



# 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 family and medical reasons.

#### **Eligibility**

Employees are eligible if they have worked for a covered employer for at least one year and for 1,250 hours over the previous 12 months, and if there are at least 50 employees within 75 miles.

#### **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, son, daughter, or parent who has a serious health condition.

To care for his or her child whose school or place of care is closed (or child care provider is unavailable) due to COVID-19 related reasons under the Expanded Family Leave Federal Families First Coronavirus Response Act (FFCRA). (Effective 4/1/2020 - 12/31/2020)

Please provide Child's Name, Age, and School or Day Care Provider/Facility: \_\_\_\_\_

#### **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:**

- The employee must provide 30 days advance notice when the leave is "foreseeable." If you do not notify the 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 days from date of your request.
- 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 to 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 medical 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.

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

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Name (Print or Type)

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Signature

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Social Security Number

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Mailing Address

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Telephone

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City

State

Zip Code

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School Site/Department

Position

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Grade and/or Subjects Taught

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*Leave of absence granted in accordance with above:*

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Chief Human Resources Officer or Designee  
Human Resource Services

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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:

**Certification of Health Care Provider must be attached.**