

APPENDIX E

FORMS - PART II

(FORMS BELOW PROVIDED FOR INFORMATIONAL PURPOSES)

ALTERNATE WORK SCHEDULE/FLEXTIME REQUEST

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NOTIFICATION OF RESIGNATION & RETIREMENT

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REQUEST FOR EDUCATIONAL PAY DIFFERENTIAL

REQUEST FOR LEAVE OF ABSENCE WITHOUT PAY

REQUEST FOR REVIEW BY PEER RESOLUTION COMMITTEE

SANTA MONICA COMMUNITY COLLEGE DISTRICT

OFFICE OF HUMAN RESOURCES

ALTERNATE WORK SCHEDULE/FLEXTIME REQUEST

EMPLOYEE NAME:	DEPARTMENT:
CURRENT POSITION/CLASSIFICATION:	

SCHEDULE REQUESTED: *9/80 <input type="checkbox"/> 10/40 <input type="checkbox"/> 8/40 <input type="checkbox"/> *FLEX <input type="checkbox"/>			
CURRENT WORK SCHEDULE		REQUESTED WORK SCHEDULE	
Week 1	*Week 2	Week 1	*Week 2
M _____	_____	M _____	_____
T _____	_____	T _____	_____
W _____	_____	W _____	_____
TH _____	_____	TH _____	_____
F _____	_____	F _____	_____
S _____	_____	S _____	_____
Lunch Break _____	_____	Lunch Break _____	_____
EFFECTIVE START DATE:		END DATE:	
REASON FOR REQUEST:			

EMPLOYEE'S SIGNATURE: _____

DATE: _____

OFFICE USE ONLY

MANAGER'S COMMENTS:

EVALUATION TO BE HELD (WITHIN 6 - 8 WEEKS):

(SPECIFY DATE)

PEAK PERIOD(S) WHEN ANOTHER SCHEDULE MAY BE REQUIRED:

(SPECIFY DATE)

AUTHORIZATION:

<input type="checkbox"/> APPROVED	<input type="checkbox"/> NOT APPROVED	IMMEDIATE SUPERVISOR SIGNATURE:	DATE:
<input type="checkbox"/> APPROVED	<input type="checkbox"/> NOT APPROVED	DEAN/DEPARTMENT HEAD SIGNATURE:	DATE:
<input type="checkbox"/> APPROVED	<input type="checkbox"/> NOT APPROVED	HUMAN RESOURCES REPRESENTATIVE SIGNATURE:	DATE:

white-office of human resources

yellow-supervisor

pink-employee

SANTA MONICA COMMUNITY COLLEGE DISTRICT
OFFICE OF HUMAN RESOURCES

**APPLICATION FOR REIMBURSEMENT OF TUITION,
REGISTRATION AND/OR COST OF BOOKS AND MATERIALS**

EMPLOYEE NAME:		DEPARTMENT:	
POSITION/CLASSIFICATION:		HIRE DATE:	
TITLE OF CONFERENCE/CLASS:		BEGINING DATE:	END DATE:
LOCATION:			
UNITS COMPLETED PRIOR TO THIS REQUEST:		EDUCATIONAL GOAL:	
HOW DOES/DO THE COURSE (S) DIRECTLY RELATE TO YOUR CURRENT CLASSIFICATION OR CLASSIFICATION WITHIN YOUR JOB FAMILY?			

EXPENSES

COST OF TUITION OR CONFERENCE:		COST OF BOOKS:	
DATE(S) AND AMOUNT(S) OF <u>PREVIOUS</u> REIMBURSEMENT:		AMOUNT REQUESTED:	

SIGNATURES/APPROVALS

EMPLOYEE:	DATE:
IMMEDIATE SUPERVISOR:	DATE:
DEAN/ADMINISTRATOR:	DATE:

ELIGIBLE: NOT ELIGIBLE: ACCOUNT #:

HUMAN RESOURCES REPRESENTATIVE SIGNATURE:	DATE:
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SANTA MONICA COMMUNITY COLLEGE DISTRICT

OFFICE OF HUMAN RESOURCES

**AUTHORIZATION FOR PAYROLL DEDUCTIONS
FROM LEAVE ACCRUALS DURING FAMILY AND MEDICAL LEAVE**

EMPLOYEE NAME:		DATE OF REQUEST:
DEPARTMENT:	CURRENT POSITION/CLASSIFICATION:	HIRE DATE:

I AUTHORIZE THE SANTA MONICA COMMUNITY COLLEGE DISTRICT TO MAKE DEDUCTIONS FROM ACCRUED LEAVE DURING MY UPCOMING FAMILY AND MEDICAL LEAVE WHICH WILL COMMENCE ON:

