CITY OF MILPITAS
REQUEST FOR FAMILY MEDICAL LEAVE (FMLA)/ CALIFORNIA FAMILY RIGHTS ACT (CFRA)

Eligible employees are entitled under the Family and Medical Leave Act (FMLA) and/or the California Family Rights Act (CFRA) for up to 12 weeks of unpaid, job-protected leave for certain family and medical reasons, and up to 26 weeks of unpaid, job-protected leave in a 12-month period to care for a covered family member who was seriously ill or injured during their active military service.
To be eligible for FMLA/CFRA leave the employee must have been employed for at least 12 months; and have worked at least 1,250 hours during the 12 months prior to the commencement of leave. Employees are expected to give as much advance notice as possible when requesting FMLA/CFRA leave and to make all reasonable efforts to minimize the disruption caused by their absence. Employees are required to substitute any available accrued paid leave for any part of the applicable leave provided under the Family Medical Leave Act.

A. EMPLOYEE INFORMATION

Employee Number	Employee Last Name	Employee First Name	Department	Home Address	Telephone

B. LEAVE INFORMATION

Action	**Leave Type**	**Leave Time Base**	**Leave Credits**
☐ New ☐ Change ☐ Cancel	☐ Birth or Placement of a Child for Adoption/Foster Care Due Date:_____ ☐ FML Self- Employees Own Personal Illness or Serious Health Condition ☐ FML Family Relationship:_____ ☐ Care for Covered Service Member Relationship:_____ ☐ Qualifying Exigency for Military Family Leave Relationship: _____	☐ Continuous leave under care of a licensed practitioner during a prolonged period of incapacity or convalescence due to catastrophic illness ☐ Intermittent leave or reduced work schedules. Attach requested schedule and provide time cards to HR. ***The employee is required to furnish a written statement from the licensed practitioner to substantiate the need for continuous or intermittent leave and whether leave will be taken as needed or on a set schedule.***	Will you be using leave credits? ☐ Yes ☐ No Please list the order in which to take leave balances. Note: Sick Leave will be exhausted first __1__ Sick ____ Vacation ____ Comp Time ____ Floating Holiday

Dates for Leave (please specify month, day, year)	**Short Term Disability (STD)/Catastrophic Leave (Cat Leave)**	
Date From:	Will you be applying for STD ☐ Yes (must exhaust all leave credits)	☐ No
Date Through and Including:	Will you be applying for Cat Leave ☐ Yes (must exhaust all leave credits)	☐ No
Expected Return to Work Date:		

C. EMPLOYEE CERTIFICATION AND ACKNOWLEDGEMNT OF LEAVE DATES

This is to certify that the information provided here is accurate and to the best of my knowledge

_____ _____
Employee Signature Date

D. APPROVALS

_____ _____
Department Approval Date

_____ _____
Human Resources Approval Date

HR Use Only

_____ Hours Worked per Week _____ Hours Worked Last 12 Months _____ FMLA Hours Used Last 12 Months _____ FMLA Hours Remaining
_____ Approval/Denial Letter Sent