**City and County of San Francisco**

**Department of Public Health**

**Zuckerberg San Francisco General Hospital and Trauma Center**

***Susan P. Ehrlich, MD, CEO***

**London N. Breed**
**Mayor**

## FAMILY MEMBER

Dear Employees:

**Important Information Regarding Requesting a Leave of Absence:**
In order to process your leave, we will require the following:

- ✓ A completed Request for Leave Form (RFL).
  Please indicate if you will be applying for **State Disability/Paid Family Leave** and please indicate if you will be supplementing this pay with your **accrued time.**
  ***Failure to do so may result in an overpayment adjustment, and/or a delay in processing your leave.***
- ✓ FML2 or other medical certification on official doctor's letterhead, documenting the dates and duration of your leave.
- ✓ Documentation verifying your child's birth, the placement of a child for adoption or foster care, or your assumption of care for that child (if applicable)

While on approved leave for your own injury/illness, you may apply for compensation through State Disability Insurance (SDI). The application and additional information is found: **http://www.edd.ca.gov/Disability/SDI_Online.htm**

While on approved leave to care for a qualified family member, or while baby bonding you may apply for compensation through Paid Family Leave (PFL). The application and additional information is found: **http://www.edd.ca.gov/Disability/Paid_Family_Leave.htm**

Our employer is listed as: City &CO San Francisco. Please list your work address as: 2789 25th Street Room 339 SF, CA 94110

You may elect to use your accrued time to supplement your pay. If you are receiving compensation from State Disability (SDI) or Paid Family Leave (PFL), provide copies of your claim start and end date to payroll to ensure your accurate pay through the City and County of SF.

- ❖ ZUCKERBERG SAN FRANCISCO GENERAL
  Payroll Fax: (415) 206-3919 Phone: (415) 206-8458

If you have exhausted your accrued time or elect to go **unpaid** through the City and County of SF, you will be responsible for your health insurance premiums. Please contact the San Francisco Health Services System (HSS) to coordinate your premium payments at (415) 554-1750.

Should you have any questions, please contact:
Zuckerberg San Francisco General Leaves Department
Phone: (415) 206-5528
Fax: (415) 206-5668
Email: Leaves@sfpdh.org

# LIST OF IMPORTANT LEAVE CONTACT INFORMATION

## City and County of San Francisco

**Health Services System**
1145 Market Street, 3rd Floor
San Francisco, CA 94103
415-554-1750/Fax: 415-554-1721
Website: http://www.myhss.org

You must contact HSS within 30 days of a life changing event to make applicable changes to your insurance elections.

Download the medical enrollment form at: http://www/myhss.org/benefits/ccsf.html

**San Francisco Employees Retirement System**
1145 Market Street. 5th Floor
San Francisco, CA 94103
General Information: 415-487-700
Email: sfersconnect@sfgov.org

**Employee Assistance Program**
1145 Market Street, 1st Floor
San Francisco, CA 94103
1-800-795-2351

## Department of Public Health

**Department of Occupational Safety and Health**
101 Grove Street, Suite 217
San Francisco, CA 94102
Fax: 415-554-2562
A thru M: Annette White 415-554-2783
N thru Z: Angela Platzer 415-554-2786

**Catastrophic Illness Program (CIP)**
One South Van Ness Avenue, 4th Floor
San Francisco, CA 94103
Contact Person: Arturo Castillo
Phone: 415-701-5870
Fax: 415-701-5884
Email: Arturo.Castillo@sfgov.org

## State Programs

**State Disability (SDI)**
English: 1-800-480-3287
Spanish: 1-866-658-8846

**Deaf or Hard of Hearing Customers**

- The EDD offers tow (2) ways to reach an EDD representative by phone:

California Relay Service (711) – Provide the PFL number (1-877-238-4373) to the operator.

- TTY: 1-800-445-1312 (This number does not accept voice calls.)