DATE LEAVE WILL COMMENCE:

DATE LEAVE WILL END:

I AUTHORIZE DEDUCTIONS TO BE MADE FROM:

VACATION

ILL

COMPTIME

EMPLOYEE SIGNATURE:

DATE:

HUMAN RESOURCES REPRESENTATIVE SIGNATURE:

DATE:

SANTA MONICA COMMUNITY COLLEGE DISTRICT

OFFICE OF HUMAN RESOURCES

CLASSIFIED EMPLOYEE MILITARY LEAVE OF ABSENCE REQUEST

I request approval for a MILITARY LEAVE OF ABSENCE as follows:

- I have been ordered to temporary military duty for a period of no more than 180 calendar days.
- I have been ordered to active duty during a time of war or national emergency.

My military duty will continue for _____ calendar days beginning on _____ and ending on _____. A copy of my orders are attached. I request paid temporary military leave for my first 30 days of duty. I certify I have been in the service of the Santa Monica Community College District for a period of not less than one year, immediately prior to the date of my ordered temporary military leave.

EMPLOYEE NAME:	CURRENT POSITION/CLASSIFICATION:
BRANCH OF THE MILITARY:	STATUS:
PLACE STATIONED:	
EMPLOYEE SIGNATURE:	DATE:

AUTHORIZATION:

<input type="checkbox"/> APPROVED	<input type="checkbox"/> NOT APPROVED	IMMEDIATE SUPERVISOR SIGNATURE:	DATE:
<input type="checkbox"/> APPROVED	<input type="checkbox"/> NOT APPROVED	DEAN/DEPARTMENT HEAD SIGNATURE:	DATE:
<input type="checkbox"/> APPROVED	<input type="checkbox"/> NOT APPROVED	AREA VICE PRESIDENT SIGNATURE:	DATE:
<input type="checkbox"/> APPROVED	<input type="checkbox"/> NOT APPROVED	HUMAN RESOURCES REPRESENTATIVE SIGNATURE:	DATE:

SANTA MONICA COMMUNITY COLLEGE DISTRICT

OFFICE OF HUMAN RESOURCES

EMPLOYEE MEDICAL LEAVE REQUEST AND VERIFICATION

(FOR ABSENCES MORE THAN 5 (FIVE) CONSECUTIVE DAYS)

EMPLOYEE NAME: (PLEASE PRINT)	DEPARTMENT:
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PAID LEAVE		<input type="checkbox"/> I REQUEST APPROVAL FOR A PAID MEDICAL LEAVE OF ABSENCE.
BEGINNING ON: (specify date)	ENDING ON: (specify date)	

THE ABSENCE IS DUE TO: *(Indicate below the type of leave you are requesting)*

<input type="checkbox"/> Illness/injury	<input type="checkbox"/> Job-related illness/injury	<input type="checkbox"/> Maternity leave	<input type="checkbox"/> Family Medical Leave*
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UNPAID LEAVE		<input type="checkbox"/> I REQUEST APPROVAL FOR AN UNPAID MEDICAL LEAVE OF ABSENCE
BEGINNING ON: (specify date)	ENDING ON: (specify date)	

The absence is due to: *(Indicate below the type of leave you are requesting)*

<input type="checkbox"/> Illness/injury	<input type="checkbox"/> Job-related illness/injury	<input type="checkbox"/> Family Medical Leave*
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*FMLA requires additional supplemental form

EMPLOYEE SIGNATURE:	DATE:
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PHYSICIAN VERIFICATION

This is to verify that _____
EMPLOYEE'S NAME
 was seen in my office on _____ and is/was unable to perform the duties of his/her position from
 _____ through _____.

The employee listed above may return to work on _____

No restrictions

With restrictions applying until _____ *(specify below):*

PHYSICIAN'S NAME:	PHYSICIAN'S LICENSE NUMBER:	
PHYSICIAN'S ADDRESS:	PHYSICIAN'S TELEPHONE NUMBER/FAX:	
CITY:	STATE:	ZIP CODE:
PHYSICIAN'S SIGNATURE:		DATE:
HUMAN REOURCES APPROVAL BY:		DATE:

SANTA MONICA COMMUNITY COLLEGE DISTRICT

OFFICE OF HUMAN RESOURCES

FAMILY MEDICAL LEAVE REQUEST

EMPLOYEE NAME:		DATE OF REQUEST:	
DEPARTMENT:	POSITION:	HIRE DATE:	

I request a Family/Medical Leave for the following reason (*check one*):

