Los Rios Community College District
Family Medical Leave
Request Form

NAME: _____ EMPLOYEE ID: _____

JOB TITLE: _____ DATE OF HIRE: _____

COLLEGE/LOCATION: ☐ ARC ☐ CRC ☐ FLC ☐ SCC ☐ DO ☐ FM ☐ EWC

I request leave under the Family Medical Leave Act (FMLA) and California Family Rights Act (CFRA) from

_____ to _____.

My leave will be (check appropriate box): ☐ continuous ☐ intermittent

Reason for leave:

☐ A serious health condition (involves inpatient care in a hospital, hospice, or residential healthcare facility; or continuing treatment or supervision by a healthcare provider) that makes you unable to perform the essential functions of your job.

☐ A serious health condition affecting an immediate family member (*spouse, domestic partner, son, daughter or parent—not including parent-in-law*) for whom I am needed to provide care. _____ (*Indicate relationship)*

☐ The birth and care of a newborn.* Expected date of birth: _____

☐ The placement of child for adoption or foster care.* Expected date of placement: _____

***Note: You have 31 days from the event date to add a newborn or newly adopted child to your medical and dental insurance.**

_____ *Initial* I will follow my college/location procedures for requesting time off. I will indicate by checking the box on the far right of my monthly absence report any absences to be counted toward FMLA /CFRA leave.

_____ *Initial* I understand FMLA/CFRA is an **UNPAID** leave unless I have accrued sick leave, vacation, or other paid leaves available for use per my collective bargaining agreement. I further understand that my paid leaves will be used in conjunction with FMLA/CFRA leave so that I will remain in paid status. At such time, all applicable accrued paid leaves or the allowable number of days for any particular paid leave such as Personal Necessity has been exhausted, I will be on an unpaid leave.

_____ *Initial* Employees on an unpaid FMLA/CFRA leave of absence will not earn service credit under their respective retirement plan (STRS or PERS).

_____ *Initial* I will be financially responsible for my share of monthly medical insurance and other benefit plan premiums, if any, and if in an upaid status, I will submit payment to Los Rios by the 25th of the month, prior to the month of coverage for the coverages I wish to continue.

_____ *Initial* I understand that I may be required to reimburse Los Rios for the employer paid portion of my health insurance if I do not return to work following FMLA/CFRA leave for a reason other than: (1) the continuation, recurrence, or onset of a serious health condition which would entitle me to another FMLA/CFRA leave; or (2) other circumstances beyond my control.

Contact the Employee Benefits Department at (916) 568-3070 if you have any questions regarding this form or FMLA/CFRA leave.

_____ _____
Employee Signature *Date*

_____ _____
Supervisor Signature *Date*

_____ _____
V.P./President/Director/Manager Signature *Date*

Distribution: White—Employee Benefits Canary—V. P./Director/Manager Pink– Employee