



# Conejo Valley Unified School District

## HUMAN RESOURCES DEPARTMENT CLASSIFIED PERSONNEL

750 Mitchell Road, Newbury Park, California 91320  
Telephone (805) 498-4557

### 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:	<input type="checkbox"/> BLOCK OF TIME (UP TO 12 WEEKS) <input type="checkbox"/> INTERMITTENT <input type="checkbox"/> REDUCED SCHEDULE
REQUESTED DATE OF LEAVE:	_____ ESTIMATED DATE LEAVE WILL END: _____
<input type="checkbox"/> MY OWN SERIOUS HEALTH CONDITION (SUBMIT CERTIFICATION OF HEALTH CARE PROVIDER FORM WITHIN 15 CALENDAR DAYS)	
<input type="checkbox"/> BIRTH OF CHILD AND/OR CHILD BONDING – ANTICIPATED/ACTUAL DELIVERY DATE: _____	
<input type="checkbox"/> ADOPTION OR FOSTER CARE OF CHILD PLACED IN MY HOME ON _____ (ANTICIPATED/ACTUAL DATE)	
<input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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:	<input type="checkbox"/> FMLA/CFRA CONCURRENT <input type="checkbox"/> FMLA ONLY <input type="checkbox"/> CFRA ONLY
CERTIFICATION OF HEALTH CARE PROVIDER:	<input type="checkbox"/> Yes <input type="checkbox"/> No      DATE RECEIVED: _____
ELIGIBILITY – 1250HRS PRECEDING DATE OF REQUEST:	<input type="checkbox"/> ELIGIBLE <input type="checkbox"/> NOT ELIGIBLE
INTERMITTENT:	<input type="checkbox"/> Yes <input type="checkbox"/> No      DATE LEAVE TO BEGIN: _____      DATE LEAVE TO END: _____
DATE REQUEST REVIEWED: _____	AUTHORIZED BY: _____

**RETURN COMPLETED FORM TO: CVUSD-HUMAN RESOURCES DEPARTMENT  
750 MITCHELL ROAD, NEWBURY PARK, CA 91320**