- 1. The birth of a child and/or in order to care for such child.
- 2. The placement of a child for adoption or foster care.
- 3. In order to care for an immediate family member because such family member has a serious health condition.
Check one: CHILD SPOUSE PARENT
(Must submit "Physician Certification" within 15 days)
- 4. Employee's own serious health condition that makes the employee unable to perform the functions of his/her position. *(Must submit "Physician Certification" within 15 days)*

METHOD OF LEAVE REQUESTED

- 1. Consecutive Leave
- 2. Intermittent or Reduced Leave Schedule (*Specify schedule below*)

<i>PRESENT SCHEDULE</i>	<i>REQUESTED REDUCED LEAVE SCHEDULE</i>
MONDAY	MONDAY
TUESDAY	TUESDAY
WEDNESDAY	WEDNESDAY
THURSDAY	THURSDAY
FRIDAY	FRIDAY
SATURDAY	SATURDAY
SUNDAY	SUNDAY
DATE LEAVE IS TO BEGIN:	EXPECTED DURATION OF LEAVE:

If the duration of my family/medical leave (total of paid and unpaid time) does not exceed 12 weeks, I will be returned to my same or equivalent position. I understand that if my family/medical leave should exceed 12 weeks, I will be returned to my same or equivalent position, only if available. If my same or equivalent position is not available, I understand that I may be terminated.

EMPLOYEE SIGNATURE:	DATE:
SUPERVISOR'S SIGNATURE:	DATE:
HUMAN RESOURCES REPRESENTATIVE SIGNATURE:	DATE:

SANTA MONICA COMMUNITY COLLEGE DISTRICT

OFFICE OF HUMAN RESOURCES

NOTIFICATION OF RESIGNATION/RETIREMENT

PLEASE ACCEPT MY RESIGNATION RETIREMENT:

EFFECTIVE DATE: (DAY FOLLOWING LAST PAYDAY)

CURRENT POSITION/CLASSIFICATION:

DEPARTMENT:

MY LAST DAY AT WORK WILL BE:

MY LAST PAID DAY WILL BE:

I WILL BE USING VACATION TIME:

FROM:

TO:

All vacation should be used prior to resignation/retirement. Any unused vacation will be paid to you as part of your last check.

REASON FOR RESIGNATION:

MY SUPERVISOR HAS BEEN ADVISED OF MY RESIGNATION/RETIREMENT.

NAME OF SUPERVISOR:

DEPARTMENT:

DATE SUPERVISOR WAS NOTIFIED:

KEYS RETURNED

IDENTIFICATION RETURNED

DISTRICT PROPERTY RETURNED

EMPLOYEE NAME: (Please Print)

TELEPHONE NUMBER:

ALTERNATIVE TELEPHONE NUMBER:

CURRENT ADDRESS:

CITY:

ZIP CODE:

FORWARDING ADDRESS*:

CITY:

ZIP CODE:

*Forwarding address will be used in mailing your last paycheck and/or future correspondence.

Retirees must submit "Application for Retirement" to the PERS Benefits Division in Sacramento or call (800) 352-2238.

EMPLOYEE SIGNATURE:

DATE:

white-office of human resources

yellow-supervisor

pink-employee

**SANTA MONICA COMMUNITY COLLEGE DISTRICT
OFFICE OF HUMAN RESOURCES**

REDUCED ASSIGNMENT REQUEST

EMPLOYEE NAME:		DATE OF REQUEST:
DEPARTMENT:	POSITION/CLASSIFICATION:	HIRE DATE:

I REQUEST A REDUCTION OF ASSIGNMENT FOR THE FOLLOWING REASON:

METHOD OF LEAVE REQUESTED

TEMPORARY REDUCTION/LEAVE <input type="checkbox"/>	PERMANENT REDUCTION /LEAVE <input type="checkbox"/>	DATE LEAVE IS TO BEGIN:	EXPECTED DURATION OF LEAVE:
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<i>PRESENT SCHEDULE</i>	<i>REQUESTED REDUCED LEAVE SCHEDULE</i>
MONDAY	MONDAY
TUESDAY	TUESDAY
WEDNESDAY	WEDNESDAY
THURSDAY	THURSDAY
FRIDAY	FRIDAY
SATURDAY	SATURDAY
SUNDAY	SUNDAY

EMPLOYEE SIGNATURE:	DATE:
SUPERVISOR'S SIGNATURE:	DATE:
AREA VICE PRESIDENT'S SIGNATURE:	DATE:
HUMAN RESOURCES REPRESENTATIVE SIGNATURE:	DATE:

