SANTA BARBARA CITY COLLEGE

Human Resources

Classified/Management Request for FMLA (Family Medical Leave Act) Leave

Employee Name:_____ Date of Request:_____

Job Title:_____ Employee K#:_____

Department:_____ Supervisor Name:_____

In order to be eligible for FMLA leave, the employee must have been employed by the District for at least 12 months prior to the leave. During that period, the employee must have worked at least 1,250 hours.

FMLA is **unpaid leave**. However, compensation may be paid through sick or vacation leave accrual. If you wish to be paid while on FMLA, please specify sick or vacation here _____

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 or foster care.
___ C. In order to care for an immediate family member* because such family member has a serious health condition. (check one):

* Immediate family members include:

□**CHILD** □**SPOUSE** □**PARENT** □**DOMESTIC PARTNER**

(Must submit "Physician Letter")

___ D. Employee's own serious health condition that makes the employee unable to perform the functions of his/her position. The definition of a "serious health condition" under FMLA is attached.

(Must submit "Physician Letter")

___ Consecutive Leave
___ Intermittent Leave Schedule (Specify schedule):_____

Begin Date:_____ Expected duration of leave:_____

If the duration of my Family/Medical Leave (total of unpaid time) does not exceed 12 weeks, I will be returned to my same position. I understand that if my Family/Medical leave should exceed 12 weeks, 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 be terminated and placed on a 39 month re-employment list.

If I participate in the District benefits, I am aware that I will be responsible for payment directly to Payroll for my out-of-pocket premium. The district will continue to contribute to the employee's health benefit allocation during this time.

_____

Employee Signature Date

_____

Human Resources Review & Signature Date

Cc: Payroll