Monterey County Office of Education

Dr. Nancy Kotowski
County Superintendent of Schools

☐ New Request ☐ Request for Extension [2]

EMPLOYEE NAME: _____ DEPARTMENT: _____

INSTRUCTIONS FOR EMPLOYEE: Complete this form 30 calendar days prior to the first day of leave, except in an emergency. Submit this form to your supervisor for review and forwarded it to Human Resources for formal action and acknowledgment. You may be entitled to office-paid health care benefits. Please consult with your Employee Benefits Specialist.

1. I am requesting Family and Medical Leave for the following reason (check one):

   ☐ A. The birth of the employee's child and in order to care for such child. _____
   (date of birth)

   ☐ B. The placement with the employee of a child for adoption or foster care and to care for such child (Attach documentation).

   ☐ C. In order to care for an immediate family member because such family member has a serious health condition. (Submit "Certification of Health Care Provider" form within 10 calendar days). Circle one:

   Circle one: CHILD SPOUSE/DOMESTIC PARTNER PARENT OTHER (explain):
   _____
   _____

   ☐ D. Employee's own serious health condition that makes the employee unable to perform the functions of his/her job[3]. Submit "Certification of Health Care Provider" form within 10 calendar days).

   ☐ E. Because of a qualifying exigency arising out of the fact that your ___spouse; ___son or daughter; ___parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves.

   ☐ F. Because you are the ___spouse; ___son or daughter; ___parent; ___next of kin of a covered servicemember with a serious injury or illness.

2. If you checked one of the above, your request, if approved, will constitute Family Medical Leave and will be designated as such. If you check "D", MCOE will, as a condition of returning to work, require you to provide a medical certification of fitness to return to work. If you fail to submit the required certification, MCOE may refuse to return you to work until the certification is submitted.

3. Inclusive dates requested: First Day of Absence: _____ Last Day of Absence: _____

4. My last day of work will be (was): _____

5. This is an unpaid leave of absence, unless I exercise my option to use my accumulated sick leave, vacation, and/or compensatory time accruals. I may exercise this option one time only during the leave.

(a) At this time, I am requesting an unpaid leave. I may elect to use my accruals at a later date. I must notify Human Resources in writing if I choose to use my accruals.

(b) At this time, I elect to use my Sick Leave, Vacation, and/or Compensatory Time accruals.

Sick Leave: _____ _____ Vacation: _____ _____ Comp. Time: _____ _____
hours or # days # hours or # days # hours or # days

6. I understand the election (Item 6-b) is not revocable.

7. If this is a request to extend a Family Care Leave, I have indicated below the pertinent information about the original leave:

First Day of Original Leave: _____ Last Day of Original Leave: _____

_____ _____
Employee Signature Date

_____ _____
Employee Name (Print or Type) Social Security Number

_____ _____
Employee Title Department

cc: Personnel File

[1] Refers to both Federal and State leaves under the Family Medical Leave Act and the California Family Rights Act.

[2] Requests for an extension of FMLA Leave must be submitted two business days prior to the end of the current scheduled FMLA leave. Failure to submit timely may delay the granting of the FMLA Leave extension.

[3] MCOE will count a Worker's Compensation absence against your FMLA leave if you suffer an on-the-job injury or illness that qualifies as a serious health condition