SANTA MONICA COMMUNITY COLLEGE DISTRICT

OFFICE OF HUMAN RESOURCES

REQUEST FOR EDUCATIONAL PAY DIFFERENTIAL

EMPLOYEE NAME:	POSITION/CLASSIFICATION:
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I REQUEST AN EDUCATIONAL PAY DIFFERENTIAL FOR (CHECK ONE OF THE FOLLOWING):

- 11.10.3.1 ASSOCIATE OF ARTS/SCIENCE DEGREE 1.5% DIFFERENTIAL
- 11.10.3.2 BACHELOR OF ARTS/SCIENCE DEGREE 1.5% DIFFERENTIAL
- 11.10.3.3 MASTER OF ARTS/SCIENCE DEGREE 1.5% DIFFERENTIAL
- 11.10.3.4 EDUCATIONAL CERTIFICATE .75% DIFFERENTIAL

With completion of certificate program requiring a minimum of 20 semester units or 30 quarter units in a job-related field. Certificate which required less than 20 semester or 30 quarter units shall be reimbursed on a pro-rata basis.

- 11.10.3.5 PROFESSIONAL LICENSE .75% DIFFERENTIAL

Upon receipt of a professional license requiring a minimum of 60 hours of training or experience in a job-related field. Licenses which require less than 60 hours of training or experience shall be reimbursed on a pro-rata basis.

THIS DEGREE, CERTIFICATE OR LICENSE WAS RECEIVED FROM:

INSTITUTION:	DATE:
EMPLOYEE SIGNATURE:	DATE:

OFFICE USE ONLY

<input type="checkbox"/> TRANSCRIPTS/LICENSE VERIFIED	<input type="checkbox"/> ELIGIBLE	<input type="checkbox"/> NOT ELIGIBLE	PERCENTAGE:	EFFECTIVE DATE:
HUMAN RESOURCES REPRESENTATIVE SIGNATURE:				DATE:

SANTA MONICA COMMUNITY COLLEGE DISTRICT

OFFICE OF HUMAN RESOURCES

REQUEST FOR LEAVE OF ABSENCE WITHOUT PAY

I request approval for a Partial Full LEAVE OF ABSENCE WITHOUT PAY beginning on _____ and ending on _____.

REASON FOR REQUEST

EMPLOYEE NAME:	
CURRENT POSITION/CLASSIFICATION:	DEPARTMENT:
ADDRESS:	TELEPHONE #:
CITY:	ZIP CODE:
EMERGENCY CONTACT NAME	TELEPHONE #
ASSIGNMENT <input type="checkbox"/> 12 Months <input type="checkbox"/> 11 Months	CURRENT WORK SCHEDULE:

PLEASE NOTE: YOU MUST CONTACT EMPLOYEE BENEFITS REGARDING MAINTAINING YOUR BENEFIT COVERAGE.

EMPLOYEE SIGNATURE:	DATE:
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AUTHORIZATION:

<input type="checkbox"/> APPROVED	<input type="checkbox"/> NOT APPROVED	IMMEDIATE SUPERVISOR SIGNATURE:	DATE:
<input type="checkbox"/> APPROVED	<input type="checkbox"/> NOT APPROVED	DEAN/DEPARTMENT HEAD SIGNATURE:	DATE:
<input type="checkbox"/> APPROVED	<input type="checkbox"/> NOT APPROVED	AREA VICE PRESIDENT SIGNATURE:	DATE:
<input type="checkbox"/> APPROVED	<input type="checkbox"/> NOT APPROVED	HUMAN RESOURCES REPRESENTATIVE SIGNATURE:	DATE:

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pink-employee

SANTA MONICA COMMUNITY COLLEGE DISTRICT
OFFICE OF HUMAN RESOURCES

REQUEST FOR REVIEW BY PEER RESOLUTION COMMITTEE

FROM GRIEVANT:

DEPARTMENT (WORK LOCATION/SITE):

DATE OF EVENT GIVING RISE TO THE GRIEVANCE: (MONH/DAY/YEAR)

DATE OF REQUIRED INFORMAL DISCUSSION: (MONTH/DAY/YEAR)

PROVISION OF CONTRACT ALLEGED TO HAVE BEEN VIOLATED:

IMMEDIATE SUPERVISOR:

STATEMENT OF GRIEVANCE *(Attach additional sheets if necessary)*

SPECIFIC REMEDY SOUGHT *(Attach additional sheets if necessary)*

SIGNATURE OF GRIEVANT:

DATE: (MONTH/DAY/YEAR)

REPRESENTATIVE *(IF ANY)*:

TO BE FILLED OUT BY PRC

DATE PRC REVIEW RECEIVED:

MEETING DATE:

LAST DAY TO RESPOND:

LAST DAY TO MEET:

RESPONSE DATE:

white-office of human resources

yellow-csea president

pink-grievant