City of Miami

REQUEST FOR PAID LEAVE DUE TO DEATH IN FAMILY

TO	Department of Human Resources	Date:
FROM	Name:	Employee No.:
	Department:	Division:

Pursuant to the current Labor Agreement, a full-time City employee may, in case of death in the immediate family be authorized up to a maximum of forty (40) hours of paid leave to attend to funeral or estate related functions of a member of the employee's immediate family, or is at home in a state of bereavement. Said paid leave days shall be taken consecutively by the employee. The immediate family is defined as father, mother, sister, brother, husband, wife, domestic partner, children, father-in-law, mother-in-law, grandparents, spouse's grandparents, grandchildren, stepchildren, stepfather and/or stepmother, and may include any other person who was an actual member of the employee's household for ten (10) or more years or as specified in your Collective Bargaining Agreement. Within thirty (30) calendar days or as permitted by your Collective Bargaining Agreement from the date the employee returns from a death in the family, the employee will file a copy of the death certificate of the deceased family member. If under any circumstances the employee is unable to provide a death certificate, in lieu of a death certificate, the employee shall submit a newspaper account showing the death and relationship of the deceased to the employee and/or other appropriate criteria as deemed appropriate by the Department of Human Resources. Any employee found to have falsified the application for death in the family will result in dismissal. In accordance with the above provision, I am requesting a leave of absence with pay due to death in family for the following purpose and duration:

Name of Deceased: _____

Relationship to Employee: _____

Date and Time of Leave:

From: (Date) ___/___/___ (Time) _____ am/pm

Through: (Date) ___/___/___ (Time) _____ am/pm

❑ I attest that this is a current immediate family member as defined above

_____ ___/___/___
Employee Signature Date

_____
Labor Relations Manager (initials)

___/___/___
Date

❑ Approved
❑ Disapproved

_____ ___/___/___
Department Director/Designee Date

NOTE: Appropriate documentation must be attached to the original copy before routing.