

County of Riverside
Medical Leave of Absence Request & Medical Certification



SECTION A. TO BE COMPLETED BY EMPLOYEE

Employee Name:	Employee ID #:	Department:	Job Title:
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Date of Hire:	Contact Address:	Contact Phone: () ()
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Type of Request: <input type="checkbox"/> New <input type="checkbox"/> Extension	Leave Request Dates: From: _____ To: _____	Last Date Worked:	Is the injury or illness work-related? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Please explain your need for leave (attach additional sheet if necessary):

Are you requesting leave as an accommodation under the Americans with Disabilities Act (ADA) or the Fair Employment and Housing Act (FEHA)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Employee Signature	Date:
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SECTION B. TO BE COMPLETED BY HEALTHCARE PROVIDER

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities governed by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or individual's family member sought or received genetic services, and genetic information of a fetus to be carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

WORK RESTRICTIONS

Bending.....	<input type="checkbox"/> No	<input type="checkbox"/> No Repetitive	Max Minutes/Hour _____	Per Day _____
Climbing.....	<input type="checkbox"/> No	<input type="checkbox"/> No Repetitive	Max Minutes/Hour _____	Per Day _____
Driving.....	<input type="checkbox"/> No	<input type="checkbox"/> No Repetitive	Max Minutes/Hour _____	Per Day _____
Grasping/Gripping.....	<input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> No	Max Minutes/Hour _____	Per Day _____
Hand Motion.....	<input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> No	Max Minutes/Hour _____	Per Day _____
Kneeling.....	<input type="checkbox"/> No	<input type="checkbox"/> No Repetitive	Max Minutes/Hour _____	Per Day _____
Operating Heavy Machinery.....	<input type="checkbox"/> No	<input type="checkbox"/> No Repetitive	Max Minutes/Hour _____	Per Day _____
Pushing/Pulling.....	<input type="checkbox"/> No	<input type="checkbox"/> No Repetitive	Max Minutes/Hour _____	Per Day _____
Reaching At/Below Shoulders.....	<input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> No	Max Minutes/Hour _____	Per Day _____
Reaching Above Shoulders.....	<input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> No	Max Minutes/Hour _____	Per Day _____
Sitting.....	<input type="checkbox"/> No	<input type="checkbox"/> No Repetitive	Max Minutes/Hour _____	Per Day _____
Squatting.....	<input type="checkbox"/> No	<input type="checkbox"/> No Repetitive	Max Minutes/Hour _____	Per Day _____
Standing.....	<input type="checkbox"/> No	<input type="checkbox"/> No Repetitive	Max Minutes/Hour _____	Per Day _____
Twisting.....	<input type="checkbox"/> No	<input type="checkbox"/> No Repetitive	Max Minutes/Hour _____	Per Day _____
Walking.....	<input type="checkbox"/> No	<input type="checkbox"/> No Repetitive	Max Minutes/Hour _____	Per Day _____
Carrying.....	Not Over _____ Pounds	<input type="checkbox"/> No	Max Minutes/Hour _____	Per Day _____
Lifting.....	Not Over _____ Pounds	<input type="checkbox"/> No	Max Minutes/Hour _____	Per Day _____

OTHER RESTRICTIONS OR COMMENTS (attach additional sheet if necessary):

Dates medically REQUIRED for leave: From: _____ To: _____	Can the employee perform modified duty within the above restrictions: <input type="checkbox"/> Yes <input type="checkbox"/> No
Health Care Provider Signature:	Date: _____
Health Care Provider's Name (Please Print):	Health Care Provider Contact Info (or attach business card): Address: _____ Phone: (_____) _____ Fax: (_____) _____

FORM CONTINUES ON NEXT PAGE

Employee Name:	Employee ID Number:
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SECTION C. TO BE COMPLETED BY DEPARTMENT

Leave not exceeding 480 hours*	<input type="checkbox"/> APPROVED	<input type="checkbox"/> APPROVED WITH MODIFICATION <small>(Attach brief explanation)</small>	<input type="checkbox"/> NOT APPROVED <small>(Attach brief explanation)</small>
Leave exceeding 480 hours* <small>(Requires approval from Human Resources)</small>	<input type="checkbox"/> RECOMMEND APPROVAL	<input type="checkbox"/> RECOMMEND APPROVAL WITH MODIFICATION <small>(Attach brief explanation)</small>	<input type="checkbox"/> DO NOT RECOMMEND APPROVAL <small>(Attach brief explanation)</small>

*Hours total to include previous leave used for same event.

