SFMTA

# Request for Leave and Leave Protections

For All Continuous and Intermittent Absences of More than 5 days, including FMLA/CFRA.
All Sick Leave are automatically designated FMLA, if the employee qualifies, regardless of whether or not such designation is requested.

**Name:** _____ **DSW#:** _____ **CAPID#:**_____ **Division:**_____

**Class/Title:** _____ **Phone:** _____ **Home Email:** _____

**Address:** _____ **City:** _____ **Zip:** _____

**Employment Status** (check one): □ Permanent □ Probationary □ Exempt □ Temporary □ Provisional
**Leave Request Type** (check one): □ New Leave Request □ Request for Extension[1]

**1. Type of Leave (must check one):**
Sick Leave. Attach Medical Certification for:
- □ 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 Family Member
- □ City Family Care Leave (Permanent Employees Only)
- □ Workers' Compensation. (Date of Injury: _____)

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

**2. Pay During Leave (must check a. or b.):**
a. □ Sick Leave Pay
*9163 Transit Operators must check Sick Leave Pay for all sick Leave Requests, unless all paid Leave balances are zero.*

b. □ In lieu of Sick Leave Pay. (Approval required, check all that apply):
□ Unpaid Sick □ Vacation □ Comp Time □ FH

**3. Other Pay Benefits (must check one):**
I □ will receive/apply for SDI, PFL or WC.
□ **will not** receive/apply for SDI, PFL or WC.

**4.** □ Check only if I **DO NOT** wish to supplement SDI/PFL/WC with accrued Sick Leave, Vacation, Comp Time, or FH.

**5. Leave Protections (check one if applicable):**
FMLA/CFRA for the purpose of (check one):
- □ My Own Illness
- □ Child Bonding (Birth/Placement Date: _____)
- □ 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 (PDL)
□ Military Leave (Reservist – Attach Orders, if issued)
□ Other, Please Specify: _____

**6. Accrued Leave.** I wish to use accrued leave 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. **(Check all that apply if applicable)**:
□ Sick Leave Pay □ Vacation □ Comp Time □ FH

**7. Amount of Leave Requested. Up to 12 weeks** for each Request for Leave, dates must match Medical Certification, unless COVID related. **(Must check one box below, and provide dates)**:

□ **Continuous** □ **Intermittent**

**from (date):** _____

**to (date):** _____

**8. Employee Signature:** _____ **Date:** _____

**Supervisor Review**

**9. Supervisor Name:** _____ **Supervisor Signature:** _____ **Date:** _____

HR Approval/Denial (to be completed by HR)

| Name (Print) | Signature | Date | Approve[2] | Deny (Attach reason, if required) |
|---|---|---|---|---|
| | | | ☐ | ☐ |

cc: Leave/Medical file
SFMTA RFL (Rev 04/14/2020)

[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 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 to 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.

[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.

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**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)

**FML 2**

**PLEASE GIVE THIS FORM TO YOUR HEALTH CARE PROVIDER AFTER COMPLETING SECTION I**

**Section I: TO BE COMPLETED BY THE EMPLOYEE**

Employee's Name: _____ Classification: _____

Department: _____

Personnel Official's Name: _____ Telephone Number: _____

Patient's Name (if different from employee): _____ Relationship: _____

**Section II: TO BE COMPLETED BY 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)
and Pregnancy Disability Leave (PDL).)

Dear Health Care Provider:

The above-named employee has requested a leave of absence or intermittent leave for his/her health condition, or the condition of a family member, which may qualify as a protected leave under the FMLA, CFRA and/or PDL. This medical certification form will provide us with information needed to determine if the employee' is eligible under the FMLA, CFRA and/or PDL. Section II must be completed 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 department.**

INSTRUCTIONS

The information sought on this form relates only to the 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.

