

MEDICAL LEAVE OF ABSENCE EMPLOYEE CHECKLIST

REQUEST FOR MEDICAL LEAVE OF ABSENCE

10 DAYS IN ADVANCE OF PROPOSED LEAVE

(Contact Department Payroll Clerk for forms - return forms to Payroll Clerk)

1. Complete Leave Of Absence Form (You complete) []
2. Medical Leave Status Report (You/physician complete) []
3. Keep in contact with your supervisor - (Suggestion: call bi-weekly) []
4. Check with your Payroll Clerk as to other available benefits such as Long Term Disability Plan, Workers' Compensation Program, Health Plan contribution. []
5. If you change your home address while on medical leave, notify your Payroll Clerk of your new address as soon as possible. []
6. (For SEIU and ESC members only) Check with SEIU, Local 707 regarding Short-Term Disability Coverage. []
7. Call Auditor-Controller's payroll office if leave is unpaid to arrange for insurance premium contribution (565-4691 or 565-4692) []

REQUEST FOR *EXTENSION* OF MEDICAL LEAVE OF ABSENCE

10 DAYS IN ADVANCE OF YOUR LEAVE EXPIRATION:

Contact Person: Department Payroll Clerk

1. Complete and submit another Leave Of Absence form []
2. Complete (you/physician) and submit Medical Leave Status Report []
3. Keep in contact with your supervisor (call bi-weekly) []
4. Contact Auditor-Controller's Payroll office if additional remittance advices are needed to continue insurance premium payments []



COUNTY OF SONOMA MEDICAL LEAVE STATUS REPORT

FOR EMPLOYEE TO COMPLETE: (INSTRUCTIONS TO EMPLOYEE: Fill in the top box and give to your doctor. When doctor completes form, take or mail to your payroll clerk.)

Name: _____ Date of Injury/Illness: _____

County Department: _____

REASON FOR REPORT (more than one can be checked):

- | | | |
|--|---|--|
| <input type="checkbox"/> Workers' Compensation Update | <input type="checkbox"/> Sick Leave | <input type="checkbox"/> Long Term Disability Update |
| <input type="checkbox"/> Medical Leave Without Pay | <input type="checkbox"/> Fitness for Duty | <input type="checkbox"/> FMLA (Family Medical Leave Act) |
| <input type="checkbox"/> Other (please specify:) _____ | | |

FOR MEDICAL PROVIDER TO COMPLETE:

Temporary Disability: from _____ to: _____ Modified Work: from: _____ to: _____

*complete **ABILITIES** section

Released for Regular Work: on: _____ Discharged from Care on: _____

ABILITIES:

Task	Unrestricted
Reaching (forward/above)	
Pushing/Pulling	
Grasping/Gripping	
Keyboarding	
Climbing	
Bending	
Kneeling/Squatting	
Twisting	

Modifications	
# of	Maximum Amount of Time

Lifting: _____ pounds allowed. Work Hours: _____ hours per day, _____ days per week

Other: _____

Comments (including comments about temporary workplace modifications which may enable your patient to return to work earlier):

Your cooperation in completing this form will expedite employee receiving benefits.

Signature of Physician: _____

Name (please print or type): _____

Address: _____

Date: _____

Phone Number: _____