City of Newport Beach

Request For Family/Medical Leave

Employee Name _____ Date of Request _____

Department _____ Position Title _____

Hire Date _____

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

_____ A. The birth of a child and/or in order to care for such child.

_____ B. The placement of a child for adoption of foster care.

_____ C. In order to care for an immediate family member because such family member has a serious health condition. Check one:

❑ **CHILD** ❑ **SPOUSE** ❑ **PARENT** ❑ **DOMESIC PARTNER**

(Must submit "Physician Certification" within 15 days.)

_____ D. Employee's own serious health condition that makes the employee unable to perform the functions of his/her position. **(Must submit "Physician Certification" 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 the duration of my family/medical leave (total of paid and unpaid time) does not exceed 4 months, I will be returned to my same or equivalent position. I understand that if my family/medical leave should exceed 4 months, I will be returned to my same or equivalent position, only if available. If my same or equivalent position is not available, I understand that I may not be entitled to reinstatement rights under FMLA.

Date _____ Employee's Signature _____