EMPLOYEE REQUEST FOR FAMILY MEDICAL LEAVE (FMLA)
California Family Rights Act (CFRA)

Employee Name_____ Date of Request_____

Department_____ Supervisor_____

Position Title_____ Hire Date_____

Personal Phone_____ Email_____

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.

C. ____ In order to care for an immediate family member because such family member has a serious health condition.

Check one: ❑ Child ❑ Spouse ❑ Parent ❑ Parent-In-Law ❑ Designated Person

The following applies to CFRA Leave only:

- ❑ **Registered Domestic Partner**
- ❑ **Grandchild**
- ❑ **Grandparent**
- ❑ **Sibling**

(Must submit "Medical Certification" within 15 days.)

D. ____ Care for an adult child with a serious health condition.
(Must submit "Medical Certification" within 15 days)

E. ____ Employee's own serious health condition that makes the employee unable to perform the functions of his/her position.
(Must submit "Medical Certification" within 15 days.)

F. ____ To assist a son, daughter, spouse, or 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.

Check one: ❑ Child ❑ Spouse ❑ Parent
❑ Registered Domestic Partner (CFRA ONLY)

(Must submit "Certification" of Qualifying Exigency)

G. ____ To care for a son or daughter, spouse, parent or "next of kin" covered servicemember with a serious injury or illness.

Check one: ❑ Child ❑ Spouse ❑ Parent ❑ Next of Kin

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

Method of Leave Requested

A. ____ Consecutive Leave

B. ____ Intermittent or Reduced Leave Schedule
(Specify schedule below)

_____

_____

_____

Date leave is to begin_____ Estimated ending date 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 servicemember), 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 servicemember), 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.

Date_____

Employee's Signature_____