



Attachment #1
CITY OF STOCKTON
LEAVE REQUEST FORM

Employee Name: _____

Position/Title: _____

Department: _____

TYPE OF LEAVE REQUESTED

Date(s) of Leave: _____

Time of Leave: Number of Days: _____ Number of Hours: _____

☐ Annual Leave

☐ Bereavement

☐ Compensatory (Comp) Time

☐ Family Sick Leave (less than 3 days)

☐ Family Medical Leave (FMLA)/California Family Rights Act (CFRA) *check appropriate box:*

☐ Birth of child or to care for a newborn

☐ Baby Bonding

☐ Placement of a child due to adoption
or foster care

☐ Employee's serious health condition

☐ Military Leave (circle one)

☐ Serious health condition (circle one)

Qualify Exigency
Care for Military Member

Child
Parent
Spouse or Domestic Partner

☐ Jury Duty

☐ Leave without pay (LWOP)

☐ Pregnancy Disability Leave (PDL) in conjunction with FMLA/CFRA, if applicable)

☐ Sick Leave

Employee Signature: _____ Date: _____

Supervisor's Signature: _____ Date: _____



Attachment #2
CITY OF STOCKTON
NOTICE OF ELIGIBILITY AND RIGHTS AND RESPONSIBILITIES
FAMILY AND MEDICAL LEAVE ACT (FMLA)/CALIFORNIA FAMILY RIGHTS ACT (CFRA)

Date: _____

Employee: _____

Supervisor: _____

PART A – NOTICE OF ELIGIBILITY

On _____, you informed us that you need leave starting on _____ due to:

- ☐ The birth of a child, or placement of a child with you for adoption or foster care
- ☐ Your own serious health condition
- ☐ Need to care for your: ☐ spouse/registered domestic partner; ☐ child; ☐ parent due to a serious health condition
- ☐ A qualifying exigency due to your ☐ spouse/registered domestic partner; ☐ child; ☐ parent being on active duty or called to active duty status in support of a contingency operation in a foreign country as a member of the Regular Armed Forces, National Guard or Reserves.
- ☐ Caring for a covered servicemember with a serious injury or illness and you are the ☐ spouse/registered domestic partner; ☐ child; ☐ parent; ☐ next of kin of this military member.

This Notice is to inform you that you

- ☐ Are eligible for FMLA/CFRA leave (See Part B below for Rights and Responsibilities)
- ☐ Are not eligible for FMLA/CFRA leave, because:
 - ☐ You have not met the FMLA's 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately _____ month(s) towards this requirement.
 - ☐ You have not met the FMLA's 1,250-hours-worked requirement.
 - ☐ You have exhausted all your FMLA/CFRA leave in the applicable 12-month period.

If you have any questions, contact your immediate supervisor or Human Resources.



PART B – RIGHTS AND RESPONSIBILITIES FOR TAKING FMLA LEAVE

As explained in Part A, you meet the eligibility requirements for taking FMLA/CFRA leave and still have FMLA/CFRA leave available in the applicable rolling 12-month period. **For us to determine whether your absence qualifies as FMLA/CFRA leave, you must return the following information to us by:_____.**

- ☐ A medical certification (completed by your health care provider) to support your request for FMLA/CFRA leave if your leave request is in excess of 3 days. (Please see attached form). Failure to provide a complete and sufficient medical certification 15 calendar days from the date of this notice may result in a denial of or delay in the processing of your FMLA/CFRA leave request.
- ☐ Sufficient documentation to establish the required relationship between you and your family member.
- ☐ Other information needed: _____
- ☐ No other information is needed

If your leave does qualify as FMLA/CFRA, you will have the following responsibilities:

- You will be required to use your available paid leave accruals (sick, vacation, compensatory time) during your FMLA/CFRA absences. This means that you will receive paid leave and the leave will also be considered protected FMLA leave and counted against your FMLA/CFRA leave benefit. (See FMLA Policy & Procedures, "Required Use of Paid Accruals".)
- If your FMLA/CFRA leave is due to your own medical condition, and your leave request is for an excess of 3 days, you will be required to submit appropriate medical documentation from the appropriate health care provider before you can return to work.
- If you pay a portion of your health benefits or participate in the City's Section 125 plan, these expenses will continue to be deducted directly from your paycheck. However, if you are in a leave without pay status while on FMLA/CFRA, you must make arrangements to continue to pay your premium payments. Please contact the Human Resources Office to make these arrangements.

If your leave does qualify as FMLA/CFRA leave you will have the following rights:

- You have a right under the FMLA/CFRA for up to 12 weeks of unpaid leave in a 12-month period. The 12-month period is measured forward from the date of your first FMLA/CFRA leave usage.