**Paid Family Leave (PFL)**
English: 1-877-238-4373
Spanish: 1-877-379-3819
Cantonese: 1-866-692-5595
Vietnamese: 1-866-692-5596
Armenian: 1-866-627-1567
Punjab: 1-866-627-1568
Tagalog: 1-866-627-1569

Website:
http://www.edd.ca.gov/Disability/SDI_Online.htm

# City and County of San Francisco

Request for Leave and Leave Protections

**For All Continuous and Intermittent Absences of More than 5 Days, Including FMLA/CFRA**

☐ New Request ☐ Request for Extension[1]

**Name:** _____ **DSW#:** _____ **Class/Title:** _____

**Address:** _____ **City:** _____ **State:** ____ **Zip:** _____

**Contact No.:** _____ **Home Email:** _____ **Dept.:** _____

**Supervisor:** _____ **Employment Status:** ☐ **Permanent** ☐ **Probationary** ☐ **Exempt** ☐ **Temporary** ☐ **Provisional**

**Type of Leave or Job Protection Requested**
**(Check All That Apply):**

**1. LEAVES**

Sick Leave for (check one): Attach Medical Certification
- ☐ My Own Illness or Care
- ☐ Child Bonding or Assumption of Child Rearing
- ☐ Pregnancy or Related Condition
- ☐ Care for a Qualifying Family Member
- ☐ Bereavement for a Qualifying Person
- ☐ City Family Care Leave (Permanent Employees Only)

☐ Personal Leave
☐ Educational Leave
☐ To Accept Other City Employment: ☐ TEX ☐ PEX
☐ Other, Please Specify: _____

**2. PAY**

☐ Sick Leave Pay
In Lieu of Sick Leave Pay (Approval Required):
☐ Unpaid Sick Leave ☐ Vacation ☐ CTO ☐ FH

**3. OTHER BENEFITS**

I ☐ will ☐ will not receive/apply for SDI, PFL or WC
☐ I **DO NOT** wish to supplement SDI/PFL/WC with accrued Sick Leave, Vacation, CTO, or FH

**5. LEAVE PROTECTIONS**

☐ Family Medical Leave Act/California Family Rights Act for the purpose of:
- ☐ Child Bonding (Birth/Placement Date: _____)
- ☐ My Own Illness
- ☐ Care for a Qualifying Family Member
  State Relationship and Type of Care to be Provided:
  _____
  _____
  _____ (attach separate sheet)
- ☐ Care for Next of Kin Covered Military Service Member
- ☐ Military Exigency Related to Deployment

☐ Pregnancy Disability Leave
☐ Military Leave (Reservist – Attach Orders, if Issued)
☐ Other, Please Specify: _____

I wish to use accrued: ☐ **SP** ☐ **VA** ☐ **CTO** ☐ **FH** to receive pay or supplement other benefits during my FMLA/CFRA, PDL or other leave. Use of accrued leave is required for unpaid FMLA/CFRA or PDL leaves.

**4. AMOUNT OF LEAVE REQUESTED**

☐ Continuous ☐ Intermittent ☐ Reduced Schedule From (dates) _____ to _____

For Intermittent Leave: How Many Leave Hours Per Day?: _____ How Many Absence Days Per Week? _____

**OR** How Many Leave Hours Per Week?: _____ How Many Absence Days Per Month? _____

Proposed Reduced Work Schedule: Days: _____ Work Hours: _____

_____ _____

Employee Signature Date

| PRINT NAME/TITLE | SIGNATURE | DATE | APPROVE[2] | DENY (Attach Reason, if Required) |
|---|---|---|---|---|
| (Employee's Supervisor) | | | | |
| (Personnel Officer/Designee) | | | | |
| (Appointing Officer/Designee) | | | | |

c: Leave/Medical File

[1] Requests for extension of FMLA/CFRA or PDL leave must be submitted two weeks prior to the end of the currently scheduled FMLA/CFRA or PDL leave when practical. Failure to submit timely requests may delay granting the extension.

