Tulare County Office of Education

Tim A. Hire, County Superintendent of Schools

REQUEST FOR FMLA/CFRA LEAVE

☐ Certificated

☐ Classified

Employee Name:_____ Last Four SSN:_____

Personal Email:_____ Phone Number:_____

Current Position:_____ Current Location: _____

Supervisor:_____

Dates of leave of absence requested: From _____ through _____

TYPE OF LEAVE REQUESTED

(*Requires Certification of Health Care Provider needed)

☐ Continuous ☐ Intermittent

☐ Personal illness (leave for employee's own illness or injury)

☐ Pregnancy related leave (Medical)

☐ Parental Leave (Bonding)

☐ Family illness (To care for a qualifying family member due to a serious health condition)

Qualifying member: ☐ Spouse/Domestic Partner ☐ Child ☐ Parent ☐ Sibling ☐ Grandparent

☐ Designated Person (Name of designated person/relationship):_____

Briefly describe the care that you will provide to your family member: (Check all that apply)

☐ Assistance with basic medical and safety concerns ☐ Transportation ☐ Other:_____

Employee Acknowledgement:

I understand that my accumulated sick leave will be used to maintain my full salary during my leave. Once my leave is exhausted, I acknowledge that I may be subject to a payroll adjustment.

Certificated Employees: Salary advancement will be impacted if the employee is not in a fully paid status for at least 75% of the school year.

Employee Signature:_____ Date:_____

Human Resource Use Only:

Eligible for FMLA/CFRA: ☐ Yes ☐ No Eligible for Medical Leave: ☐ Yes ☐ No ☐ Approved ☐ Denied

Comments:_____

Signature:_____ Date:_____