EMPLOYMENT PHYSICIAN SERVICES
1720 Termino Avenue, Long Beach, CA 90804
(562) 494-0735 ◆ Fax: (562) 494-0733

REQUEST FOR STATUTORY LEAVE OF ABSENCE

*****Classified*****

When an employee has used all accumulated leave balances (sick leave, vacation accrual, and personal/discretionary leave) he/she shall submit this form requesting statutory leave and return it to the site Payroll Designee. The employee must then have their personal physician complete the Confidential Request form both for non-work related and work related medical absences, pending approval of the workers' compensation claim. Return completed forms to Physician Services. No request or physician's statement is necessary for the initial (one time use) of statutory leave for four (4) consecutive working days or less. No Confidential Request is required for maternity or pregnancy disability leave.

Family Medical Leave Act (FMLA) and California Family Rights Act (CFRA) leave will run concurrent with statutory leave for eligible employees as permitted by law.

I. EMPLOYEE'S STATEMENT (Please print or type - use payroll name)

Name (Last, First, MI) ______________________________ Employee #______________________

Home Phone Number (   )_________________Assignment Location__________Position_____________

Home Address (Street, City, Zip)____

I hereby authorize my health care provider to release medical information to Juan A. Escobar, M.D. I understand that Family Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leave will run concurrent with statutory leave.

Signature (Use Payroll Name)_______________________________ Date______________________

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2. TO BE COMPLETED BY SITE PAYROLL DESIGNEE:

Employee is (check one):______200 day _____202 day _____204 day _____Track _____ 212 day
______217 day _____12 month

Has the employee used 2 days of personal/discretionary leave at half pay? __________________

Statutory leave to begin ______________ Number of statutory leave hours used as of this date _________

Date 100 days of statutory leave balance used ____

ADMINISTRATIVE REVIEW:
Site Administrator ______________________________________ Date_____________________

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3. ATTENDING PHYSICIAN'S STATEMENT:

(Please complete attachment - Confidential and return this form to the above address/fax)

☐ Illness ☐ Surgery ☐ Injury ☐ Pregnancy ☐ Other ____________________________

Anticipated date this employee will return to work (Month/Day/Year) ________________________________

Physician's Address (Street, City, Zip) ____

Physician's Name (Please Print or Type) ____________________________Phone# (   )______________

Attending Physician's Signature ______________________________________Date____________________

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4. LBUSD DISTRICT PHYSICIAN'S REVIEW: ☐ Approved ☐ Denied

Employment Physician____ Date _______________________