City of FRESNO	REQUEST FOR FAMILY/MEDICAL LEAVE Family and Medical Leave Act of 1993 (FMLA) and California Family Rights Act of 1993 (CFRA)

Employee's Name: _____ Employee ID:_____

Employee's Address:_____

_____

Date of Request: _____

Department/Division: _____

Position: _____ Hire Date: _____

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

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

☐ The placement of a child for adoption or foster care.

☐ To care for an immediate family member because such family member has a serious health condition. Must submit "Certification of Health Care Provider" within 15 days.
Check one: ☐Spouse ☐Child ☐Parent ☐Registered Domestic Partner (CFRA only)

☐ To 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.) Must submit "Certification of Health Care Provider" within 15 days.

☐ Employee's own serious health condition that makes the employee unable to perform the functions of his/her position. Must submit "Certification of Health Care Provider within 15 days.

☐ To assist a son or 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. Must submit "Certification" of the Qualifying Exigency.
Check one: ☐Spouse ☐Son ☐Daughter ☐Parent

☐ To care for a son or daughter, spouse, parent, or "next of kin" who is a covered servicemember with a serious injury or illness. Must submit "Certification" from Department of Defense or Department of Veteran Affairs within 15 days.
Check one: ☐Spouse ☐Son ☐Daughter ☐Parent ☐Next of Kin

Method of Leave Requested

☐ Consecutive Leave beginning on_____ Expected Duration:_____

☐ Intermittent Leave beginning on_____ Expected Duration:_____
(Specify schedule below)

Frequency: _____ times per ☐week ☐month Duration: ____☐hours ☐day(s) per event

☐ Reduced or Modified Schedule (Specify schedule below)

_____hour(s) per day; _____days per week from _____ through _____

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.

Employee's Signature_____ Date _____