Los Rios Community College District

FAMILY AND MEDICAL LEAVE ACT CERTIFICATION OF ADOPTION OR FOSTER CARE

NAME: _____ EMLOYEE ID: _____

JOB TITLE: _____ DATE OF HIRE: _____

I request leave under the Family Medical Leave Act from _____ to _____.

COLLEGE: ☐ ARC ☐ CRC ☐ SCC ☐ FLC/EDC ☐ DO ☐ ARC

Qualifying Event: ☐ Adoption ☐ Foster Care Placement

_____ _____

Employee signature *Date*

Professional/Agency Certification (to be completed by the placement professional or agency) - Documentation on placement of the child must be attached to this form.

I hereby certify placement was made to the above named employee's family on _____.

Agency Name: _____

Street Address: _____ Telephone: _____

City: _____ State: _____ Zip Code: _____

Name and Title of Agency Official: _____

Agency Official's Signature: _____ Date: _____

If you have any questions please contact the Employee Benefits Department at 916·568·3070.