COUNTY OF VENTURA

Natural Disaster Attestation Form (April 5-18, 2020)

This form should be completed by any employee whose absence from work during the period of April 5, 2020, through April 18, 2020, was directly related to the COVID-19 crisis per the Board of Supervisor's Resolution dated March 24, 2020.

Employee Name: _____ ID# _____

Agency/Division: _____

Dates Absent from Work: _____

Total Hours Absent from Work: _____

Leave of absence was directly related to the COVID-19 crisis, due to (choose one or more):

- ☐ Quarantine in the event of a high-risk exposure to COVID-19 (as defined by the U.S. Centers for Disease Control and Prevention (CDC)) or exhibiting COVID-19 symptoms.
- ☐ COVID-19 illness.
- ☐ Necessity to care for a dependent with COVID-19 illness.
- ☐ Necessity to care for a minor child if the child's school or place of care has been closed.
- ☐ Direction from agency/department.
- ☐ Local/state emergency orders to remain at home due to:
  - Age 75 or older, or age 70 or older and with an underlying health condition.
  - Underlying health condition that increases vulnerability to COVID-19 illness.
- ☐ Other (explain below).

Explanation: _____

_____

_____

My signature on this form attests that all hours reported above for the period April 5, 2020, through April 18, 2020, were directly related to the natural disaster set forth by the Board of Supervisors on March 24, 2020. I shall be paid at my regular rate of pay for the period of absence utilizing the appropriate Natural Disaster time code. I agree that by receiving my regular rate of pay for the above noted Dates Absent from Work, the County has fulfilled its payment obligations under the Families First Coronavirus Response Act detailed in the Family Public Health Emergency Leave and Emergency Paid Sick Leave provisions.

Employee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

*Agency/Dept. Head: _____ Date: _____

**Requires approval of the Agency/Department Head prior to processing.*

Completed and signed form must be submitted to CEO-Human Resources L#1970.

County of Ventura
Human Resources

Leave of Absence Request

INSTRUCTIONS: After completion, please return this form to your Leave of Absence Coordinator.

SECTION I:

Name (Last, First, Middle):		EE ID:	
Mailing Address (Include Apt/Unit #):			
Home Phone:		Cell Phone:	
Email:		Work Phone:	
Department:		Last Day Worked (month/day/year):	
Supervisor Name:		Supervisor Phone:	
Date Leave Begins:		Date Leave Ends:	Extension: ☐ Yes ☐ No

During this leave or extension, I request: ☐ PAID Leave ☐ UNPAID Leave

Will you be applying for disability benefits during this leave? ☐ Yes ☐ No

Type of Leave Request: ☐ Continuous Leave ☐ Intermittent or Reduced Schedule (Specify schedule below)

SECTION II:

I request a leave of absence for the following reason (check one):

☐ Employee's own serious health condition that makes the employee unable to perform the functions of his/her position.
Is the injury work related? ☐ Yes ☐ No Injury Date:

☐ Disabled by pregnancy or childbirth.
If my Pregnancy Disability Leave (PDL) entitlement exhausts prior to my doctor releasing me to return to work, I wish to use my CFRA (bonding) entitlement immediately after my PDL. ☐ Yes ☐ No Expected due date:

☐ In order to care for an immediate family member because such family member has a serious health condition.
Check one (and provide name): Name:
☐ Spouse ☐ Parent ☐ Domestic Partner ☐ Child/child of domestic partner (under 18 only) Age:

☐ Bonding Leave: Check one: ☐ Newborn ☐ Adoption ☐ Foster Care Placement Date Acquired/Born:

☐ Care for an adult child who is incapable of self-care (A child is "incapable of self-care" if she/he requires active assistance or supervision to provide daily self-care in three or more of the activities of daily living or instrumental activities of daily living, such as grooming and hygiene, bathing, dressing and eating, cooking and cleaning, shopping, taking public transportation, paying bills, maintaining a residence, using telephones and directories, etc.).

