COUNTY OF MARIN

Request for Family Medical Leave

Form sent to employee by HR:_____

Or, Form given to employee by:_____

Employee Name:_____ **Today's date:**_____

Department:_____ **Supervisor Name:**_____

I request Family/Medical Leave for the following reason:

☐ A. Birth of a child or the placement of a child for adoption or foster care (bonding leave).

☐ B. My own serious health condition. ☐ non-work related ☐ work-related

☐ C. A serious health condition affecting my: child, spouse, registered domestic partner, child of registered domestic partner, parent.

☐ D. A qualifying exigency resulting from my own, spouse, registered domestic partner, child, parent's active duty or call to active duty.

Method of Leave Requested

☐ Consecutive

☐ Intermittent or reduced leave schedule (specify anticipated schedule below).

I will need the leave beginning on_____. I expect my leave to continue until, or about_____.

I understand that my own paid leave time will be applied during my absence.

I understand that I am required to submit a completed Physician's Certification within 15 days of this request. (In the case of Workers Comp, the Physician's Certification is not required).

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In the event my return to work date changes, I understand that I am responsible for contacting the County and providing updated medical certification.

I understand that if the leave is for my own serious health condition, I am required to provide the Fitness for Duty to Return from Leave Certification Form upon my return to work.

I understand that the leave may be used only for the purpose described above and use of leave for any other purpose will be grounds for disciplinary action, up to and including termination.

I understand that if the duration of my family/medical leave (total of paid and unpaid time) does not exceed 12 weeks, I will be returned to my same or equivalent position. And that if my family/medical leave should exceed 12 weeks, I will be returned to my same or similar position, only if available, in accordance with applicable laws. If my same or similar position is not available, I understand that I may be terminated. County reserves the right to request fitness for duty certification before and employee returns to work.

During my leave, I can be reached at:

Phone:_____**Email:**_____

Address:_____

Signature:_____**Date:**_____

Please email, fax, or send completed Request form and Physicians Certification form to:

Email: HRLeaves@marincounty.org
Fax: (415) 473- 5960

County of Marin
Leave Coordinator
Human Resources, Room 415
3501 Civic Center Drive
San Rafael, CA 94903- 4177

Call if you have any questions: (415) 473 - 6598

This form covers: the Family Medical Leave Act (FMLA), California Family Rights Act (CFRA), and Pregnancy Disability Leave (PDL).