

Things to consider when requesting leave:

- No service credit or leave accruals will be earned in a pay period in which fewer than 11 days are paid.
- CalPERS Service Credit will not be earned on a leave of absence without pay or while receiving pay under NDI (Non-Industrial Disability Insurance); service credit will be prorated if leave is less than a full month.
- To continue health benefits during a leave of absence without pay (full time), the employee must request enrollment in Direct Pay and pay the employer's and the employee's share of the premium.
- To continue health benefits during a partial leave of absence without pay:
    - For staff or management employees, work at least 20 hours per week to maintain coverage, if working less than 20 hours per week, employee will lose benefits eligibility and will need to request enrollment in Direct Pay and pay the employer's and the employee's share of the premium.
    - For full-time faculty, work a minimum of 7.5 units to maintain coverage. If working less than 7.5 units, you will lose benefits eligibility and will need to request enrollment in Direct Pay and pay the employer's and the employee's share of the premium.
    - For part-time temporary faculty, work a minimum of 6 units to maintain coverage. If working less than 6 units, you will lose benefits eligibility and will need to request enrollment in Direct Pay and pay the employer's and the employee's share of the premium.
- Effect on probation:
    - Staff employees- the probationary period will be extended for the same number of days an employee is on paid sick leave or family medical leave of over thirty (30) days, parental leave, and for any day an employee is on Workers' Compensation (WC), Industrial Disability Leave (IDL), Non-Industrial Disability Insurance (NDI), Military Leave or formal leave without pay (LWOP). Please consult the appropriate Collective Bargaining Agreement for further information.
    - Faculty - An extension of the probationary period due to a leave of absence may be requested. For more information, please consult Article 13.7&8 of the faculty Collective Bargaining Agreement or contact HRDI at x2425.
- Consult the appropriate Collective Bargaining Agreement for information regarding eligibility for a leave of absence and accumulation of seniority points during a leave of absence.
- If you will be on an extended leave and have no need to return to campus during your leave, you may want to return your parking permit and cancel your payroll deduction. You are responsible for the monthly payment for as long as the parking permit is in your possession. Payments not received through deduction will be invoiced to the permit holder. To cancel your parking deduction, contact Parking and Transportation Services at 657-278-3082, Bldg. T-1400.

Clear Print

CALIFORNIA STATE UNIVERSITY
FULLERTON
Human Resources, Diversity & Inclusion http://hr.fullerton.edu

PROCEDURES FOR CATASTROPHIC LEAVE DONATION PROGRAM

ELIGIBILITY TO PARTICIPATE

Any CSU employee who accrues vacation or sick leave credits may voluntarily donate either of those credits to any other CSU employee on the same campus if the recipient employee has exhausted all accrued leave credits, i.e., sick leave, vacation, and CTO, due to a catastrophic illness or injury.

CATASTROPHIC ILLNESS

Catastrophic illness or injury is defined as an illness or injury that totally incapacitates an employee. The total donated leave credits shall normally not exceed an amount necessary to continue the employee for three calendar months calculated from the first day of catastrophic leave. An additional three-month period may be approved in exceptional cases.

The same definition applies to a catastrophic illness or injury of an incapacitated member of the employee's immediate family if it requires the employee to take time off for an extended period in order to care for the family member and the employee has exhausted all of his/her available leave credits. Only donated vacation credits may be used for such family care catastrophic leave. Immediate family member is defined in the sick leave provisions of the collective bargaining agreement covering the recipient employee.

Donated leave credits may be used to supplement only Industrial Disability Leave, Nonindustrial Disability Leave, or Temporary Disability payments from the State Compensation Insurance Fund upon the application for these benefit(s) by an eligible employee. An incapacitated employee may elect to defer a request to participate during a period of Industrial Disability Leave eligibility. The total amount of leave credits donated and used may not exceed an amount sufficient to ensure the continuance of the employee's regular monthly rate of compensation for the three calendar months.

HOW TO REQUEST PARTICIPATION IN THE PROGRAM

The employee or his/her designee must request participation in the Catastrophic Leave Credits Program by completing the Request for Solicitation of Donated Leave Credits (HR 500) from an a Hold Harmless Agreement (HR 501) from available in the Academic Affairs and Human Resources offices and providing appropriate medical certification. The Employee Relations Designee(s) will determine eligibility. Employees or their designees refusing to complete and submit these forms will be not authorized to receive catastrophic leave credit donations.

