COUNTY OF ALAMEDA

FAMILY AND MEDICAL LEAVES
EMPLOYEE REQUEST FOR LEAVE

Employee's Name: _____ Employee's ID #: _____

Classification: _____ Department: _____

Contact Telephone Number: _____ Immediate Supervisor:_____

This is a request for leave as provided under the Family Medical Leave Act (FMLA)/California Family Rights Act (CFRA) and/or Pregnancy Disability Leave (PDL).

My requested ☐ **continuous** ☐ **intermittent** leave is from _____ through _____ for the reason(s) indicated below:

☐ 1. My own serious health condition (including industrial and/or non-industrial injury/illness/medical condition).

☐ 2. To care for my ☐ spouse/domestic partner ☐ child ☐ parent due to his/her serious health condition.

☐ 3. My own disability due to pregnancy, child birth, or related medical condition, or for prenatal care.
(Note: Disability due to pregnancy/child birth/related medical condition is covered under FMLA/PDL only)

☐ 4. To bond/care for my new born, adopted child or foster child (child bonding).
Date of birth/placement with my family: _____

☐ 5. Because of a qualifying exigency arising out of the fact that my ☐ spouse ☐ son or daughter ☐ parent who is a covered service member on covered active duty in the Arm Forces.

☐ 6. To care for my ☐ spouse ☐ son or daughter ☐ parent ☐ next of kin who is a covered military member with a serious injury or illness.

EMPLOYEE ACKNOWLEDGMENT

I certify that the information I have provided above is true and correct.

Employee's Signature: _____ **Date:** _____

TO BE COMPLETED BY SUPERVISOR & HUMAN RESOURCES

Upon receipt of this form, immediately complete and forward to your Human Resources Office for processing.

Date Received: _____ **Supervisor's Signature:** _____

Date Received: _____ **Department Head/HR Representative:**_____