Conejo Valley Unified School District

PERSONNEL SERVICES DIVISION
CLASSIFIED PERSONNEL
1400 E. Janss Road, Thousand Oaks, California 91362-2198
Telephone (805) 497-9511 • FAX (805) 494-3741

EMPLOYEE REQUEST FOR FAMILY MEDICAL LEAVE

EMPLOYEE INFORMATION

EMPLOYEE NAME:	**LAST**	**FIRST**	**MIDDLE INITIAL**
JOB CLASSIFICATION TITLE:			
DEPARTMENT/SCHOOL:			
IMMEDIATE SUPERVISOR:			
CONTACT INFORMATION:	**ADDRESS**		
	PHONE	**EMAIL**	

BASIS FOR LEAVE REQUEST

TYPE OF LEAVE REQUESTED: ☐ BLOCK OF TIME (UP TO 12 WEEKS) ☐ INTERMITTENT ☐ REDUCED SCHEDULE

REQUESTED DATE OF LEAVE: _____ ESTIMATED DATE LEAVE WILL END: _____

☐ MY OWN SERIOUS HEALTH CONDITION (SUBMIT CERTIFICATION OF HEALTH CARE PROVIDER FORM WITHIN 15 CALENDAR DAYS)
☐ BIRTH OF CHILD AND/OR CHILD BONDING – ANTICIPATED/ACTUAL DELIVERY DATE: _____
☐ ADOPTION OR FOSTER CARE OF CHILD PLACED IN MY HOME ON _____ (ANTICIPATED/ACTUAL DATE)
☐ CARE FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION (MUST MEET DISTRICT/CBA DEFINITION OF "MEMBER OF THE EMPLOYEE'S FAMILY"). PLEASE SPECIFY THE NAME AND RELATIONSHIP OF THE FAMILY MEMBER:

FAMILY MEMBER NAME: _____ RELATIONSHIP: _____

IF LEAVE IS REQUESTED ON AN INTERMITTENT OR REDUCED LEAVE SCHEDULE, PLEASE INDICATE THE DAYS OF THE WEEK AND/OR HOURS DURING THE DAY YOU WILL BE ABSENT: _____ _____ _____

IS YOUR SPOUSE EMPLOYED BY CVUSD? ☐ YES ☐ NO

REQUESTS FOR LEAVE FOR AN EMPLOYEE'S SERIOUS ILLNESS OR FOR THE CARE OF A FAMILY MEMBER REQUIRE SUBMISSION OF A "CERTIFICATION OF HEALTH CARE PROVIDER" FORM WITH THIS REQUEST OR WITHIN 15 CALENDAR DAYS FROM THE DAY YOU SUBMIT THIS FORM. YOU MAY ALSO BE REQUIRED TO PROVIDE DOCUMENTATION FOR LEAVE IN CONNECTION WITH THE BIRTH, PLACEMENT, OR ADOPTION OF A CHILD. IF I DO NOT PROVIDE THE CERTIFICATION AS REQUESTED, I UNDERSTAND THAT MY LEAVE MAY BE DENIED OR DISCONTINUED UNTIL I DO.

I UNDERSTAND THAT I MUST ALSO COMPLETE A RETURN TO WORK/*FITNESS FOR DUTY* CERTIFICATION IF THE LEAVE IS FOR MY OWN SERIOUS HEALTH CONDITION. THE CERTIFICATION MUST BE SUBMITTED PRIOR TO RETURNING BACK TO WORK. IF THE CERTIFICATION IS NOT RECEIVED, I UNDERSTAND THAT MY RETURN TO WORK MAY BE DELAYED UNTIL THE CERTIFICATION IS PROVIDED.

_____ _____
EMPLOYEE/APPLICANT SIGNATURE *DATE*

_____ _____
PRINCIPAL/DEPARTMENT ADMINISTRATOR SIGNATURE *DATE*

CLASSIFIED PERSONNEL DEPARTMENT USE ONLY

TYPE OF LEAVE REQUESTED: ☐FMLA/CFRA CONCURRENT ☐FMLA ONLY ☐ CFRA ONLY

CERTIFICATION OF HEALTH CARE PROVIDER: ☐ YES ☐ NO DATE RECEIVED: _____

ELIGIBILITY – 1250HRS PRECEDING DATE OF REQUEST: ☐ ELIGIBLE ☐ NOT ELIGIBLE

INTERMITTENT: ☐ YES ☐ NO DATE LEAVE TO BEGIN: _____ DATE LEAVE TO END: _____

DATE REQUEST REVIEWED: _____ AUTHORIZED BY: _____

RETURN COMPLETED FORM TO: CVUSD-CLASSIFIED PERSONNEL DEPARTMENT
1400 E. JANSS ROAD, THOUSAND OAKS, CA 91360