CITY OF SANTA CLARA
REQUEST FOR FAMILY AND MEDICAL LEAVE

Employee Name _____ Employee Number _____

Department/Division _____ Hire Date _____

Print Supervisor's Name _____ Unit # _____

Family and Medical Leave is requested for the following reason (Check one):

- ☐ The birth of a child and/or care for that child. Expected delivery date: _____
- ☐ The placement of a child for adoption or foster care. Scheduled date of adoption: _____
- ☐ The care for an immediate family member because such family member has a serious health condition (Must submit "Physician Certification" within 15 days.) Please check one:
  - ☐ Child ☐ Spouse ☐ Parent
- ☐ Employee's own serious health condition that makes the employee unable to perform the functions of his/her position (Must submit "Physician Certification" within 15 days.)
- ☐ Military Caregiver Leave: Please check one:
  - ☐ Child ☐ Spouse ☐ Parent ☐ Next of Kin
- ☐ Military Exigency Leave: Please check one:
  - ☐ Child ☐ Spouse ☐ Parent

The requested dates for Family and Medical Leave are _____ through _____.
The type of leave that is requested is:

- ☐ Consecutive Leave
- ☐ Intermittent or reduced leave schedule (please specify) _____
  _____.

During my Family and Medical Leave, please use my following leave accruals, as available:

- ☐ Sick leave (City Manager approval is required for Family Sick leave usage over the maximum allowed by MOU).
- ☐ Vacation
- ☐ Compensatory Time Off (comp time, CTO)
- ☐ Do not use my leave accruals while I am on leave. I understand with this option, I will not accrue vacation, sick leave, or holidays while on a no-pay status.

During my Family and Medical Leave, I elect to:

- ☐ continue health coverage
- ☐ continue dental coverage
- ☐ continue basic life insurance
- ☐ drop health coverage
- ☐ drop dental coverage
- ☐ drop basic life insurance

If the duration of my Family and Medical Leave (total of paid <u>and</u> unpaid time) does not exceed 12 weeks, I will be returned to my same or equivalent position. I understand that if my Family and Medical Leave should exceed 12 weeks, or 26 weeks for military caregiver leave, I will be returned to my same or equivalent position **only if available**. If my same or equivalent position is not available, I understand I may be terminated.

Signature _____ **Date** _____

Supervisor's Acknowledgment _____ **Date** _____

Human Resources Approval _____ **Date** _____

<u>Human Resources Use Only</u>:
Current Leave Accrual Balances: Sick _____Vacation _____CTO_____ As of _____
Number of prior Family and Medical Leave hours taken in 12-month cycle: _____(hours)
Has employee worked at least 1250 regular hours in 12-month cycle? _____Yes _____No Letter Sent _____