**SERIOUS HEALTH CONDITION**

1. 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:

1) 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
2) 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:

1) 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;
2) Continues over an extended period of time, including recurring episodes of a single underlying condition; and
3) 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 employee or 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:

1) Restorative surgery after an accident or other injury; or
2) 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**

**SUPPORTING MEDICAL FACTS**

1. State the approximate date the condition commenced **[NOTE: THE HEALTH CARE PROVIDER IS NOT TO DISCLOSE THE UNDERLYING DIAGNOSIS WITHOUT THE PATIENT'S WRITTEN CONSENT]:**

   _____

2. State the probable duration of the condition or need for treatment:

   _____

3. State the probable duration of the employee's/patient's incapacity, if different from the duration of the condition.

   _____

**IF THE CERTIFICATION IS FOR THE EMPLOYEE'S SERIOUS HEALTH CONDITION, ANSWER THE FOLLOWING:**

4. Is employee able to perform work of any kind? (If no, proceed to question 5) ☐ YES ☐ NO

   a. If the employee is able to perform some work, is employee unable to perform any one or more of the essential functions of employee's position due to the serious health condition? (Answer after discussing essential job functions with employee.) ☐ YES ☐ NO

   b. If yes, please specify the work restrictions that preclude the employee from performing one of more of his or her essential job functions:

      _____

      _____

      _____

**IF THE EMPLOYEE IS ASKING FOR INTERMITTENT LEAVE, OR A REDUCED WORK SCHEDULE, ANSWER THE FOLLOWING.**

5. Is it medically necessary for the employee to be off work on an intermittent basis due to the employee's serious health condition? ☐ YES ☐ NO

   a. If yes, estimate the frequency of flare-ups or treatments and the duration of related incapacity or absence that the patient may have and for what period of time (e.g., *"1 episode every 3 months lasting 1-2 days, for the next year"* or *"PT 2 x wk for 6 wks"*):

      Episodic Incapacity: _____times per (circle): week/month
      Flare-ups may occur from (date): _____through:_____

      Comments:_____

      _____

      Treatments: _____times per (circle): week/month
      Treatments can be scheduled during non-work hours ☐ YES ☐ NO
      Duration from (date): _____through:_____

   b. Is it medically necessary for the employee to work a reduced schedule due to the serious health condition of the employee? ☐ YES ☐ NO
      If yes, please estimate the hours the employee needs for the reduced work schedule:

      Employee can work _____hours/day for _____days/week

Employee's Name: _____ Patient's Name: _____

**IF THE EMPLOYEE IS NOT THE PATIENT, AND THE CERTIFICATION IS FOR THE EMPLOYEE'S FAMILY MEMBER WHO NEEDS CARE, ANSWER THE FOLLOWING:**

Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation? ☐ YES ☐ NO

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

Estimate the period of time care will be needed or during which the employee's presence would be beneficial:

Duration from (date): _____through:_____

If the patient will require assistance on an intermittent or "as needed" basis, please estimate the frequency and duration during which the employee's presence would be beneficial

Intermittently: _____times per (circle): week/month, from (date): _____through:_____

Comments:_____

_____

_____

_____ _____
(Signature of Health Care Provider) (License No.)

_____ _____
(Print Name of Health Care Provider) (Date)

_____ _____
(Address) (Fax number)

_____ _____
(City) (State) (Zip Code) (Telephone number)

# STATE DISABILITY INSURANCE DEPARTMENTAL NOTIFICATION

## INSTRUCTIONS TO EMPLOYEES

Your State Disability Insurance (SDI) payments will be automatically supplemented with sick pay credits (if you have sick pay credits and are eligible to use them) to provide up to your normal salary ***UNLESS***:

- you choose not to supplement, or
- you choose to supplement with either compensatory time off, floating holiday, vacation, or
- you choose not to apply for SDI

If you choose any of the above options, you must notify your departmental Payroll Office ***within seven calendar days of your first day of absence***, *by filling out the information below. (The above ruling is outlined in Civil Service Rule 22, Section 22.02(F)).*

## TO BE COMPLETED BY EMPLOYEE

***(Check one)***

☐ 1. I do **not** wish to supplement SDI **(Contact HSS if you will not be receiving a paycheck)**

☐ 2. I wish to supplement SDI with sick pay, vacation and/or compensatory time* in the order listed:

*1st* _____ *2nd* _____ *3rd* _____

☐ 3. I do not wish to apply for SDI benefits. Instead, I wish to receive full salary form any sick pay, floating holiday, vacation, or compensatory time* credits I have coming to me. I understand that, if at any time in the future I file for SDI benefits for the injury or illness that occurred on the date below ("First full day of absence"), I must notify my departmental Payroll Office ***the next business day after filing***; otherwise, I will be in violation of State law.

