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|  | **OFFICE OF HUMAN RESOURCES** |
| * Forty S. Market Street  San José, CA 95113
 | 408-270-6404  |

FAMILY MEDICAL LEAVE APPLICATION

NAME: TITLE:

WORK LOCATION: DEPARTMENT:

**Pregnancy Disability Leave**

Beginning Date of Leave: Ending Date of Leave:

 **California Family Rights Act/Family Medical Leave Act (CFRA/FMLA)**

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 child (biological, adopted, foster, step, legal ward, or child of domestic partner), spouse, parent (biological, foster, adoptive, in-law, step, or legal guardian), domestic partner, grandparent, grandchild, sibling, designated person, or member of the immediate household, which requires the employee to care for the family member.

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A leave request based on an employee's serious health condition or the serious health condition of an employee's child (biological, adopted, foster, step, legal ward, or child of domestic partner), spouse, parent (biological, foster, adoptive, in-law, step, or legal guardian), domestic partner, grandparent, grandchild, sibling, or member of the immediate household, designated person or due to pregnancy disability **must** be accompanied by a health care provider certification.

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.

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| Signature of Employee |  |  | Date |
| Administrator |  |  | Date |
| HR ReviewApproved  | Denied  |  | Date |

Director of Human Resources Date

HR: 05/07/12; revised: 04/05/13; revised: 06/12/24