☐ Military Service Leave (attach Military Service Notification) ☐ Emergency Rescue Personnel Leave

☐ To assist a child, spouse, or parent who is a member of the National Guard or Reserves with a "qualifying exigency" related to active duty or a call of active duty status in support of a contingency operation.
Check one: ☐ Child ☐ Spouse ☐ Parent

☐ To care for a child, spouse, parent, or "next of kin" service member of the United States Armed Forces who has a serious injury or illness incurred in the line of duty while on active duty (up to 26 weeks of leave).
Check one: ☐ Child ☐ Spouse ☐ Parent ☐ Next of Kin (as defined by FMLA regulations)

☐ Donor Leave: Check one: ☐ Bone Marrow Donation ☐ Organ Donation

☐ Other Reason (including personal, educational, and death of family member). Explain:

EMPLOYEE SIGNATURE REQUIRED ON NEXT PAGE

Initials:

READ THE TERMS CAREFULLY BEFORE SIGNING BELOW.

Name (Last, First, Middle):		EE ID:	

I understand that:

1. I am bound by all the terms and conditions of the County's Leave of Absence Program and that the County has the right to grant or deny any request for a leave of absence or an extension thereof, subject by provisions of the Federal Family Medical Leave Act, the State Family Rights Act, the State Pregnancy Disability Leave rights, applicable collective bargaining agreements, Article 22, Section 2203 of the County of Ventura Personnel Rules and Regulations, and the County Administrative Policy Manual.
2. I may be required to make premium payments directly to the County while on leave of absence. If I fail to make payments on a timely basis, coverage under that benefit will be canceled until I return from leave and deductions resume. If the County mistakenly pays any premiums on my behalf, I agree to repay the County directly or through wage/salary deduction.
3. The failure to return to work on the day following the "Date Leave Ends" may be considered inexcusable absence without leave and subject me to disciplinary action. I also understand that if I am absent from work without authorization for three (3) days or two (2) consecutive twenty-four hour work shifts beginning with the day following the "Date Leave Ends" I have entered on the front of this form, the County may deem that I have voluntarily abandoned my job under Article 22, Section 2203, of the County of Ventura Personnel Rules and Regulations.
4. Failure to provide a complete and sufficient medical certification within 15 calendar days of this request may result in a denial of my leave of absence request. I further understand that I may be required to provide periodic reports on my status and intent to return to work. I agree to notify BOTH, my supervisor and leave of absence coordinator of my availability to return to full or restricted duty if I am released by my doctor prior to the end of an approved medical leave of absence.
5. I agree to comply with the County's Integration policy to which employees may use approved leave bank hours in conjunction with disability benefits that result in the employee's full biweekly base pay. The policy prevents employees from using leave bank hours that result in pay that is greater than their biweekly base rate. I understand that the appropriate use of your leave bank hours must be because of and consistent with the leave granted and that I have provided my department with payroll instructions during my leave of absence.
6. My dependent(s) eligibility for health care coverage is contingent on my submitting the proper forms within 31 days of (1) acquiring a new dependent (birth, marriage, placement for adoption, permanent legal custody), (2) a current dependent losing eligibility (divorce, dependent child turns age 26, death), even when the event occurs during my leave of absence.
7. I must comply with the Flexible Benefits Program Open Enrollment rules even if I am on leave of absence. Any applicable forms must be completed and submitted during the open enrollment period, not when I return from leave of absence and failure to comply may jeopardize my participation.
8. I agree to notify my department of any change of address and/or phone number. I understand and agree that all communications from the County of Ventura will be sent to the address I have on file and that I am responsible for acknowledging information sent to the address on file.

I affirm that I have read, understand and agree to the terms of this request as stated above and on the front of this form. I have been given a copy of the Family Medical Leave Act (FMLA), California Family Rights Act (CFRA) and if applicable, the California Pregnancy Disability Leave Notice to Employees (PDL).

Employee Signature: **Date:**

SECTION III:

☐ **Leave request approved** ☐ **Leave request approved *WITH CHANGES*** ☐ **Leave request denied**

Department Signature:	EE ID:		Date:	
Department Signature:	EE ID:		Date:	
CEO / HR Signature:	EE ID:		Date:	

County of Ventura
Leave of Absence Payroll Instructions Form

Employee and payroll/department representative should complete and discuss this form. Return this form with your Leave of Absence Request in advance of your absence.