[2] **FOLLOWING VERIFICATION OF ELIGIBILITY AND MEDICAL NECESSITY, CERTAIN LEAVES MUST BE DESIGNATED ON FORM FML 3, EVEN IF NOT REQUESTED. THIS FORM CANNOT BE USED TO APPROVE OR DENY FMLA, CFRA OR PDL PROTECTIONS. SIGNATURE ACKNOWLEDGES RECEIPT OF FMLA, CFRA OR PDL REQUEST ONLY.**

**Leaves of Absence - General Provisions**

Leaves of absence are governed by the following general provisions:

1. Leave requests must be submitted to a department head or designee for approval.
2. A request for leave in excess of five days must be approved in advance on the appropriate form by the employee's supervisor, department's human resources representative, and the appointing officer/designee.
3. Employees who do not return to work when they are expected are absent without leave (AWOL) and may be subject to disciplinary action or automatic resignation.
4. Disapproval of certain types of leave may be appealed either through the grievance procedure in the respective collective bargaining agreement or the Civil Service Commission Rules.
5. Except for personal leave and in cases where the employee has obtained the prior approval of the appointing officer and the human resources director, an employee may not accept employment outside of the City and County service, other than military service, while on a leave of absence.

Employees should consult their human resources representatives if they have questions or need more information on any of the leaves or leave requirements described below.

**Sick Leave:** Except for leave under Labor code Section 233, sick leave requests for over five days must be certified by a licensed medical doctor, dentist, podiatrist, licensed clinical psychologist, Christian Science practitioner or licensed doctor of chiropractic medicine. Verification of sick leave for less than five days may be required on an individual basis. Employees are responsible for notifying their supervisors when they are unable to report for duty because of illness, and of the approximate date of their return to work. The duration of leave requested by the employee on this form should be the same as the duration certified as medically necessary by the health care provider. Only the amount of sick leave certified by the health care provider will be approved.

**Family Care Leave:** If an employee's leave to care for a newborn, newly adopted child or sick family member extends beyond the 12-week FMLA/CFRA leave maximum, or if the employee is not eligible for FMLA/CFRA leave, he or she may seek additional unpaid leave of up to a total of one year for any of the same reasons. This type of leave is available to permanent employees who have completed at least one year of service and is at the discretion of the department's appointing officer.

**Military Leave:** Military leave is governed by the provisions of applicable federal and state laws, Charter provisions, and by the Civil Service Commission Rules. A copy of the employee's official orders must be attached to his or her request for military leave. Certain employees on military leave may receive their regular compensation for a period not to exceed 30 days, and may qualify to receive supplemental pay and benefits during a qualified active military duty leave.

**Leave for Spouse/Registered Domestic Partner While Qualified Member on Leave From Deployment:**

In compliance with the State of California Military and Veterans Code, a qualified employee who is a spouse or registered domestic partner of a qualified member of the Armed Forces, National Guard, or reserves shall be allowed to take up to 10 days of unpaid leave during a period of leave from deployment of the qualified member.

**Family Medical Leave Act/California Family Rights Act (FMLA/CFRA):** Eligible employees may take up to 12 workweeks of unpaid, job-protected leave in a 12-month period to care for themselves or family members who are ill, or for child bonding and military exigency. See *Notice of Eligibility, Rights and Responsibilities -- FML1* for more information on this leave entitlement.

**Jury Duty Leave:** Employees must notify their supervisor when a jury summons is received. Any employee who is called to jury duty for a municipal, state or federal court during the employee's working hours is allowed his or her regular compensation less the amount of jury fees paid while serving as a juror. An employee called as a witness in a non-work related matter may be granted leave without pay unless vacation leave or compensatory time is granted.

**Educational Leave:** Educational leave is unpaid and is generally available to permanent employees only. An employee may be granted leave not to exceed one year for the purpose of securing additional education in a field related to his or her position.

