CITY OF OAKLAND

FAMILY MEDICAL LEAVE TIME REPORTING FORM

For assistance completing this form, contact your Agency Payroll Representative.

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

I wish to use Family Medical Leave from ____ through ____ to a maximum of 12 weeks per rolling 12 month period.

Family Medical Leave Time Reporting

DESCRIPTION	**TIME & ATTENDANCE CODE**
California Family Rights Act	CFRA LWOP
Fam/Med Leave No Pay	FMLA LWOP
Fam/Med Leave Vacation Taken	FMLA Vacation
Fam/Med Leave Comp Day Used	FMLA Comp Day
Fam/Med Leave Extra Vacation Day	FMLA Extra Vac
Fam/Med Leave Mgmt Leave	FMLA Mgmt Lv
Fam/Med Leave Executive Vacation	FMLA Exec Vac
Fam/Med Leave Comptime Used	FMLA Comp Time
Fam/Med Leave Floating Holiday	FMLA Float Hol
Fam/Med Leave Sick	FMLA Sck Taken
Fam/Med Leave Family Sick Leave	FAM
Fam/Med Leave Sick Leave (Sworn) 50%	ESP
Pregnancy Disability Leave	PDL LWOP

To Be Completed by Agency Payroll Representative

Eligibility Certification:

I certify this employee has worked for the City of Oakland for at least one year. He/she also has worked at least 1,250 hours during the twelve (12) month period before leave begins

_____

Agency Payroll Representative Date

Family Medical Leave Taken in Last Twelve Months_____ hours
Family Medical Leave Available_____ hours

Leave Balances as of _____:

Vacation_____ **Sick Leave***_____

Management Leave _____

Comp Time_____ Other Paid Leave (specify type)_____ Other Paid Leave (specify type)_____

***Use all but ten (10) days of available accrued sick leave for employee's own serious health condition. Employee must notify his/her supervisor in writing to elect to use any accrued leave concurrently with unpaid Family Medical Leave so that he/she can be paid while on Family Medical Leave.**