LEAVE REQUEST FORM

Family and Medical Leave Act ("FMLA")
California Family Rights Act ("CFRA")
Pregnancy Disability Leave ("PDL")
Health/Disability (H/D)

Employee Name: _____ Date of Hire: _____

Home Address: _____ Position: _____

_____ Site: _____

Phone Number: _____

Personal Email: _____ Is it ok to send emails to this address?
☐ Yes ☐ No

Date of Request: _____

BASIS FOR FAMILY MEDICAL LEAVE OR PREGNANCY DISABILITY LEAVE

I'm providing the School with written notification of my need to take family medical leave due to:

☐ The **birth of a child**, or the placement of a child with me for **adoption or foster care**
☐ CFRA ☐ PDL

☐ A **serious health condition** (may include disability resulting from pregnancy) that makes me unable to perform the essential functions of my job

☐ A **serious health condition affecting my ☐ spouse, ☐ child, ☐ parent,** for which I am needed to provide care. Family Member:_____

☐ The **extension of ☐ FMLA, ☐ CFRA or ☐ PDL previously approved:**
Dates prior approved are: _____ to _____

☐ To **care for a "covered service member" or an "active service member,"** allowable under the provisions of the law

DATES ANTICIPATED/REQUIRED FOR LEAVE

I expect this leave to begin on or about _____ and end on or about _____.
(*Date*) (*Date*)

REQUIRED MEDICAL CERTIFICATION

FOR ☐ FMLA ☐ CFRA ☐ PDL ☐ Health/Disability LEAVES I understand that in order for my leave to be approved, I must provide a medical certification to GCC Human Resources prior to my leave addressing 1) the date the serious health condition began; 2) the duration of the condition; and 3) a statement that I am unable to work due to a serious health condition, or that a serious health condition of a family member warrants my absence from work.

INTENT TO RETURN

I ☐ do ☐ do not intend to return to my position at the school after the end of my leave.

PAYMENT

☐ I understand that this is an unpaid leave of absence. If I would like to be paid for any portion of the leave I understand that I need to use my sick/personal time (please attach an Employee Absence Request for any days you wish to use your sick/personal time).

EMPLOYEE REQUEST ADDITIONAL ACKNOWLDGEMENTS:

☐ I understand my continuing obligation to pay my share of all health insurance premiums in a timely manner during the leave, unless I decline to continue my coverage during my leave by submitting a written waver prior to, or within 31 days, of my leave start date. I further understand that my failure to return to work after my leave may result in GCC's enforcement of its legal right to recover from me costs of health insurance premium payments paid by GCC during my leave.

☐ I acknowledge that, under FMLA/CFRA/PDL, I will be reinstated, upon return from an approved leave herein, to the same or an equivalent position, subject to applicable law.

☐ I acknowledge that I have carefully read this request and the applicable sections of the Employee Handbook and understand and agree with the provisions therein.

_____ _____

(Date) *(Employee Signature)*

_____ _____

(Date) *(Supervisor/Principal's Acknowledgement)*

To Be Completed By Employer

The request leave is approved to begin on _____ and end on_____

(*Date)* (*Date)*

Additional Comments:

_____ _____

(Date) *(HR Coordinator)*

Process:

- ☐ Updated Payroll Changes Spreadsheet
- ☐ Updated LOA Spreadsheet
- ☐ Updated COBRA Spreadsheet
- ☐ Entered in QSS
- ☐ Copy of approval/denial letter to: Employee/Supervisor/Cindy