SOLICITATION OF LEAVE CREDITS

Academic Affairs for Unit 3 and Human Resources for all other collective bargaining units will notify the designated representative that the request to solicit or receive donated leave credits has been approved or denied. Solicitation an d publication may not begin until approval has been given. Solicitation and publication will be the sole responsibility of the union or personal friends/acquaintances of the employee.

DONATION OF LEAVE CREDITS

An employee in bargaining units 1, 8, 10 and 11 (TA's only) may donate a maximum of sixteen (16) hours, employees in bargaining units 3, 4, 2, 5, 6, 7, 9, Confidential (C99), Management Personnel Plan (M80), and Executive (M98) classifications may donate a maximum of forty (40) hours of leave credits per fiscal year to any one employee or a combination of employees. Leave credits may be donated in increments of one hour only. Pledged leave credits will be formally transferred to the recipient employee only at the end of the pay period, and then in chronological order of the dates and times at which they were pledged. In the even that an employee is unable to use all pledged credits in a pay period, the leave credits which cannot be utilized (i.e., those most recently donated) will not be formally transferred until the employee can use them.

To donate leave credits, an employee must complete a Catastrophic Leave Donation (HR 502) form and send directly to Payroll. Leave credits should not be deemed donated until actually transferred by the Payroll Department to the record of the employee receiving the credits. Donations are irrevocable.

Clear Print

CALIFORNIA STATE UNIVERSITY
FULLERTON
Human Resources, Diversity & Inclusion http://hr.fullerton.edu

PROCEDURES FOR CATASTROPHIC LEAVE DONATION PROGRAM

CATASTROPHIC LEAVE PROGRAM

INSTRUCTIONS: Employee or designee is to complete Part A, Requestor Information, and attach to this form: a) medical certification from a physician and b) hold Harmless Agreement, available from Human Resources or Academic Affairs. The completed forms are to be forwarded as a package to Academic Affairs (Unit 3) or to Human Resources (for all other collective bargaining units).

PART A -- REQUESTOR INFORMATION

Recipient's First Name	Recipient's Last Name	EMPL ID	EMPL RCD#

Department Name	Department ID	Bargaining Unit	Check One
			☐ Personal Illness ☐ Family Illness

Estimated length of illness: _____

A copy of the physician's meddical certification, including a diagnosis/prognosis must be attached

Estimated amount of donated sick leave needed: _____

I have applied for: ◯ Nonindustrial Disability Leave ◯ Industrial Disability Leave ◯ Temporary Disability

I authorize the university to notify the union representative and/or _____

on my behalf of the status of my certification of eligibility. _____

Employee/Employee Designee's Signature

PART B -- CERTIFICATION OF ELIGIBILITY

◯ ELIGIBLE -- The above employee meets all the criteria outlined in the respective collective bargaining unit agreement and is eligible to receive donated

- ◯ vacation credits only.
- ◯ all leave credits.

◯ NOT ELIGIBLE -- The above employee dot not meet all the criteria outlined in the respective collective bargaining unit agreement and is not eligible to receive donated

Reason: _____

_____ _____

Staff Unit Employee Relations Designee Date

_____ _____

Unit 3 Employee Relations Designee Date

Clear Print

CALIFORNIA STATE UNIVERSITY
FULLERTON
Human Resources, Diversity & Inclusion http://hr.fullerton.edu

PROCEDURES FOR CATASTROPHIC LEAVE DONATION PROGRAM

Employee's Name	EMPL ID	EMPL RCD#
Department	Date	

I hereby agree to allow Academic Affairs and/or Human Resources to notify the representative I designated on the Request for Solicitation of Donated Leave Credits (HR 500) form, my department, and Payroll of the approval or denial of my request to receive donated leave credits. I understand that my representative must obtain from me my permission before publicizing or soliciting donations of leave credits on my behalf. I hereby authorize Academic Affairs, Human Resources, and Payroll to have discussions concerning this request with my representative as needed.

In addition, I agree to hold harmless the Trustees of the California State University and California State University, Fullerton and its employees from liability concerning all aspects of my request for solicitation of donated leave credits for myself or family member.

_____ _____

Signature of Employee/Employee's Designee Date