TOWN OF LOS GATOS

EMPLOYEE REQUEST FOR FAMILY OR MEDICAL LEAVE

Employee Name:_____ **Date:**_____

Employee Number:_____ **Department:**_____

Reason for Leave: I am requesting this Family/Medical Leave for:

☐ Birth /Adoption / Foster Placement (Circle one)

☐ My Own Serious Health Condition **(Medical Certification Required)**

☐ The Serious Health Condition of Family Member **(Medical Certification Required)**

☐ Child ☐ Spouse ☐ Parent

☐ Exigent circumstances arising from Family Member called to active military duty **(Medical Certification Required)**

☐ To care for a Family Member injured on active military duty **(Medical Certification Required)**

Duration of Family / Medical Leave

Expected date of birth / adoption / or placement for foster care: _____

Leave Start Date _____ Expected Return To Work Date _____

I understand the following:

1. The leave indicated above will be counted against my entitlement under the Family and Medical Leave Act (FMLA). This leave is 12-weeks in any given 12-month period, except for the special one-time leave of up to 26 weeks to care for a family member injured while on active military duty.
2. Upon return to work; I am entitled to be restored to the same or an equivalent position;
3. If my leave is due to my serious health condition, that of a family member, or to care for a family member injured while on active military duty, I will be required to provide a medical certification, or risk having my leave request denied;
4. I may choose to use any paid leave for which I am eligible concurrent with my FMLA Leave;
5. If my leave is for my own serious health condition, I may be required to provide a fitness-for-duty certificate upon my return;

_____ _____
Signature of Employee Date

_____ _____ _____
Signature of Supervisor Signature of Department Director Date

Please return one copy of this form to the Human Resources Department, and retain the other for your records.