- **Military Leave Only:**

- You have a right under the FMLA for up to 26 weeks of unpaid leave in a rolling 12-month period to care for a military member with a serious injury or illness. This rolling 12-month period commenced on
- Your health benefits must be maintained during any period of FMLA unpaid leave. However, you will still be responsible for any premiums you would normally pay while working.
- Unless you are determined to be a "key employee", you will be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA-protected leave. (If your leave extends beyond the end of your FMLA benefit, you do not have return rights under FMLA.)
- If you do not return to work following FMLA period for a reason other than: 1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; 2) the continuation, recurrence, or onset of a military member's serious injury or illness which would entitle you to FMLA leave; or 3) other circumstances beyond your control, you will be required to reimburse the City for any health expenses paid on your or your family member's behalf.

Upon receipt of the information specified above, you will be informed, within five (5) business days, whether your leave will be designated as FMLA/CFRA leave and count towards your FMLA/CFRA leave benefit. If you have any questions, please contact the Human Resources Department at (209) 937-8233 or (209) 937-7555.

By signing below, I certify that the above noted employee has met the FMLA's 12-month length of service requirement and has met the minimum 1,250-hours-worked requirement. I also certify that the above-noted employee has not exhausted all his/her FMLA/CFRA leave in the applicable 12-month period.

Supervisor's Name: _____ Title: _____

Supervisor's Signature: _____ Date: _____

cc: Human Resources Technician (Benefits – Leave Coordinator)



Attachment #3

EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Benefit

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son/daughter, parent, with a serious health condition; or
- For a serious health condition that makes the employee unable to perform their job.

Military Family Leave Benefits

Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the Regular Armed Forces, National Guard or Reserves in support of a contingency operation to a foreign country may use their 12-week leave benefit to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, caring for a parent who is incapable of self-care, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave benefit that permits eligible employees to take up to 26 weeks of leave to care for a military member during a single 12-month period. A military member is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty or that existed before the beginning of the member's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces that may render the military member medically unfit to perform his or her duties for which the military member is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list. Covered veterans who are undergoing medical treatment, recuperation, or therapy for a serious injury or illness qualify as well.

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.



Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave benefit in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days' notice of the need to take FMLA leave when the need is foreseeable. When 30 days' notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.



Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave benefit. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.



**Attachment #4
City of Stockton
Designation Notice
Family and Medical Leave Act**

Leave covered under the Family and Medical Leave Act (FMLA) must be designated as FMLA protected and the City of Stockton must inform the employee of the amount of leave that is counted against the employee's FMLA leave benefit. In order to determine whether leave is covered under FMLA, the City will require that the leave be supported by a medical certificate.

DATE (Notice Sent):	
TO (Employee):	

On _____, you notified us of your need to take family medical leave. This is to inform you that:

☐ **Your FMLA leave request is approved and will be designated as FMLA leave.**

The FMLA requires that you notify us as soon as practicable if dates of scheduled leave change or are extended or were initially unknown. Based on the information you have provided to date, we are providing the following information about the amount of time that will be counted against your leave benefit:

☐ Provided there is no deviation from your anticipated leave schedule, the following number of hours, days, or weeks will be counted against your leave benefit:

_____.

☐ The leave you will need is currently unknown or unscheduled; therefore, it is not possible to provide the specific hours, days, or weeks that will be counted against your FMLA benefit at this time.

☐ You will be required to present a Return to Work Certificate to be restored to employment. If the certificate is not received timely, your return to work may be delayed until the certificate is provided.

Please be advised that you are required to use paid leave during your FMLA leave.

If you normally pay a portion of the premiums for your health insurance or other benefits, such as voluntary products under the Section 125 plan, these payments will continue during the period of FMLA leave. Arrangements for payment have been discussed with you and it is agreed that you will make premium payments as follows: _____



☐ **Additional information is needed to determine if your FMLA leave request can be approved.**

☐ The medical certification you provided is not complete or sufficient enough to determine whether the FMLA applies to your leave request. You must provide the following information no later than _____ (provide at least 7 calendar days)
Specify information needed to make the certification complete and sufficient:

☐ We are exercising our right to have you obtain a second (or third) opinion medical certification at our expense, and we will provide further details at a later time.