**Religious Leave:** Employees may be granted religious leave when personal religious beliefs require the abstention from work during certain periods of the work day or work week. Religious leave is without pay unless a request to utilize accumulated compensatory time off, vacation time, or floating holidays is approved.

**Leave to accept other City and County employment.** Leave to accept a temporary or exempt appointment in the City is available at the discretion of the department head for permanent civil service employees only.

**Personal Leave:** Permanent employees may request unpaid personal leave for up to 12 months within any two year period. The department head has discretion to grant or deny requests for personal leave. With certain exceptions, temporary or provisional employees may request personal leave for a maximum of one month, and only if a replacement for their position is not required.

**Leave Extension:** An employee who wishes to extend a leave of absence must submit a completed Request for Leave form to his or her immediate supervisor or department's human resources representative at least two weeks, if practical, before the expiration date of the current leave. If the request is for sick leave, the employee must provide documentation from their health care provider.

**Leave Abridgment:** An employee who wishes to abridge a leave must submit an amended Request for Leave form before returning to work and, if the employee was on sick leave, the health care provider must certify that the employee is physically able to return to work.

# CITY AND COUNTY OF SAN FRANCISCO

Certification of Health Care Provider under the
Family and Medical Leave Act (FMLA), California Family Rights Act (CFRA) And
Pregnancy Disability Leave (PDL)

**Use This Form For A Family Member's Serious Health Condition**
**PLEASE GIVE THIS FORM TO YOUR FAMILY MEMBER'S**
**HEALTH CARE PROVIDER AFTER COMPLETING SECTION A**

## Section A: To Be Completed By the Employee

Employee's Name: _____ Classification: _____

Department: _____

Personnel Official's Name: _____ Telephone Number: _____

Patient/Family Member's Name: _____ Relationship: _____

## Section B: Instructions to the Health Care Provider

**Certification of Health Care Provider of a Serious Health Condition**
(Family and Medical Leave Act (FMLA) of 1993, California Family Rights Act (CFRA).)

Dear Health Care Provider:

The above-named employee has requested a leave of absence or intermittent leave for the condition of a family member, which may qualify as a protected leave under the FMLA and/or CFRA. This medical certification form will provide us with information needed to determine if the employee is eligible for leave under FMLA and/or CFRA. Sections C-F must be completed by you and returned to the department by the employee or your office. **In all cases, it is the employee's responsibility to ensure that sufficient medical certification is provided to the employer.**

**INSTRUCTIONS**

The information sought on this form relates only to the family member's condition for which the employee is taking leave. For the purposes of this form, "incapacity" is defined as the inability to work, attend school, or perform other regular daily activities due to the serious health condition itself, treatment of the serious health condition, or recovery from the condition. "Treatment" includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations. A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include taking over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, or other similar activities that can be initiated without a visit to a health care provider.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by GINA. To comply with GINA, 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.

## Section C: Definition of a Serious Health Condition

The definitions below describe what is meant by a "serious health condition" under the FMLA and/or CFRA. Does the patient's condition(s) qualify under any of the categories described? If so, please check the appropriate category.

☐ **CATEGORY 1: In-Patient Care**

Any period of incapacity or treatment connected with inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

☐ **CATEGORY 2: Absence Plus Treatment**

A period of incapacity of more than three (3) consecutive full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, which also involves:

a) Treatment two (2) or more times, within 30 days of the first day of incapacity, by a health care provider, by a nurse under direct supervision of a health care provider, or by a provider of health care services, e.g., physical therapist, under orders of, or on referral by, a health care provider; or
b) Treatment by a health care provider on at least one (1) occasion, which results in a regimen of continuing treatment under the supervision of the health care provider, e.g., prescribed medication.

