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COUNTY OF RIVERSIDE
Human Resources Department

REQUEST FOR FAMILY/MEDICAL LEAVE

♦ Family and Medical Leave Act (FMLA) ♦ California Family Rights Act (CFRA)
♦ California Pregnancy Disability Act (PDL)

SECTION I: For Completion by the EMPLOYEE

Employee Name (Last, First, Middle):	Employee ID Number:	Date of Hire:
Employee Mailing Address:		Home Phone: ( )
Official County Job Title:		Work Phone: ( )
Department:		Last Day Worked:
Supervisor Name:		Supervisor Phone: ( )
Is spouse a County employee? If yes, please provide his/her name:		Spouse's Employee ID Number:

Date leave begins: _____ Date leave ends: _____

If you are giving less than 30 days notice, please specify reason: _____

_____

Type of Leave Request: ◯ Consecutive Leave ◯ Intermittent or Reduced Schedule (Specify schedule below.)

_____

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

☐ Disabled by pregnancy or childbirth.
- If my PDL entitlement exhausts prior to my doctor releasing me to return to work, I wish to use my CFRA (bonding) entitlement immediately after my PDL. ◯ **yes** ◯ **no**

☐ Bonding leave after the birth of a child or bonding leave after placement of a child for adoption or foster care.

☐ In order to care for an immediate family member because such family member has a serious health condition.

Check one: ◯ **child/child of domestic partner** ◯ **spouse** ◯ **parent** ◯ **domestic partner**
(must be under the age of 18)
(Must submit completed certification of Health Care Provider within 15 calendar days.)

☐ 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 grooming and hygiene, bathing, dressing and eating, cooking, and cleaning, shopping, taking public transportation, paying bills, maintaining a residence, using telephones and directories, etc.).
(Must submit completed certification of Health Care Provider within 15 calendar days.)

☐ Employee's own serious health condition that makes the employee unable to perform the functions of his/her position.
(Must submit completed certification of Health Care Provider within 15 calendar days.)
Is the injury or illness work-related? ◯ **yes** ◯ **no**

☐ To assist a child, spouse, or parent who is a member of the National Guard or Reserves with a "qualifying exigency" related to active duty or a call of active duty status in support of a contingency operation.

Check one: ◯ **child** ◯ **spouse** ◯ **parent**
(Must submit completed "Certification" of Qualifying Exigency within 15 calendar days.)

☐ To care for a child, spouse, parent, or "next of kin" service member of the United States Armed Forces who has a serious injury or illness incurred in the line of duty while on active duty (up to 26 weeks of leave).

Check one: ◯ **child** ◯ **spouse** ◯ **parent** ◯ **next of kin (as defined by FMLA regulations)**
(Must submit completed certification from Department of Defense or Department of Veteran Affairs within 15 calendar days.)

EMPLOYEE SIGNATURE REQUIRED ON NEXT PAGE

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Employee Name: _____ Employee ID Number: _____

I understand:

- If the duration of my family/medical leave (total paid and unpaid time) does not exceed 12 weeks (or 26 weeks to care for an injured service member), I will be returned to my same or equivalent position.
- If I need additional family/medical leave beyond the 12 weeks (or 26 weeks to care for an injured servicemember), I must submit a leave of absence request at least 5 work days prior to the expiration of my current leave.
- I am responsible to pay my share of the premiums to maintain my health and supplemental life coverage.
- Depending on the leave requested, I may be required to use my applicable leave balances. (Please refer to the *Use of Accruals for Family and Medical Leave* chart.)
- If I am on paid leave, my share of health premiums will be paid through payroll deduction whenever I have sufficient leave balances to cover my leave time.
- If I am on an unpaid leave , I must make arrangements to continue to make my share of premium payments to maintain my health benefits while I am on leave. My share of premiums is due on the first day of the month of coverage (e.g., premiums for January are due on January 1st). If my leave is designated as FMLA and/or CFRA, I will be eligible to continue receiving Flexible Benefit Credits for the duration of the approved FMLA and/or CFRA leave and will be responsible only for the difference between Flexible Benefit Credits and total premium cost. If I fail to make timely payment for my portion of premiums during FMLA and/or CFRA leave, the the County will maintain my coverage and recover my share of premiums when I return to work. If I do not return to work, I may be responsible for reimbursing the County the full share of premiums paid on my behalf.
- **I may elect to use applicable leave balances as allowed by policy/MOU in situations where use of accrued leave is not required. I ☐ Do ☐ Do Not authorize the use of my accrued leave balances for the unpaid portion of leave. (Please see attached *Use of Accruals for Family and Medical Leave* chart.)**

I have read and understand the above information. I acknowledge that it is my responsibility to furnish the required medical certification within 15 calendar days and to communicate with my supervisor regarding my leave status.

I have attached the required certification: ☐ Yes ☐ No

_____ _____
Employee's Signature Date

SECTION II: For Completion by the EMPLOYER

Depending on the employee's eligibility, one or more of the following leave types is being designated (**check all that apply**):

☐ FMLA ☐ CFRA ☐ PDL ☐ Exigency ☐ Service Member Was a **30-day** notice given? ☐ Yes ☐ No

(Dates and type of leave designation(s) will be finalized once medical certification and eligibility approved)

Has employee taken any family/medical leave during this qualifying period? ☐ Yes ☐ No
Number of hours used: _____

Has the employee been employed for at least 12 months (over the past 7 years) prior to the leave date shown? ☐ Yes ☐ No
Original Hire Date: _____

Does the employee meet the eligibility requirements for the leave(s)? ☐ Yes ☐ No

Has the employee worked 1,250 hours during the 12-month period prior to the leave date shown? ☐ Yes ☐ No
Number of hours worked during the qualifying period: _____

☐ **Leave request approved** ☐ **Recommend denial** **Reason for recommending denial:** _____

_____

If the department finds an employee to be ineligible and recommends denial, the department is required to obtain concurrence from Human Resources Services Manager <u>before</u> notifying the employee.

_____ _____
Department Head/Designee Printed Name Print name of person completing department information

_____ _____ _____ _____
Department Head/Designee Signature Date Department Information Completed by Signature Date

☐ I concur with denied request

☐ I do not concur with denied request (specify reason):

_____ _____ _____
Human Resources Services Manager Signature Date