SCOTTS VALLEY FIRE PROTECTION DISTRICT

7 Erba Lane, Scotts Valley, California 95066 (831) 438-0211 Fax (831) 438-0383

REQUEST FOR FAMILY MEDICAL LEAVE (FMLA/CFRA)1

Employee Name: _____ Employee #: _____

Date of Request: _____ Date of Hire: _____ Position: _____

I request Family Medical Leave for the following reason (check applicable below):

☐ The birth of a child and/or in order to care for such child.

☐ The placement of a child for adoption or foster care.

☐ Employee's own serious health condition that makes the employee unable to perform the functions of their position. Must submit "Certification of Health Care Provider."

☐ To care for an immediate family member because such family member has a serious health condition. Must submit "Certification of Health Care Provider."

FLMA/CFRA: ☐ Spouse ☐ Child ☐ Parent
CFRA Only: ☐ Domestic Partner ☐ Grandchild ☐ Grandparent
CFRA Only: ☐ Parent-in-law ☐ Sibling ☐ Designated Person: _____

☐ To care for an adult child who is incapable of self-care (A child is "incapable of self-care" as defined by FMLA).

☐ To assist a child, spouse, or parent who is a member of the Armed Forces, including the National Guard or Reserves, with a "qualifying exigency" related to covered active duty or a call to active duty status. Documentation issued by the military may be required.
☐ Spouse ☐ Child ☐ Parent ☐ Domestic Partner (CFRA Only)

☐ To care for a child, spouse, parents or 'next of kin who is a covered service member with a serious injury or illness. Must submit "Certification of Health Care Provider."
☐ Spouse ☐ Child ☐ Parent ☐ Next of Kin

LEAVE REQUESTED

☐ Consecutive Leave Beginning: _____ Expected Duration: _____

☐ Intermittent Leave Beginning: _____ Expected Duration: _____

☐ Reduced or Modified Schedule (Please see Administrative Office for Scheduling)

☐ Sick Leave Hours: _____ ☐ Vacation Leave Hours: _____

☐ Unpaid Leave Hours: _____ (Check all leave that apply)

If the duration of my family medical leave (total paid and unpaid time) does not exceed 12 weeks (26 weeks to care for an injured service member), I will return to my same or equivalent position if available. If my same or equivalent position is not available, I understand I may be terminated.

Employee Signature: _____ Date: _____

Chief Approval: _____ Date: _____