FMLA/CFRA Request Form

Human Resources Office – County of Yolo
Phone (530) 666-8055 – Fax (530) 666-8049

FAMILY AND MEDICAL LEAVE ACT (FMLA)
AND CALIFORNIA FAMILY RIGHTS ACT (CFRA)

Employee Instructions: Complete the following information to request FMLA/CFRA leave:			
Last Name	**First Name**	**Middle Name**	**Supervisor Name**

Department/Unit	**Job Title**	**Daytime Telephone Number**

1. Requested leave:

Start Date: _____ Anticipated Return to Work Date: _____

Intermittent or reduced work schedule (describe): _____

2. Mark the applicable reason/s for requesting leave:

☐ Own serious health condition
☐ Pregnancy disability leave
☐ Military caregiver leave
☐ Work related injury
☐ Designated Person: _____
☐ Other: _____
☐ Care for parent/spouse/child with serious health condition
☐ Care for newborn/newly placed child
☐ Care for grandparent/grandchild/sibling/parent-in-law with serious health condition
☐ Qualifying military exigency leave

I certify the following information by requesting FMLA/CFRA leave protection:

- I have read the FMLA/CFRA Policy prior to completing this form.
- I understand that this request does not guarantee me FMLA/CFRA leave.
- I must provide at least 30 days advance notice if my need for leave is foreseeable, or my FMLA/CFRA leave may be delayed. If my need for leave is unexpected, I must provide notice as soon as possible and practicable.
- If I am eligible for leave under FMLA/CFRA, I understand my time away from work will be charged against my 12 weeks of protection.
- FMLA/CFRA is an unpaid leave protection. Paid leave (accrued sick time and/or other leaves balances) shall be substituted for unpaid leave in accordance with applicable policy/contract. I may be eligible for wage replacement programs such as State Disability Insurance, Paid Family Leave, or County Disability Insurance, and I will have the option to integrate leave balances.
- If I go into an unpaid status while on FMLA/CFRA leave, I understand I must contact Human Resources to arrange payment of my portion of health insurance premiums. HR Payroll: payroll@yolocounty.org
- I am required to submit a completed FMLA/CFRA Certification of Health Care Provider form *before* my leave commences if I need leave for a serious health condition of myself or a qualifying family member.
- Additional information about my FMLA/CFRA rights, responsibilities, and eligibility will be provided to me in writing within five business days of receipt of this form, absent extenuating circumstances.

Employee Signature **Date**

_____ _____