Employee Signature _____ Date _____

Employee Print Name _____ Home Address *(Street, City, Zip Code)* _____

First Full Day of Absence _____ Date SDI applied for *(fill out unless Box 3 above is checked)* _____ Employee Number *(from check stub)* _____

Classification _____ Department Name _____

Work Phone Number _____ Home Phone Number _____

***Use of compensatory time requires your Appointing Officer's approval. If you choose this option, your departmental Payroll Office will contact your Appointing Officer to obtain approval.***

## FOR DEPARTMENTAL USE ONLY

Appointing Officer's Signature *(for comp time approval only)* _____ Date _____

Departmental Contact: Name _____ Phone Number _____

## NOTICE – YOU MAY BE ELIGIBLE FOR STATE DISABILITY INSURANCE BENEFITS

### YOU MAY BE ELIGIBLE FOR SDI BENEFITS

You may be eligible for State Disability Insurance benefits if:

- you've been absent from work for more than seven calendar days or hospitalized for at least 24 hours because of an illness or accident that is not work-related and
- you've been treated by a doctor or practitioner during this time

### HOW TO APPLY FOR SDI BENEFITS

If you wish to apply for SDI benefits, you must complete an SDI Claim Form at http://www.edd.ca.gov/. Fill out the form and ask your doctor/practitioner to complete the "Doctor's Certification" section. Your doctor/practitioner will submit their portion of the form electronically to EDD. Regardless if you apply for SDI benefits or not, the City will reduce your pay starting on the eighth day of your absence, as described below.

### YOUR PAY WILL BE LOWERED ON THE EIGHTH DAY OF YOUR ABSENCE

...and you will be paid with your sick-pay credits

On the eighth calendar day of your absence or the first day of your hospitalization (whichever comes first), the City is required to reduce your wages and utilize your sick pay credits, if available, to compensate for your reduced salary. This lowered salary supplements (adds to) the amount the City expects you to receive from SDI. Using your sick pay credits to supplement the amount you receive from SDI allows you to continue receiving your normal salary.

If you want to choose another option

(1) If you want to utilize your any floating holiday, vacation or compensatory time to supplement SDI rather than sick pay **OR**
(2) If you do not want to supplement SDI at all **OR**
(3) If you will not be applying for SDI benefits, you must fill out this form and submit it to your departmental Payroll Office within seven calendar days from your initial date of absence.

If you choose not to apply for SDI, you will be paid your full salary from whichever paid-leave credits you designate (sick pay, floating holidays, vacation or compensatory time) until these paid-leave credits run out.

### SDI OFFICES

**State of California, Employment Development Department:**

San Francisco and San Mateo Counties

745 Franklin Street, Suite 300, San Francisco, CA 94102
1-800-480-3287

Alameda and Contra Costa Counties

1600 Harbor Bay Parkway, Suite 120, Alameda, CA 94502
1-800-480-3287

Marin, Sonoma, Napa and Lake Counties

606 Healdsburg Avenue, Santa Rosa, CA 95401
1-800-480-3287

Sacramento and Solano Counties

5009 Broadway, Sacramento, CA 95818
1-800-480-3287

### QUESTIONS

If you have any questions, please call your departmental Payroll Office.

# STATE OF CA. PAID FAMILY LEAVE DEPARTMENTAL NOTIFICATION

## INSTRUCTIONS TO EMPLOYEES

Your State of California Paid Family Leave (PFL) payments will be automatically supplemented with sick pay credits (if you have sick pay credits and are eligible to use them) to provide up to your normal salary ***UNLESS***:

- you choose not to supplement, or
- you choose to supplement with either compensatory time off or vacation, or
- you choose not to apply for PFL

If you choose any of the above options, you must notify your departmental Payroll Office ***within seven calendar days of your first day of absence***, *by filling out the information below. (The above ruling is outlined in Civil Service Rule 22, Section 22.02(F)).*