Department Head/Designee Signature: _____ Date: _____

SECTION D. TO BE COMPLETED BY HUMAN RESOURCES

	<input type="checkbox"/> APPROVED	<input type="checkbox"/> APPROVED WITH MODIFICATION	<input type="checkbox"/> NOT APPROVED
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Comments: _____

Asst. CEO/Human Resources Director or Designee Signature: _____ Date: _____

Human Resources Action/Reason: Initials: Date

INSTRUCTIONS FOR COMPLETING THE MEDICAL LEAVE OF ABSENCE FORM

The Medical Leave of Absence Form is to be completed for requests for medical leave only. (For care of a family member, military, personal and educational leave - See Non-Medical Leave of Absence Form)

SECTION A - EMPLOYEE

- The form may be obtained from your Department Representative or from the HR Toolbox tab at www.rc-hr.com.
- Fill in your name, employee ID#, department name, date of hire, job title, contact address and phone number where you can be reached during your requested leave
- Type of Request
 - **NEW:** Use this option for initial leave request or when FMLA/CFRA/PDL has been either exhausted or you don't meet the requirement for these leaves
 - **EXTENSION:** Use this option to request extension of a previously approved leave
- Complete projected leave dates (leave start date to anticipated return date)
- Identify "Last Day Worked" (last physical day at work)
- Identify whether or not the request is for a work-related injury or illness
- Explain your need for leave - attach relevant detailed information to support your request for leave or extension
- Identify whether or not you are requesting leave as an accommodation under the Americans with Disabilities Act (ADA) or the Fair Employment and Housing Act (FEHA). (Information about reasonable accommodation under ADA/FEHA can be obtained by selecting "Disability Access Office" from the HR Toolbox tab on Workforce Exchange.)
- Sign and date the document
- Take form to Healthcare Provider or Workers' Comp. Primary Treating Physician (as applicable) to complete

SECTION B - HEALTHCARE PROVIDER (Doctor or Healthcare Provider to complete)

- Please have Healthcare Provider complete this section in its entirety
- Submit completed form to your Department Designee

SECTION C - DEPARTMENT (For Department Designee to complete)

- For leaves not exceeding 480 hours*, the department head has the approval authority. These hours are inclusive of any previous FMLA/CFRA/PDL or other leave hours used for the same event on a continuous basis.
 - Check appropriate box (APPROVED, APPROVED W/ MODIFICATION, NOT APPROVED)
 - If approved with modification, attach a brief explanation
 - Sign, date and forward to HR Services Team
 - HR Services Team forwards to HR Employee Services for processing
- For leaves exceeding 480 hours*, the Department Head recommends approval or denial.
 - If department recommends approval, sign and date the form
 - If department recommends approval with modification, note recommended modifications and attach brief explanation, sign and date the form
 - If department does not recommend approval, an explanation must be provided with the form. Sign and date the form
 - Forward to the HR Services Team
 - HR Services Team will forward to Central HR Administration for review and approval
- For employees returning from leave of absence:
 - Complete a *Return From Leave* form (available from the HR Toolbox at www.workforceexchange.net) and forward to the HR Services Team.
 - HR Services Team logs and forwards to HR Employee Services for processing

SECTION D - HUMAN RESOURCES

- The Assistant CEO/Human Resources Director has final approval authority on leave requests exceeding 480 hours*
- HR Services Managers may approve requests up to 6 months. However, all denials require the HR Director's signature
- After review, the Assistant CEO/Human Resources Director will note if the request is approved, not approved or approved with modification, and may include any comments relevant to the decision
- When the request process is complete, the form will be logged and forwarded to HR Services Team and HR Employee Services for processing
- The HR Employee Services staff will process the leave request in PeopleSoft
- The HR Services Team will forward copies to the requesting department
- The Department Designee will notify the employee of the decision

*Hours total includes previous leave used for same event.