☐ **CATEGORY 3: Pregnancy or Prenatal Care**

Any period of incapacity due to pregnancy, or for prenatal care. Expected delivery date: _____

☐ **CATEGORY 4: Chronic Conditions**

Any period of incapacity or treatment for such incapacity due to a chronic serious health condition. A chronic serious health condition is one which:

a) Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;
b) Continues over an extended period of time, including recurring episodes of a single underlying condition; and
c) May cause episodic rather than a continuing period of incapacity, e.g., asthma, diabetes, epilepsy, etc.

☐ **CATEGORY 5: Permanent or Long-Term Conditions Requiring Supervision**

A period of incapacity, which is permanent or long-term, due to a condition for which treatment may not be effective. The family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

☐ **CATEGORY 6: Conditions Requiring Multiple Treatments**

Any period of absence to receive multiple treatments, including any period of recovery therefrom, by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, for:

a) Restorative surgery after an accident or other injury; or
b) A condition that would likely result in a period of incapacity of more than three (3) consecutive, full calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), or kidney disease (dialysis).

☐ **NO CATEGORY APPLIES**

## Section D: Supporting Medical Facts

**Note: The health care provider is not to disclose the underlying diagnosis without the patient's consent.**

1. State the approximate date the condition began: _____
2. State the probable duration of the condition or need for treatment: _____
3. State the probable duration of the patient's incapacity, if different from the duration of the condition:

   _____

4. After review of the employee's signed statement (see attached Request for Leave form), does the condition warrant the participation of the employee? (This participation may include psychological comfort and/or arranging for third-party care for the family member.) ☐ Yes ☐ No

5. Does (or will) the patient require assistance from the employee with basic medical, hygiene, nutritional, safety, transportation needs or the participation of physical or psychological care? ☐ Yes ☐ No

## Section E: Amount of Leave Requested
## (Only Check and Complete the Section(s) That Apply)

### ☐ CONTINUOUS LEAVE

The patient will be incapacitated for a continuous period of time and will require the employee to be on **CONTINUOUS LEAVE** for the patient's treatment and/or recovery.

Estimate the beginning and ending dates for the period of incapacity: From _____ through _____

### ☐ INTERMITTENT LEAVE

It is medically necessary for the employee to take **INTERMITTENT LEAVE** because the family member's serious health condition causes episodic incapacity due to flare-ups or urgent care.

a. Estimate the frequency of flare-ups or the need for urgent care:

   Frequency: _____ times per _____ week / month / year (circle one)

b. Estimate the duration of time the employee is required to care for the family member on each occasion:

   Duration: _____hours / days per incident (circle one)

   Dates flare-ups or need for urgent care may occur: From _____ through _____

### ☐ TREATMENT OR APPOINTMENTS

It is medically necessary for the employee to attend or transport the family member to follow- up **TREATMENT** or **APPOINTMENTS** because of the family member's serious health condition.

Scheduled Treatment/Appointments: _____times per _____ week / month / year (circle one)

Estimate dates, times and length of scheduled appointments: _____

_____

_____

**Continue To Next Page**

**Section E: Amount of Leave Requested**
**(Continued)**

## ☐ PART-TIME SCHEDULE

It is medically necessary for the employee to work a **PART-TIME SCHEDULE** due to the family member's serious health condition.

Indicate the part-time schedule the employee needs:

Employee can work _____ hours per day for_____ days per week from _____ through _____

Additional Comments:_____

_____

_____

_____

**Section F: Definition of Health Care Provider**

Department of Labor regulations for the Family and Medical Leave Act define a "health care provider" as a

a. doctor of medicine or osteopathy, podiatrist, dentist, chiropractor, clinical psychologist, optometrist, nurse practitioner, nurse-midwife, or clinical social worker, physician's assistant, who is authorized to practice by the State and performing within the scope of their practice as defined by State law, or a Christian Science practitioner.
b. any provider the employee's group health plan will accept certification of a serious health condition to substantiate a claim for benefits.

_____ _____
(Signature of Health Care Provider) (Date)

_____ _____
(Print Name of Health Care Provider) (License No.)

_____ _____
(Address) (Phone No.)

**Thank you for your assistance.**