Print Form

California State University, Sacramento
Employee Disability Programs

FAMILY CARE AND MEDICAL LEAVE EMPLOYEE APPLICATION

Sacramento Hall, Room 162, 6000 J Street, Sacramento, CA 95819-6032 916-278-3522 ♦ 278-3411 (fax)

Instructions:
1. *This application is provided for employees to document their request for Family Care and Medical Leave (FML). Any request for FML leave for any purpose and its approval or denial must be properly documented.*
2. *Employees should retain a copy of this application for their files with all related documentation.*
3. *Contact Disability Leaves Office, 278-3522, if you have any questions or concerns.*

EMPLOYEE INFORMATION

Employee Name:	Employee ID Number:
Department:	Campus Phone:
Current mailing address:	Home Phone:

Dates for which employee is requesting leave: from _____ to _____

Reason for Leave:
- ❑ Employee's serious health condition
- ❑ Pregnancy disability
- ❑ To care for newborn
- ❑ To care for newly adopted child or newly placed foster child
- ❑ To care for child, spouse, or parent with a serious health condition

To document leave, submit the following materials to HR:
- ❑ Certification of Health Care Provider Form

Eligibility:

All full-time and part-time employees (excluding student employees) employed for at least one academic year or 12 months (not necessarily continuously) preceding the leave are eligible.

Student employees employed at least one year (not necessarily continuously) and who worked at at least 1,250 hours in the 12 months preceding the leave are eligible.

Is employee eligible for FML? ☐ Yes ☐ No

Has employee used FML leave within the past 12 months? ☐ Yes ☐ No

If Yes, remaining weeks of entitlement for Federal FML:

_____

_____
Employee Signature Date

DISABILITY PROGRAMS OFFICE RESPONSIBILITIES

Provide the following to the employee:
- ❑ Family and Medical Leave Application
- ❑ Employee Rights and Responsibilities
- ❑ Transitional Employment Information
- ❑ Certification of Health Care Provider Form
- ❑ Work Status Form

Date information was provided to the employee:
_____
Method of Presentation:
- ❑ In person
- ❑ U.S. Mail with Proof of Service

Name of person who provided the packet:

Document Retention

All FML documents are retained for at least 3 years in the Disability Leaves Office.

Date of Request: _____

File Destruction Date: _____

_____ _____ _____
Appropriate Administrator: (PRINT) Appropriate Administrator Signature Date