

FAMILY MEDICAL LEAVE REQUEST FORM

ELIGIBLE EMPLOYEES: ALL PERMANENT FULL-TIME & PERMANENT PART-TIME EMPLOYEES WHO HAVE WORKED 1250 HOURS IN THE YEAR PRECEDING THE LEAVE REQUEST WILL BE ELIGIBLE FOR A MAXIMUM FOR 12-WEEKS OF LEAVE IN A 12-MONTH PERIOD. AUTHORIZATION IS REQUESTED WITHIN 15-DAYS OF THE FMLA LEAVE WITH LUSD.

CHECK (✓) ASSIGNED UNIT:

☐ CSEA ☐ Local 99 ☐ Confidential ☐ Supervisory ☐ Management

EMPLOYEE NAME:	LAST	First
JOB CLASSIFICATION TITLE:		
DEPARTMENT/SCHOOL:		
DATES OF ABSENCE	From: ____ / ____ / ____	To: ____ / ____ / ____

EMPLOYEE'S PERSONAL ILLNESS

AN EMPLOYEE MAY RECEIVE PAY FOR HIS/HER OWN PERSONAL ILLNESS OR INJURY. PLEASE CHECK ANY OR/ALL (AVAILABLE) PAID LEAVE TIME OR UNPAID LEAVE you DESIRE TO YOUR OWN PERSONAL ILLNESS LEAVE OF ABSENCE TO AS LISTED:

☐ Sick Time ☐ Vacation ☐ Floating Holiday(s) ☐ Unpaid Leave

FOR LOCAL 99, CONFIDENTIAL, SUPERVISORY & MANAGEMENT MEMBERS ONLY

ELIGIBLE FAMILY MEMBER OF THE EMPLOYEE

PLEASE INDICATE A CHECK ✓ MARK IN THE APPROPRIATE BOX THAT SPECIFIES THE ELIGIBLE FAMILY MEMBER THAT LEAVE IS REQUESTED FOR:

☐ SPOUSE ☐ CHILD ☐ PARENT

PLEASE CHECK ANY/OR ALL (AVAILABLE) PAID LEAVE TIME OR UNPAID LEAVE THAT YOU DESIRE TO CHARGE ILLNESS LEAVE OF ABSENCE TO AS LISTED:

☐ Sick Time ☐ Vacation ☐ Floating Holiday(s) ☐ Unpaid Leave

FOR CSEA MEMBERS ONLY (ARTICLE 12, SECTION 11.10)

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MY SIGNATURE ACKNOWLEDGES THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION,

EMPLOYEE'S SIGNATURE:		DATE:
ADMINISTRATOR'S SIGNATURE:		DATE:

For More Information from EDDI visit: www.edd.ca.gov/eddmill.htm OR Call (877) 238-4373

DISTRIBUTE COPIES TO THE FOLLOWING: ① Employee ② Personnel ③ Payroll ④ Supervisor