

**COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH
HUMAN RESOURCES BUREAU**

Return to Work
550 S. Vermont Ave, 9th Floor
Los Angeles, CA 90020

REQUEST FOR LEAVE OF ABSENCE

EMPLOYEE NAME:		EMPLOYEE #
PATIENT'S NAME (if different from employee):		
HOME/MAILING ADDRESS:		
Number and Street		City ZIP
PAY LOCATION#	Immediate Supervisor:	
WORKSITE NAME:		

I hereby request a leave of absence beginning on _____ ending on _____

Complete the attached Designation of Leave Benefits.

☐ Attached to my request is the completed designation form.

Check purpose for this leave and attach appropriate document(s): *(Check appropriate box(es))*

☐ Maternity ☐ Medical ☐ Family ☐ Personal ☐ Other (Explain)

I am requesting Family Medical Leave for the following reason(s): *Check only if appropriate:*

- ☐ the birth of a child, or placement of a child for adoption or foster care;
☐ a serious health condition that makes me unable to perform the essential functions of my job;
☐ a serious Health Condition affecting my ☐ spouse ☐ child ☐ parent, for which I need to provide care.

Maternity Leave: DMH provides that the employee's sick leave benefits may be used for the length of time that the employee is disabled. Medical certification will be required of the employee.

I understand that I must attach the appropriate certification that corresponds with the type of leave I am taking. This could include more than one certification form (i.e., Physician's Statement or/and Certification of Health Care Provider (FMLA))

SIGNATURES:

Employee:	Date:
Immediate Supervisor:	Date:
Manager:	Date:

☐ Approved ☐ Denied

Deputy Director:

DISTRIBUTION: Original Payroll
Copy Employee
Copy Immediate Supervisor