RANCHO SANTIAGO
Community College District

LEAVE OF ABSENCE REQUEST FORM
FMLA, CFRA, PDL and/or Parental Leave

TO BE COMPLETED BY EMPLOYEE (PLEASE PRINT OR TYPE)			
Date of Request:	Name (First, M, Last):		Employee ID:
Classification:	Department:		Supervisor:
E-mail:		Employee Phone Number:	
Leave Begin Date:	Leave End Date:	Last Day Physically Worked:	Expected Return to Work Date:

REASON FOR LEAVE REQUEST

☐ Serious Medical Condition of Employee
☐ Serious Medical Condition of Family Member
Specify Relationship: _____
☐ Employee's Pregnancy
☐ Parental Leave
☐ Adoption
☐ Placement of Foster Child with Employee
☐ Military Leave
☐ Military Caregiver Leave

TYPE OF LEAVE REQUEST (Check one box)

☐ Continuous leave of absence from: _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy)

☐ Intermittent Leave/Reduced Schedule. Please indicate your requested schedule or frequency and duration of your intermittent leave:

_____

_____

MEDICAL CERTIFICATION

Please attach or provide a completed copy of the required medical certification form within 15 calendar days. If a medical certificate is not submitted, the leave will not be eligible for approved FMLA/CFRA leave. The absences may be considered unapproved and disciplinary action up to and including termination of employment may result.

Medical certification must clearly state the following:

- Contact information of the health care provider
- Start and end dates of serious health condition
- Please do not disclose medical diagnosis or condition on the medical certificate

Check one box:
☐ I have attached a medical certificate/doctors note.
☐ I will submit a medical certificate/doctors note within the next 15 days.

PAY DURING LEAVE

Please be advised that while FMLA/CFRA and PDL are unpaid leaves, your available accrued leaves (sick leave, vacation leave, compensation time, and/or extended illness leave) will run concurrent with FMLA/CFRA to ensure that you remain in a paid status. Please refer to your applicable contract for further information on use of accrued paid leaves.

ACKNOWLEDGEMENTS

I understand that a leave of absence of 2 weeks or more, will require medical certification from my health care provider, releasing my return to work. If such certification is not furnished at least 2 days prior to return. I understand that my return may be delayed until certification is provided.

I certify that all the facts are true and correct to the best of my knowledge. If my request for a leave of absence is approved, I understand that I must abide by all the terms and conditions of my leave of absence. If I am unable to return to work on the specified date, I am to notify Human Resources of the change. Failure to notify the Human Resources Department may result in my being absent without authorization.

Employee Signature _____ Date _____