Employee:		Employee ID:	
Biweekly scheduled work hours:		Last day of work (estimated):	

During this Leave of Absence, I request the following pay status:	Effective Date
☐ Full integration with disability benefits up to 100% of base biweekly compensation (Required if receiving disability benefits, optional if receiving TTD)	
☐ Leave bank hours equal to total biweekly scheduled work hours (Required if not receiving disability benefits or if disability benefits waived)	
☐ Leave without pay (LWOP) equal to total biweekly scheduled work hours (Fully unpaid, no leave bank hours may be reported for the duration of the leave)	
☐ Partial integration with temporary total disability (TTD) benefits (Reported hours must be consistent each pay period)	

Estimated Leave Bank Balances and *preference* to be used during my Leave of Absence:

Pref. #		Current floating holiday balance:		Hours to be used:	
Pref. #		Current sick leave balance:		Hours to be used:	
Pref. #		Current vacation/annual leave balance:		Hours to be used:	
Pref. #		Current comp bank balance:		Hours to be used:	

Expected Disability Benefits (check all that apply):	Benefit Waiting Period	Weekly Benefit Amount
☐ State Disability Insurance ☐ Paid Family Leave		$
☐ LTD (County of Ventura group plan)		$
☐ Workers Compensation _____ TTD _____ 4850		$
☐ Wage Supplement Plan (circle) - HIGH or LOW option		$
☐ Union Disability Plan (PORAC, other)		$

To ensure proper integration with disability benefits, send a copy of your first benefit award statement to your payroll/department representative. Please contact your payroll/department representative immediately if your disability benefit(s) amount increases, decreases, or is terminated/exhausted.

Once your leave turns unpaid, you may not report any further leave bank hours or resume a paid leave during the remainder of this Leave of Absence. These payroll instructions will remain in effect unless my leave status changes or I file revised payroll instructions.

I have read and I agree to comply with the County's integration policy to which employees may use leave bank hours in conjunction with disability benefits that result in the employee's full biweekly base pay. I further acknowledge that any over utilization of my leave bank balances may result in an overpayment and I agree to repay the County of Ventura directly or through wage/salary deduction(s).

Employee Signature:_____ Date:_____

WAIVER OF DISABILITY BENEFITS

EMPLOYEE NAME: _____ **EMPLOYEE ID #:** _____

If you choose not to file a claim for disability benefits with your group disability plan(s) and are requesting a paid leave, you must read and sign this waiver, and submit it to your agency/department in advance of your leave of absence. After receiving the signed Waiver, you will be allowed to use the appropriate hours from your leave bank balances in increments to equal your full biweekly schedule, and until balances are exhausted or you stop authorizing leave bank usage.

By not filing a claim with your disability plan(s), you may be forfeiting a variety of benefits including but not limited to: full and partial disability benefit payments, Return to Work Incentive payments, Reasonable Accommodation Expense Benefits and Temporary Recovery benefits. Please note that each plan has an application deadline, after which you forfeit all rights to benefits. Your department representative may provide a copy of this signed Waiver to your group disability plan(s) and to County Human Resources.

I understand that leave bank usage must begin at the onset of my leave of absence. I further understand that if I change my decision and later elect to file a claim for any group disability plan(s), I will be expected to repay the County of Ventura and/or any group disability plan(s) that has paid me any disability benefit(s) for the same time period of this Waiver.

I have read this form and acknowledge that I understand and agree not to file for disability benefits with any group disability plan(s) for this leave of absence. I authorize use of my leave bank balances in order to receive pay equal to my full regular work schedule for the following period(s): Beginning date _____ Ending date _____:

I choose to waive benefits from the following sources indicated below:	
☐ SDI (State Disability Insurance)	☐ PFL (Paid Family Leave)
☐ LTD (COV group plan)	☐ Wage Supplement Plan (circle) High or Low option

Employee Signature_____ **Date Signed**_____

Keep a copy for your personal records

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