LEAVE OF ABSENCE APPLICATION

Family and Medical

Return to the Human Resources Department

Name: _____   ID# _____

Department: _____   Work Location & Telephone: _____

Job Title: _____   Entered Service Date: _____

While on FMLA, I can be reached at:

_____

Address   **City**   **State**   **Zip**

Telephone: (___) _____

Family or Medical Leave

I hereby apply for leave for the following reason: (check one)

☐ The birth and care of my child;

☐ The placement of a child with me for adoption or foster care;

☐ The care of my spouse, son, daughter, or parent, who has a serious health condition; or

☐ A serious health condition that makes me unable to perform my job.

I understand that I must use all accrued vacation/holidays while off on state/federal family and medical leave for any reason other than my own serious illness.

Please specify dates and times leave is requested:

From: _____   **To:** _____

If scheduled is unknown or other than a continuous block of time, describe the types of activities that will require leave and the approximate amount of time needed on a daily or weekly basis.

_____

_____

A COMPLETED MEDICAL CERTIFICATE OR APPROPRIATE DOCUMENTATION MUST ACCOMPANY THIS REQUEST IN ORDER FOR IT TO BE CONSIDERED.

State and federal family and medical leaves, including Workers' Compensation leaves and Kin Care run concurrently, except for leaves taken in accordance with California pregnancy disability leave. The maximum allowable time for such a leave is 12 weeks per a rolling 12-month period, measures backward from the date an employee uses any family and medical leave.

I understand that engaging in any occupation or employment during this absence without the express written consent of Long Beach Transit may result in termination of my employment.

_____   _____
Signature of Employee   Date

-- *FOR ADMINISTRATIVE USE ONLY*--

_____ **Total FMLA hours used in the twelve months prior to** _____

                                                                                          Date

_____   _____
Immediate Supervisor   Date

Approved:

☐ Yes

☐ No   _____   _____   _____
                    Human Resources Department   Date   Reason for denial. If more space needed, attach additional sheets.