CITY OF STOCKTON

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
  - ☐ Placement of a child due to adoption or foster care
  - ☐ Military Leave (circle one)
    Qualify Exigency
    Care for Military Member
  - ☐ Baby Bonding
  - ☐ Employee's serious health condition
  - ☐ Serious health condition (circle one)
    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: _____

CITY OF STOCKTON

Attachment #2
CITY OF STOCKTON
NOTICE OF ELIGIBILITY AND RIGHTS AND RESPOSIBILITIES
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.

CITY OF STOCKTON

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 <u>does qualify</u> as FMLA/CFRA, you will have the following <u>responsibilities</u>:

- 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 <u>does qualify</u> as FMLA/CFRA leave you will have the following <u>rights:</u>

- 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.

CITY OF STOCKTON

- **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)

CITY OF STOCKTON

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.

CITY OF STOCKTON

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.

CITY OF STOCKTON

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.

CITY OF STOCKTON

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:_____

CITY OF STOCKTON

☐ **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 #8

Certification for Serious Injury or Illness of a Current Servicemember for Military Caregiver Leave under the Family and Medical Leave Act

U.S. Department of Labor
Wage Hour Division

WAGE AND HOUR DIVISION

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR. RETURN TO THE PATIENT.

OMB Control Number: 1235-0003
Expires: 6/30/2023

The Family and Medical Leave Act (FMLA) provides that eligible employees may take FMLA leave to care for a covered servicemember with a serious illness or injury. The FMLA allows an employer to require an employee seeking FMLA leave for this purpose to submit a medical certification. 29 U.S.C. §§ 2613, 2614(c)(3). The employer must give the employee **at least 15 calendar days** to provide the certification. If the employee fails to provide complete and sufficient certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

SECTION I - EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, it asks the health care provider for the information necessary for a complete and sufficient medical certification. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. § 825.310. Recertifications are not allowed for FMLA leave to care for a covered servicemember. Where medical certification is requested by an employer, an employee may not be held liable for administrative delays in the issuance of military documents, despite the employee's diligent, good-faith efforts to obtain such documents.** An employer requiring an employee to submit a certification for leave to care for a covered servicemember **must** accept as sufficient certification invitational travel orders (ITOs) or invitational travel authorizations (ITAs) issued to any family member to join an injured or ill servicemember at the servicemember's bedside. An ITO or ITA is sufficient certification for the duration of time specified in the ITO or ITA.

Employers must generally maintain records and documents relating to medical information, medical certifications, recertifications, or medical histories of employees or employees' family members created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

(1) Employee name: _____
First *Middle* *Last*

(2) Employer name: _____ Date: _____ *(mm/dd/yyyy)*
(List date certification requested)

(3) This certification must be returned by: _____ *(mm/dd/yyyy)*
(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee's diligent, good faith efforts.)

SECTION II - EMPLOYEE and/or CURRENT SERVICEMEMBER

Please complete all Parts of Section II before having the servicemember's health care provider complete Section III. The FMLA allows an employer to require that an employee submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a serious injury or illness of a covered servicemember. If requested by your employer, your response is required to obtain or retain the benefit of FMLA-protected leave.

PART A: EMPLOYEE INFORMATION

(1) Name of the current servicemember for whom employee is requesting leave:_____

Employee Name: _____

(2) Select your relationship to the current servicemember. You are the current servicemember's:

☐ Spouse ☐ Parent ☐ Child ☐ Next of Kin

Spouse means a husband or wife as defined or recognized in the state where the individual was married, including a common law marriage or same-sex marriage. The terms "child" and "parent" include *in loco parentis* relationships in which a person assumes the obligations of a parent to a child. An employee may take FMLA leave to care for a covered servicemember who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave to care for a covered servicemember for whom the employee has assumed the obligations of a parent. No biological or legal relationship is necessary. "Next of kin" is the servicemember's nearest blood relative, other than the spouse, parent, son, or daughter, in the following order of priority: (1) a blood relative as designated in writing by the servicemember for purposes of FMLA leave, (2) blood relatives granted legal custody of the servicemember, (3) brothers and sisters, (4) grandparents, (5) aunts and uncles, and (6) first cousins.

PART B: SERVICEMEMBER INFORMATION AND CARE TO BE PROVIDED TO THE SERVICEMEMBER

(3) The servicemember (☐ is / ☐ is not) a current member of the Regular Armed Forces, the National Guard or Reserves. If yes, provide the servicemember's military branch, rank and unit currently assigned to: _____

_____

(4) The servicemember (☐ is / ☐ is not) assigned to a military medical treatment facility as an outpatient or to a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients, such as a medical hold or warrior transition unit. If yes, provide the name of the medical treatment facility or unit: _____

(5) The servicemember (☐ is / ☐ is not) on the Temporary Disability Retired List (TDRL).

(6) Briefly describe the care you will provide to the servicemember: *(Check all that apply)*

☐ Assistance with basic medical, hygienic, nutritional, or safety needs

☐ Psychological Comfort ☐ Physical Care

☐ Transportation ☐ Other: _____

(7) Give your **best estimate** of the amount of leave needed to provide the care described: _____

_____

(8) If a reduced work schedule is necessary to provide the care described, give your **best estimate** of the reduced work schedule you are able to work. From _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*, I am able to work: _____ *(hours per day)* _____ *(days per week)*.

