County of Marin

Request for Family/Medical Leave Form

Human Resources Department

PMR 44 – Leaves of Absence

(Family and Medical Leave Act of 1993)

Employee name: _____ Today's date: _____

Department: _____ Hire date: _____

Position title: _____

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

- ○ A. The birth of a child and in order to care for such child or the placement of a child for adoption or foster care.
- ○ B. In order to care for an immediate family members if such family member has a serious health condition. Circle one: CHILD – SPOUSE – PARENT (Must submit "Physician or Practitioner Certification - Family Member" within 15 days).
- ○ C. Employee's own serious health condition that makes the employee unable to perform the functions of his/her position. (Must submit "Physician or Practitioner Certification - Employee" within 15 days).

Method of Leave Requested

- ○ A. Consecutive leave
- ○ B. Intermittent or reduced leave schedule (specify schedule below):

_____

Date leave is to begin: _____ Expected duration of leave: _____

If 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. I understand 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 an employee returns to work.

_____ _____

Department head signature Employee signature

Date _____ Date _____

Attach either 2A or 2B