COUNTY OF RIVERSIDE, CALIFORNIA
BOARD OF SUPERVISORS POLICY

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Policy:

Except as otherwise provided in County Ordinance No. 440, the Memoranda of Understanding (MOU) between the County of Riverside and Recognized Employee Organizations, and/or the Resolution of the County of Riverside and Other Agencies Providing Salaries and Related Matters for Exempt Management, Management, Confidential, and Other Unrepresented Employees, the use of accrued sick leave shall be allowed for the purpose of preventative medical, dental care and care of the family. Family is defined to mean a spouse, child, registered domestic partner, or child of a registered domestic partner, parent, brother, or sister of the employee living in the same household as the employee, who is disabled by illness or injury; or when the employee is compelled to be absent from duty by reason of the death or critical illness where death appears imminent of the employee's, father, father-in-law, mother, mother-in-law, brother, sister, spouse, child, grandparent, or grandchild, and the equivalent step-relationships or relationships through a registered domestic partnership (subject to the limitations of the applicable Ordinance, MOU or Resolution).

The agency/department head or designee may require the use of the "Medical Certificate" and/or "Request for Use of Accrued Sick Leave" when in the judgment of the agency/department head, or designee, good reason exists for believing an employee may be abusing sick leave. Sample forms are attached to this policy.

Reference:

Minute Order 6.18 of 10/09/79
Minute Order 3.3 of 04/10/07

(ATTACHMENT #1)

MEDICAL CERTIFICATION

TO: COUNTY OF RIVERSIDE

SUBJECT: MEDICAL CERTIFICATION

I, Dr. _____, examined _____
,
on _____, and determined that this patient, in my opinion, was
Date
unable to work, due to illness or injury, on _____
Date(s)

I recognize that my certification is to be utilized by the County of Riverside to authorize expenditure of public funds. Accordingly, I hereby declare under penalty of perjury that the foregoing is true and correct.

Executed on _____, _____, County, California, on _____
Date **Place** **Date**

Signature: _____
M.D. /D.D.S. **Street** **City**
Phone

INFORMATION TO RIVERSIDE COUNTY EMPLOYEES

THIS IS THE FORM WHICH COUNTY EMPLOYEES MUST SUBMIT, FILLED OUT AND SIGNED BY A DOCTOR, AS VERIFICATION OF ILLNESS OR INJURY TO AUTHORIZE PAYMENT OF SICK LEAVE.

EVEN THOUGH YOU HAVE OTHER DOCUMENTATION, WHEN DIRECTED BY THE COUNTY, THIS FORM MUST BE PROPERLY EXECUTED AND ATTACHED TO OTHER DOCUMENTATION THE EMPLOYEE MAY WISH TO SUBMIT.

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(ATTACHMENT #2)

REQUEST FOR USE OF ACCRUED SICK LEAVE

Pursuant to the provisions of Riverside County Ordinance 440 D(8);

I hereby request that I be permitted to use accrued sick leave for the _____
Day(s)

of _____, _____.
month **year** Total hours requested _____

My absence form work on the above date(s) was for the purpose of caring for the illness of the hereinafter named person(s), who was (were) disabled by illness or injury on said dates.

COMPLETE THE FOLLOWING INFORMATION

Name of person(s) residing in my household who was (were) disabled by illness or injury

_____
Full Name(s)

Relationship to Employee: (Check appropriate person(s)

_____Spouse _____Parent _____Brother _____Sister _____Child

I accompanied the foregoing person(s) to a medical facility and I was at the medical facility from _____A.M./P.M., to _____A.M./P.M.

I recognize that my request for the use of accrued sick leave is to be utilized by the County of Riverside to authorize expenditure of public funds. Accordingly, I hereby declare under penalty of perjury that the foregoing is true and correct.

Executed at _____ County, California, on_____.
Date

TO COUNTY EMPLOYEES:

In addition to this form the employee also must submit documentation from a medical doctor/dentist verifying the fact of disabling illness or injury to the person(s) set forth above.