Human Resource Services

Application for FMLA/CFRA

Family Member's Serious Health Condition

Date:______________________

The Family and Medical Leave Act and California Family Rights Act ("FMLA/CFRA" require covered employers to provide up to 12 weeks of unpaid, job-protected leave to "eligible" employees for certain fam and medical reasons.

Eligibility

Employees are eligible if they have worked IRU DW OHDVW RQH \HDU DQG IRU PRQWKV

Job Benefits

Employers are required to maintain coverage, except life insurance and accidental death and dismemberment benefits, for employees on leave under a group health plan on the same basis as if they had continued regular employment during the leave period. The employer and employee contribution responsibilities for maintaining continued health coverage remain unchanged during the leave period.

I hereby apply for a Family Leave for the period beginning at the beginning of the day on _________________ and terminating at the close of the day on _________________.

Reason for Taking the Family Leave:

- ☐ To care for my child(ren) after birth, or placement for adoption or foster care.
- ☐ To care for my spouse, GRPHVWLF SDUWQHU SDUHQW PLQRU RU DGXOW FKLOG KHDOWK FRQGLWLRQ %HJLQQLQJ -DQXDU\ 1 HPSOR\HHV PD\ WDNH OHDYH WR FD PHPEHUV LQFOXGLQJ DQ DGXOW FKLOG D FKLOG RI D GRP
- ☐ %HJLQQLQJ -DQXDU\ &)5\$ OHDYH PD\ EH WDNHQ IRU D WKH HPSOR\PHQW ,QVXUDQFH &RGH ´

Type of Leave Requested:

- ☐ _______ Consecutive weeks (Up to 12 weeks, but not less than two weeks.)
- ☐ Intermittent or reduced schedule (please explain and specify number of days a week and/or hours a day or week): ____

Advance Notice and Medical Certification:

¾ The employee must provide 30 days advance notice when the leave is "foreseeable." If you do not notify District in advance for foreseeable leave, the District may delay your leave as necessary to make appropriate arrangements for your temporary replacement. Such delay will not postpone your leave for more than 30 d from date of your request.

¾ Medical certification to support a request for leave because of a serious health condition is required. Form WH-380-F attached. You must provide a medical certificate at the time you request leave if your leave is care for a qualifying family member.

Certification of Health Care Provider must be attached.

Advance Notice and Medical Certification (continued)

The District may require an employee requesting intermittent or reduced leave as a result of planned med treatment, to transfer to an alternate position which has equivalent pay and benefits and accommodates recurring periods of leave better than the employee's regular position.

Restoration Rights

You will be reemployed in the same, comparable, or equivalent position upon return from full leave.

By my signature, I attest that I have read and understand the above.

Name (Print or Type)	Signature
Social Security Number	Mailing Address
Telephone	City State Zip Code
	School Site/Department Position
	Grade and/or Subjects Taught

Leave of absence granted in accordance with above:

Chief Human Resources Officer or Designee Human Resource Services	Date

(Do not write in this space. For office use only.)	
Eligibility Certified By:	
Medical Certification, Form WH-380-F Verified:	
Agenda Date:	Position Number:
Hold Position:	Transfer to Unassigned:
Recommended By:	