Request for Family/Medical Leave

Under City policy, the Federal Family Medical Leave Act (FMLA) and the State California Family Rights Act (CFRA), and/or the California Pregnancy Disability Leave (PDL) you may request an unpaid leave of absence or a reduced work schedule.

To request such leave, please complete the employee section of this Leave Request form, attach a medical certification if available, and forward to Human Resources for processing. Please refer to the applicable sections of your Memorandum of Understanding and the City's policy on Family Care and Medical Leave for more information on the use of accrued vacation, compensatory time and/or sick leave hours while on an FMLA leave.

To be completed by Employee

Employee Name _____ Date of Request _____

Department _____ Hire Date _____

Position Title _____

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

___ A. The birth of a child and/or in order to care for such child

___ B. The placement of a child for adoption or foster care

(Must submit "Certification of Health Care Provider" within 15 days):

___ C. In order to care for an immediate family member (Check one: ☐ Child ☐ Spouse ☐ Parent ☐ Domestic Partner) because such family member has a serious health condition

___ D. Care for an adult child who is incapable of self-care. (A child is "incapable of self-care" if he/she requires active assistance or supervision to provide daily self-care in three or more of the activities of daily living or instrumental activities of daily living, such as caring for grooming and hygiene, bathing, dressing and eating, cooking, cleaning, shopping, taking public transportation, paying bills, maintaining a residence, using telephones and directories, etc.)

___ E. Employee's own serious health condition that makes the employee unable to perform the functions of his/her position.

(Must submit "Certification" of Qualifying Exigency):

___ F. To assist a ☐ Son ☐ Daughter ☐ Spouse ☐ Parent who is a member of the Armed Forces, including the National Guard or Reserves with a "qualifying exigency" related to covered active duty or a call to active duty status.

(Must submit "Certification" from Department of Defense or Department of Veteran Affairs within 15 days):

___ G. To care for a ☐ Son ☐ Daughter ☐ Spouse ☐ Parent or ☐ "Next of Kin" covered service member with a serious injury or illness.

Method of Leave Requested

___ A. Consecutive Leave

___ B. Intermittent or Reduced Leave Schedule (Specify schedule below, if known):

_____

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 (or 26 weeks to care for an injured service member), I will be returned to my same or equivalent position. I understand that if my family/medical leave should exceed 12 weeks (or 26 weeks to care for an injured service member), 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's Signature _____ Date _____