CITY OF OAKLAND

FAMILY MEDICAL LEAVE REQUEST

Employee should complete this leave request, and then forward with appropriate medical or other verification along with a Family Medical Leave Time Reporting Form to HRM Risk or your designated Agency/Department Personnel Representative.

Name (Last, First, MI)	Employee Number
Home Address	City/Zip
Home Phone	Work Phone
Agency/Department	Supervisor/Extension

I am requesting Family Medical Leave for the following eligible purpose:

- ❑ the birth of my child and to care for the child due date: _____
- ❑ bonding with my newborn child to conclude within one year of the birth
- ❑ the placement in my home of a child for adoption or foster care placement date: _____
- ❑ to care for my ❑ spouse ❑ child ❑ parent who has a serious illness
- ❑ to care for my ❑ grandparent ❑ grandchild ❑ sibling ❑ domestic partner child who has a serious illness (CFRA)
- ❑ Unpaid Family Leave (UFL) ❑ in-law who has a serious illness
- ❑ to care for a service-member
- ❑ my own Qualifying Exigency related to Military Leave
- ❑ to care for my domestic partner for which I have registered with the City or State of California
- ❑ my own serious health condition that makes me unable to perform my job
  _____ non-industrial _____ worker's compensation

☐**Continuous Leave Request:**
I wish to use Family Medical Leave from _____ through _____ to a maximum of 12 weeks per rolling 12-month period.

☐**Intermittent Leave Request (**time off in separate blocks)**:**
I wish to use Family Medical leave on an intermittent basis between _____ through _____ to a maximum of 12 weeks per rolling 12-month period. Each time that I need to take FMLA leave during the period referenced above, I must give at least 30 days notice when the need is foreseeable. When it is not, I must provide notice as soon as practicable. I must follow usual and customary call-in procedures for reporting my absence, unless there are unusual circumstances. I may be required to provide proof that the absence was related to my FMLA entitlement.

☐**Reduced Work Schedule Request** (reduce the amount of hours worked per day or per week):
I wish to use Family Medical leave to reduce my work schedule during the period of _____ through _____. I request to work _____ hours per day and _____hours per week. I understand my pay will be reduced consistent with my reduced work hours if I do not substitute accrued leave for the unpaid leave.

☐**Unpaid Family Leave Request** I wish to use UFL from _____ through_____ to a maximum of 6 weeks per rolling 12-month period.

☐**Pregnancy Disability Leave (PDL):**
I wish to use Pregnancy Disability Leave from _____ through _____ to a maximum of 16 weeks.

☐**California Family Rights Act (CFRA) Bonding Leave:**
I wish to use California Family Rights Act Bonding leave from _____ through _____ to a maximum of 12 weeks.

Military Family Leave as ☐ Qualifying exigency or ☐ Caregiver/kin-care:
I wish to use FMLA/Military Family Leave from _____ through _____ to a maximum of 12wks for qualifying exigency and 26 weeks for caregiver/kin-care.

Verification Required
You must submit verification from your health care provider for personal illness or the illness of an eligible family member on the City provided form; or a photocopy of a birth certificate or a letter from the hospital indicating the baby's name, gender, date of birth, name of mother, name of father, if known, or registered domestic partner; or the appropriate legal documents for adoption or placement of a child in foster care. Please attach your Medical Verification Form to this application.

Employee Certification
I understand that the maximum FMLA/CFRA leave I can take in a rolling 12-month period is 12 weeks; the maximum PDL I can take in a rolling 12-month period is 4 months; and the maximum Military Family Leave I can take in a rolling 12-month period is 26 weeks. I affirm that this request does not exceed these limits.

I understand I am required to use all but ten (10) days of my available accrued sick leave during my FMLA absence when I take FMLA for my own serious health condition. I may choose to use any accrued sick, vacation, or other accrued paid leave that I am otherwise eligible to use during the otherwise unpaid family medical leave absence. I understand I may be transferred to accommodate my leave request.

Except in the instance of Pregnancy Disability Leave, during any unpaid leaves of absence, I will not accrue seniority, sick or vacation leave or retirement credit. I further understand I am eligible for continue coverage under the City's group health plans under the same conditions as I would as an active employee during any designated periods of FMLA, CFRA, or PDL. My employee contribution amounts will be subject to any change in rates that occur while I am on leave. If my employee contribution is more than 30 days late, the City will terminate my insurance coverage.

I understand that if I do not return to City service after the expiration of my Family or Medical Leave, I may be required to repay the City of Oakland for any City paid insurance contributions made on my behalf during any periods designated as FMLA, CFRA and/or PDL. During this period, I will notify the City of changes in my address and/or telephone number.

_____
Employee Signature Date

NOTE: *Approval is contingent on providing medical certification confirming leave needed is related to a serious health condition, my eligibility and verification I have not exhausted my Family or Medical Leave entitlements.*
NOTE: *Leave exceeding my Family or Medical Leave entitlements must be submitted separately to my department and approved by my department head.*