



Human Resource Services

REQUEST FOR FAMILY AND MEDICAL LEAVE

Family Medical Leave Act (FMLA), California Family Rights Act (CFRA), Pregnancy Disability Leave (PDL)

INSTRUCTIONS: This form is to be filled out by the employee and returned to Human Resources with the appropriate certifications. If the leave is determined to qualify for FMLA, CFRA, and/or PDL Leave, the employee will receive a designation notice.

If your leave does qualify as FMLA, CFRA, and/or PDL leave you will have the right for up to 12 weeks (480 hours) of unpaid leave (26 weeks for military caregiver leave) in a 12-month period calculated as a fiscal year (July 1 – June 30). You may opt to use your eligible paid leave (sick, vacation, half-pay) during your absence.

Date of Request: _____

Employee's Name: _____

ID# _____

Position Title: _____

Department: _____

Classification: Faculty Administrator CAST

Classified

Begin date of Leave: _____

Expected Return Date: _____

Total Temporary Disability (completely off work)

Intermittent Leave: off work approximately ____ hour(s) per day ____ day(s) per week ____ frequency of flare-ups ____

Did you have an approved leave in the past fiscal year? Yes Date: _____ No

I would like to use my eligible sick, vacation, and/or half-pay to be paid during my leave. I will submit an absence report for leave time used to payroll on a monthly basis.

I request a Leave for the following reason (check only one)

Parental Leave following the birth of a child, or placement of a child with you for adoption or foster care

Own serious health condition (not work-related)

Pregnancy/Disability Leave

To care for an immediate family member because such family member has a serious health condition.
Relationship: _____

Military Caregiver Leave/Exigency Leave

Work-Incurred injury/Illness
Date of injury or illness ____/____/____

I do not wish to request Family Medical Leave and/or California Family Rights Leave for my absence

Acknowledgment

While in unpaid status, I understand that I will not accrue sick or vacation leave and I may choose to continue my insurance coverage by arranging full payment with Human Resource Services.

Employee Signature

Date

<i>Human Resource Services Use Only</i>	
Date supporting documentation received _____	Begin date of leave _____
Governing Board Date _____	End date of leave _____
Date designation notice sent _____	Hours of leave remaining _____