City of Garden Grove

REQUEST FOR FAMILY/MEDICAL LEAVE (FMLA)

Employee Name _____

Department _____

Employee ID# _____

TYPE OF FAMILY / MEDICAL LEAVE REQUESTED

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

☐ The birth of a child and / or in order to care for such child

☐ The placement of a child for adoption or foster care

☐ In order to care for an immediate family member because such family member has a serious health condition. Please indicate which family member below:

_____ (Attach Physician Certification form to request)

☐ For my own serious health condition which makes me unable to perform the essential functions of my position (must provide Physician Certification or note from physician).

METHOD OF FAMILY / MEDICAL LEAVE REQUESTED

☐ Consecutive Leave

☐ Intermittent Leave

☐ Reduced Hours as described below:

_____

_____

LEAVE DATES

Leave Begin _____ Duration of leave _____ Anticipated return_____

If the duration of my family / medical leave (total of unpaid and paid leave) does not exceed 12 weeks, I will return to my same or equivalent position. I understand that if my family / medical leave should exceed 12 weeks and I am approved for other leave, I will return to my same or equivalent position **only** if available. If my same or equivalent position is not available, I understand that I may be terminated.

_____ _____

Employee Signature Date