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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	Employee E-mail Address	Home Phone
Official County Job Title	Work E-mail Address	Work Phone
Department	Regular Work Schedule	Supervisor Phone
Supervisor Name		Last Day Worked

Date leave begins: _____ **Date leave ends:** _____

Type of Leave Request: ◯ Continuous Leave ◯ Intermittent or Reduced Schedule

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

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

☐ 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**

☐ Disabled by pregnancy or childbirth.

•If my PDL entitlement exhaust 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.
◯ Date of Birth (or expected date of birth) _____
◯ Date of Placement (or expected date of placement) _____

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

Check one: ☐ **Spouse** ☐ **Domestic Partner** ☐ **Child/Child of Domestic Partner** ☐ **Parent-in-law**
☐ **Parent** ☐ **Grandchild** ☐ **Other Designated Person**
☐ **Sibling** ☐ **Grandparent**
Specify relationship: _____

Family member's Date of Birth: _____

(must submit completed certification of Health Care Provider within 15 calendar days)

☐ To assist a child, spouse, parent or domestic partner who is a member of the Armed Forces (includes the National Guard and 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** ◯ **Domestic Partner**

(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 Name (Last, First, Middle): **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 service member), 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 leaves 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 applied or intend to apply for short/long-term disability, state disability, paid family leave and/or Workers' Compensation benefits.**

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 Leave Administrator

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 are 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 within the last 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:**

_____

_____

Department Head/Designee Printed Name _____

Department Head/Designee Signature _____ Date _____

Print name of person completing department information _____

Department Information Completed by Signature _____ Date _____