Santa Barbara
SCHOOL DISTRICTS
Excellence for All

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REQUEST FOR FAMILY/MEDICAL LEAVE
(FMLA/CFRA)

This form is to be used for requesting leave under family medical leave laws for the purposes of bonding following the birth, adoption or foster care placement of a child **OR** to care for an immediate family member due to the family member's serious health condition. To be eligible for such leave, an employee must meet the following qualifications:

1. the employee must have been employed for at least 12 months.
2. during the immediately preceding 12-month period, the employee must have rendered at least 1,250 hours of service.

Leaves are for a maximum of 12 weeks in a 12-month period and are assumed to be consecutive unless a request for an intermittent or reduced leave schedule (for family medical leaves only) is attached.

NOTE: Request for leave due to an employee's own serious health condition or leave for pregnancy disability should be made using the "Request for Medical Leave" form.

Employee's full name _____

Site _____ Position _____

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. Date of birth :_____
Effective dates: from _____ through _____

☐ The placement of a child for adoption or foster care. Date of placement: _____
Effective dates: from _____ through _____

☐ In order to care for myself or for an immediate family member because such family member has a serious health condition. Check one: ☐ Employee ☐ Child ☐ Spouse ☐ Parent
(Physician Certification, below, must be completed)

PHYSICIAN CERTIFICATION

The physician certifies that the above-named employee is required to care for the immediate family member due to the family member's serious health condition. Leave effective dates must be specific but may be amended in writing as necessary. **Do not disclose the medical diagnosis.**

Leave is required from _____through _____

Doctor's comments/additional information _____

_____

Doctor's name (Type/print) _____ License number _____

Address _____ Telephone _____

Doctor's signature _____ Date _____