☐ **Your FMLA leave request is not approved because:**

☐ FMLA does not apply to your leave request

☐ You have exhausted your FMLA leave benefit for this rolling 12-month period

Supervisor's Name: _____ Title: _____

Supervisor's Signature: _____ Date: _____

cc: Human Resources Technician (Benefits – Leave Coordinator)



Attachment #6
Family Member's Health Care Provider's Certification Form

Section I: To be Completed by the Employee

INSTRUCTIONS TO THE EMPLOYEE: Please complete Section I before giving this form to your family member or his/her medical provider. FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to care for a covered family member with a serious health condition. Failure to provide this medical certification within **15 calendar** days from the date you requested FMLA/CFRA, may result in a denial of or delay in the processing of your FMLA request.

Employee Name (First, Middle, Last)

Name of family member for whom you will provide care

Relation of family member to you

Date of Birth, if family member is your son or daughter

Describe the care you will provide to your family member and the estimated amount of leave time needed to provide care:

Employee Signature

Date



Section II: To be Completed by the Health Care Provider

INSTRUCTIONS TO THE HEALTH CARE PROVIDER: The employee listed above has requested leave under the Family and Medical Leave Act (FMLA) / California Family Rights Act (CFRA) to care for your patient. Please answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA/CFRA coverage. Please be sure to sign the form on the last page.

Provider's Name (please print): _____

Provider's Address: _____

Provider's Telephone Number: () _____

Provider's Fax Number: () _____

Type of Practice/Medical Specialty: _____

License Number: _____

MEDICAL FACTS

1. Approximate date on which health condition began: _____
2. Probable duration of condition: _____
3. **The serious health condition to which you are treating the patient for.** (Please note that the following are **not** normally considered serious health conditions: Common cold or flu, upset stomach, headache-excluding migraines, earache, routine dental problem, or treatments that involve only over-the-counter medicines, bed rest, exercise, and other activities that can be done without visiting a health care provider):
 - ☐ Inpatient care during an overnight stay in a hospital, hospice, or residential health care facility; or was the patient expected to have an overnight stay?
Date of Admission: _____
 - ☐ Prenatal care;
 - ☐ Pregnancy (leave taken for disability due to pregnancy, childbirth, or related medical conditions); Expected delivery date: _____
 - ☐ Chronic conditions (e.g., asthma, diabetes, epilepsy, etc.) that (1) require periodic visits (at least twice a year) for treatment, (2) continue for a long time, and (3) may cause episodic rather than a continuing period of incapacity;



- ☐ Permanent or long-term conditions that require continuing supervision, with or without active treatment (such as Alzheimer's, severe strokes, terminal stages of a disease);
- ☐ Multiple treatments for either (1) restorative surgery after an injury, or (2) conditions likely to result in three day's incapacity if not treated (including chemotherapy, physical therapy for severe arthritis, and dialysis);
- ☐ Incapacity for more than three consecutive days during which the patient is either (1) treated two or more times, or (2) treated and referred to a nurse, physician's assistant, physical therapist, or nurse practitioner for further treatment; or (3) treated and prescribed a course of prescription medication or therapy requiring special equipment to resolve or alleviate the health condition;
- ☐ None of the above categories apply. Patient does not have a serious health condition as defined by FMLA.

4. Date(s) you treated the patient for condition:

5. Was medication, other than over-the-counter medication, prescribed?

☐ Yes ☐ No

6. Was the patient referred to other health care provider(s) for evaluation or treatment (e.g. physical therapist)? ☐ Yes ☐ No

If "Yes", state the nature of such treatment and expected duration of treatment:

AMOUNT OF CARE NEEDED

7. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery?

☐ Yes ☐ No

If "Yes", estimate the beginning and ending dates for the period of incapacity:

8. Will the patient require follow-up treatments including any time for recovery?

☐ Yes ☐ No



9. Please estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

During this time, will the patient need care? ☐ Yes ☐ No

If "Yes", explain the care needed by the patient and why it is medically necessary for the employee to take time off from work to provide this care:

Complete the following ONLY if employee requires intermittent leave or reduced schedule to care for your patient:

10. Will the patient require follow-up treatment appointments because of his/her medical condition? ☐ Yes ☐ No

If "Yes", please estimate the hours the patient needs care on an intermittent basis:

_____ Hour(s) per day; _____ days per week from _____ through _____

11. Will the condition cause episodic flare-ups preventing the patient from participating in normal daily activities?

☐ Yes ☐ No

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per _____ week(s) _____ month(s) and

Duration: _____ hours or _____ day(s) per episode

Does the patient require care during these flare-ups? ☐ Yes ☐ No

If "Yes", explain the care needed by the patient and why it is medically necessary for the employee to take time off from work to provide this care:

Health Care Provider's Signature: _____ **Date:** _____