EMPLOYEE REQUEST FOR FAMILY/MEDICAL LEAVE OF ABSENCE

Employee Name: _____ Date: _____

I have worked for the City for 12 months or more, and during the past 12 months I have worked at least 1250 hours. ☐ True ☐ False

I request a Family/Medical Leave of Absence for the following reason (check one):

☐ My own serious health condition that makes me unable to perform the functions of my position. (Must submit completed "Certification of Health Care Provider" to Human Resources within 15 days.)

☐ The birth of a child and/or in order to care for such child.
☐ The placement of a child for adoption or foster care.
☐ In order to care for an immediate family member because such family member has a serious health condition.
☐ Care for an adult child who is incapable of self care. (A child is "incapable of self care" if he/she requires active assistance or supervision to provide daily self care in three or more of the activities of daily living or instrumental activities of daily living, such as caring for grooming and hygiene, bathing, dressing and eating, cooking, cleaning, shopping, taking public transportation, paying bills, maintaining a residence, using telephones and directories, etc.)

Check one: ☐CHILD ☐SPOUSE ☐PARENT ☐DOMESTIC PARTNER
(Must submit completed "Certification of Health Care Provider" to Human Resources within 15 days, except for adoptions and foster care placements.)

☐ 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 of active duty status.

Check one: ☐CHILD ☐SPOUSE ☐PARENT
(Must submit "Certification" of Qualifying Exigency)

☐ To care for a child, spouse, parent or "next of kin" covered service member of the United States Armed Forces who has a serious injury or illness incurred or aggravated in the line of duty while on active duty (up to 26 weeks of leave).

Check one: ☐CHILD ☐SPOUSE ☐PARENT ☐NEXT OF KIN
(Must submit "Certification" from the Department of Defense or Department of Veteran Affairs within 15 days.)

(OVER**)**

METHOD OF LEAVE REQUESTED

Check one:

☐ Consecutive Leave

☐ Intermittent or Reduced Leave Schedule (Specify schedule below)

_____

_____

_____

Date requested leave to begin: ____ / ____ / _____
Expected duration of leave: ____ / ____ / _____

I have previously taken medical leave or family leave. ☐ True ☐ False

If the duration of my family/medical leave (total of paid and unpaid time) does not exceed 12 weeks (or 26 weeks to care for an injured service member), I will be returned to my same or equivalent position. I understand that if my family/medical leave should exceed 12 weeks (or 26 weeks to care for an injured service member), I will be returned to my same or equivalent position, only if available. I also understand that per the Genetic Information Nondiscrimination Act of 2008 (GINA), the City of San Mateo will not ask for genetic information from my health care provider. The exception being if the health care provider is completing the forms regarding my family member, in which case the family medical history may need to be included in order to make the medical certification complete and sufficient under FMLA.

Employee Signature: _____ Date: _____

For more information about the Family Medical Leave Act (FMLA), go to www.dol.gov. To access the City of San Mateo City-Wide Leave Policy, go to the Human Resources Page on the City's Intranet in the Policies section.