|  |  |
| --- | --- |
| ***NEWsjeccdlogo*** | OFFICE OF HUMAN RESOURCES  |
|  |
| ▪ Forty South Market St. ▪ San José, CA 95113 | 408-270-6406 ▪ 408-239-8825 fax  |

**Family Medical Leave Application**

NAME: EMPLOYEE ID:

CAMPUS: DEPARTMENT:

Beginning Date of Leave: Ending Date of Leave:

Reason for Leave (check one):

 a) birth or adoption of a child, or the receipt of a child into foster care, within one year of such birth or placement, or

 b) the employee's own serious health condition that makes it impossible to perform essential job functions, or

 c) a serious health condition of an employee's eligible child, spouse, parent or member of the immediate household, which requires the employee to care for the family member.

------------d) military exigency

Description of Leave (if necessary):

A leave request based on an employee's serious health condition or the serious health condition of an employee's spouse, child, parent or member of the immediate household must be accompanied by a verifying medical certification from a physician.

I hereby authorize the San Jose/Evergreen Community College District Office of Human Resources to contact my physician if necessary to verify the reason for my requested leave or for any other information concerning my requested Family Medical Leave.

I concur with the terms and conditions of the leave and understand that it will be my obligation to return to District employment on the working day following the ending date of the leave. I am aware that failure to return from leave may be construed as abandonment of the employee's position.

Signature of Employee Date

Administrator Date

HR Review Date

Approved Rejected

Director of Human Resources Date