## TO BE COMPLETED BY EMPLOYEE

***(Check one)***

☐ 1. I do **not** wish to supplement PFL **(Contact HSS if you will not be receiving a paycheck)**

☐ 2. I wish to supplement PFL with sick pay, vacation and/or compensatory time* in the order listed:
*1st* _____ *2nd* _____ *3rd* _____

☐ 3. I do not wish to apply for PFL benefits. Instead, I wish to receive full salary form any sick pay, vacation, or compensatory time* credits I have coming to me. I understand that, if at any time in the future I file for PFL benefits for the injury or illness that occurred on the date below ("First full day of absence"), I must notify my departmental Payroll Office ***the next business day after filing***; otherwise, I will be in violation of State law.

_____ _____
Signature Date

_____ _____
Print Name Home Address *(Street, City, Zip Code)*

_____ _____ _____
First Full Day of Absence Date PFL applied for *(fill out unless Box 3 above is checked)* Employee Number *(from check stub)*

_____ _____
Classification Department Name

_____ _____
Work Phone Number Home Phone Number

***Use of compensatory time requires your Appointing Officer's approval. If you choose this option, your departmental Payroll Office will contact your Appointing Officer to obtain approval.***

## FOR DEPARTMENTAL USE ONLY

_____ _____
Appointing Officer's Signature *(for comp time approval only)* Date

_____ _____
Departmental Contact: Name Phone Number

## NOTICE – YOU MAY BE ELIGIBLE FOR STATE OF CA. PAID FAMILY LEAVE BENEFITS

| | |
|---|---|
| **YOU MAY BE ELIGIBLE FOR PFL BENEFITS** | You may be eligible for State of CA Paid Family Leave benefits if:<br>➢ You've been absent from work for more than seven calendar days to care for a seriously ill child, spouse parent, or domestic partner.<br>➢ To bond with a new child.<br>➢ To bond with a minor child in connection with the adoption or foster care of that child. |
| **HOW TO APPLY FOR PFL BENEFITS** | If you wish to apply for PFL benefits, you must complete a PFL Claim Form at http://www.edd.ca.gov/. Fill out the form and ask your doctor/practitioner to complete the "Doctor's Certification" section. Your doctor/practitioner will submit the forms electronically to EDD. The City will begin supplementing your pay starting on the eighth day of your absence, as described below. |
| **YOUR PAY WILL BE LOWERED ON THE EIGHTH DAY OF YOUR ABSENCE**<br><br>And you'll be paid from your sick-pay credits | On the eighth calendar day of your absence, the City is required to lower your salary and to use your sick pay credits, if you have any, to pay your lowered salary. This lowered salary supplements (adds to) the amount the City expects you to receive from PFL. Using your sick pay credits to supplement the amount you receive from PFL allows you to continue receiving your normal salary. |
| If you want to choose another option | If you want vacation or comp time used to supplement PFL instead of your sick pay, if you don't want to supplement PFL at all, or if you will not be applying for PFL benefits, you must fill out the enclosed form and submit it to your departmental Payroll Office within seven calendar days of your first day of absence.<br><br>If you won't be applying for PFL, you will be paid full salary from whichever paid-leave credits you specify (sick pay, vacation or comp time) until these paid-leave credits run out. |
| **EDD Paid Family Leave Offices**<br><br>San Francisco and San Mateo Counties<br><br>Alameda and Contra Costa Counties<br><br>Marin, Sonoma, Napa and Lake Counties<br><br>Sacramento and Solano Counties | **State of California, Employment Development Department:**<br><br>745 Franklin Street, Suite 300, San Francisco, CA 94102<br>1-877-BE-THERE (1-877-238-4373)<br><br>1600 Harbor Bay Parkway, Suite 120, Alameda, CA 94502<br>1-877-BE-THERE (1-877-238-4373)<br><br>606 Healdsburg Avenue, Santa Rosa, CA 95401<br>1-877-BE-THERE (1-877-238-4373)<br><br>5009 Broadway, Sacramento, CA 95818<br>1-877-BE-THERE (1-877-238-4373) |
| **QUESTIONS** | If you have any questions, please call your departmental Payroll Office. |