



FAMILY AND MEDICAL LEAVE REQUEST

This form is to request leave for three (3) or more days under Family and Medical Leave which encompasses the Family and Medical leave Act (FMLA) and the California Family Right Acts (CFRA). You are eligible for up to 12 weeks of unpaid leave in a 12 month period for one of the reasons stated below. Please complete this form along with a Medical Certification Form. **Return both forms to Human Resources.**

E M P L O Y E C O M P L E T E S	Employee Name	Department Name	Workday Employee ID #	Home Phone
	Employee Complete Mailing Address			
	Have you used FML in the past 12 months? <input type="checkbox"/> No <input type="checkbox"/> Yes			
	Leave Type/Dates: I hereby request <input type="checkbox"/> Continuous/ <input type="checkbox"/> Intermittent Leave (Check one box) FROM _____ THROUGH _____ (These dates <u>MUST</u> be the exact dates indicated on the doctor's certification)			
	Leave Reason: <input type="checkbox"/> Birth of a child or to care for the newborn. Child's date of birth: _____ <input type="checkbox"/> Employee is unable to perform the essential functions of his/her job due to a serious health condition. <input type="checkbox"/> Care for the employee's: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Adult Child <input type="checkbox"/> Child of Domestic Partner <input type="checkbox"/> Grandparent <input type="checkbox"/> Grandchild <input type="checkbox"/> Sibling Name of Employee's Kin _____ <input type="checkbox"/> Placement with the employee of a child for adoption of foster care (legal documentation required). <input type="checkbox"/> Qualified Exigency Leave for an employee with a covered military member Name/Relationship to employee _____ <input type="checkbox"/> Military Caregiver Leave to care for the employee's: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent or <input type="checkbox"/> Next of Kin who suffered injury or illness in the line of military duty (up to 26 weeks of leave). Name: _____			
Supervisor Section	Benefit Payments Agreement – Signature Required While on Family Medical Leave (FML), GCCCD will continue paying the employer's premium contribution of your health and welfare benefits. You will be required to pay your regular share of your benefits premiums, if any. If you do not return to work after taking FML, you will still be responsible for repayment of the employer and employee portion of your health and welfare premiums, if applicable. Employee Signature _____ Date _____			
	I acknowledge that my employee's absence is preliminarily approved for Family Medical Leave (FML) for the dates listed above pending receipt of a completed Certification from a Healthcare Provider and that HR will contact me of any changes. _____ Supervisor's Signature _____ Date _____ _____ Supervisor's Printed Name			
Human Resources	FML is <input type="checkbox"/> Granted <input type="checkbox"/> Not Granted Type: <input type="checkbox"/> FMLA <input type="checkbox"/> CFRA <input type="checkbox"/> Parental Leave Most recent intermittent FML hours used if applicable: _____		Signature of Appointing Authority (or designee) _____ Print Name _____ Date _____	
	For the period of: _____ to _____			



NOTICE OF EMPLOYEE RIGHTS AND OBLIGATIONS

FAMILY MEDICAL LEAVE (FML)

1. This is a notice to employees eligible for leave under the Federal Family Medical Leave Act (FMLA) of their specific rights and obligations (pursuant to 29 C.F.R. section 825.301(c)). The District's FML policies and procedures are established in Governing Board BP 7340.
2. The FML leave you take will be deducted from your annual Federal Medical Leave Act (FMLA) allotment and your annual California Family Rights Act (CFRA) allotment. This notice refers to Family Medical Leave (FML) taken under these acts.
3. FML may be taken continuously or intermittently. If FML is taken intermittently, you are required to report to your supervisor and Human Resources when the leave is related to your FML situation.
4. If you are taking FML due to your own serious health condition or a serious health condition of a family member, you must provide a medical certification. If you do not submit a medical certification, FML may not be granted. Under certain circumstances, re-certification of the serious health condition may be required. Certification is not required for the purpose of bonding leave when taken during the initial one-year period following the adoption, birth, or placement of a child.
5. FML is an unpaid leave of absence. An employee may be required to use any applicable paid sick leave balance concurrently with FML, unless they choose an unpaid leave of absence. Should an employee's leave needs extend beyond their accrued leave balances, they may be eligible to receive additional sick leave compensated at fifty percent (50%) pay. Faculty employees may be eligible for remuneration days. See applicable sections of your collective bargaining agreement for details.
6. While on FML, GCCCD will continue paying the employer's premium contribution of your health and welfare benefits for a maximum period of up to 12 workweeks. You will be required to pay your regular share of your benefits premiums, if any. If your FML is unpaid, those payments will be collected by way of payroll adjustments upon your return to work. If you do not return to work after taking FML, you will still be responsible for repayment of the employer and employee portion of your health and welfare premiums, if applicable.
7. When you are returning to work from approved FML for your own serious health condition, Human Resources may request a note from your health care provider certifying that you are able to return to work, the date you can return, any limitations or restrictions, and their anticipated duration. If you do not return to work by the first working day following the conclusion of your FML, and you continue on some other form of District approved leave, the District may require you to complete a Fitness for Duty Evaluation prior to your return to work (pursuant to 29 C.F.R. section 825.312).
8. If you return to work by the first working day following the conclusion of your FML, you are entitled to return to the same or equivalent position.