SECTION III - HEALTH CARE PROVIDER

Please provide your contact information, complete all Parts of this Section fully and completely, and sign the form below. The employee listed at Section I has requested leave under the FMLA to care for a family member who is a current member of the Regular Armed Forces, the National Guard, or the Reserves who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list for a serious injury or illness. Note: For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty in the Armed Forces 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 servicemember medically unfit to perform the duties of the servicemember's office, grade, rank, or rating. "Need for care" includes both physical and psychological care. It includes situations where, for example, due to his or her serious injury or illness, the servicemember is not able to care for his or her own basic medical, hygienic, or nutritional needs or safety, or needs transportation to the doctor. It also includes providing psychological comfort and reassurance which would be beneficial to the servicemember who is receiving inpatient or home

care. A complete and sufficient certification to support a request for FMLA leave due to a current servicemember's serious injury or illness includes written documentation confirming that the servicemember's injury or illness was incurred in the line of duty on active duty or if not, that the current servicemember's injury or illness existed before the beginning of the servicemember's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces, and that the current servicemember is undergoing treatment for such injury or illness by a health care provider listed above.

PART A: HEALTH CARE PROVIDER INFORMATION

Health Care Provider's Name: *(Print)* _____

Health Care Provider's business address: _____

Type of practice/Medical specialty: _____

Telephone: (___) _____ Fax: (___) _____ E-mail: _____

Please select the type of FMLA health care provider you are:

- ☐ DOD health care provider
- ☐ VA health care provider
- ☐ DOD TRICARE network authorized private health care provider
- ☐ DOD non-network TRICARE authorized private health care provider
- ☐ Health care provider as defined in 29 C.F.R. § 825.125

PART B: MEDICAL INFORMATION

Please provide appropriate medical information of the patient as requested below. Limit your responses to the servicemember's condition for which the employee is seeking leave. If you are unable to make some of the military-related determinations contained below, you are permitted to rely upon determinations from an authorized DOD representative, such as a DOD recovery care coordinator. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. §1635.3(e).

(1) Patient's Name: _____

(2) List the approximate date condition started or will start: _____ *(mm/dd/yyyy)*

(3) Provide your **best estimate** of how long the condition will last: _____

(4) The servicemember's injury or illness: *(Select as appropriate)*

- ☐ Was incurred in the line of duty on active duty.
- ☐ Existed before the beginning of the servicemember's active duty and was aggravated by service in the line of duty on active duty.
- ☐ None of the above.

(5) The servicemember (☐ is / ☐ is not) undergoing medical treatment, recuperation, or therapy for this condition. If yes, briefly describe the medical treatment, recuperation or therapy: _____

Employee Name: _____

(6) The current servicemember's medical condition is classified as: *(Select as appropriate)*

☐ **(VSI) Very Seriously Ill/Injured** Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately. *Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.*

☐ **(SI) Seriously Ill/Injured** Illness/injury is of such severity that there is cause for immediate concern, but there is no imminent danger to life. Family members are requested at bedside. *Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.*

☐ **OTHER Ill/Injured** A serious injury or illness that may render the servicemember medically unfit to perform the duties of the member's office, grade, rank, or rating.

☐ **NONE OF THE ABOVE.** *Note to Employee: If this box is checked, you may still be eligible to take leave to care for a covered family member with a "serious health condition" under 29 C.F.R. § 825.113 of the FMLA. If such leave is requested, you may be required to complete DOL FORM WH-380-F or an employer-provided form seeking the same information.*

PART C: AMOUNT OF LEAVE NEEDED

For the medical condition checked in Part B, complete all that apply. Some 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 coverage.

(7) Due to the condition, the servicemember will need care for a **continuous period of time**, including any time for treatment and recovery. Provide your **best estimate** of the beginning date _____ *(mm/dd/yyyy)* and end date _____ *(mm/dd/yyyy)* for this period of time.

(8) Due to the condition, it is medically necessary for the servicemember to attend **planned medical treatment** appointments (scheduled medical visits). Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery _____ *(e.g. 3 days/week)*

(9) Due to the condition, it is medically necessary for the servicemember to receive care on an **intermittent basis** (periodically), such as the care needed because of episodic flare-ups of the condition or assisting with the servicemember's recovery. Provide your **best estimate** of how often (frequency) and how long (the duration) the intermittent episodes will likely last.

Over the next 6 months, intermittent care is estimated to occur _____ times per (☐ day / ☐ week / ☐ month) and are likely to last approximately _____ (☐ hours / ☐ days) per episode.

Signature of Health Care Provider _____ **Date** _____ *(mm/dd/yyyy)*

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years, in accordance with 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 15 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THE DEPARTMENT OF LABOR. RETURN IT TO THE PATIENT.

CITY OF STOCKTON

Attachment #9
FMLA/CFRA PAYROLL CODES

Hours Type Code	Hours Type Description
FY	FMLA-SICK LV- 4 HR
FQ	FMLA-SICK/FAM 4 HRS
F6	FMLA-SICK LV - FIRE-40HRS
F9	FMLA-SICK LV-FIRE 56 HR
SF	FMLA-SICK/FAM FIRE 56
FB	FMLA - OE3/O&M SICK LV BK
F4	FMLA-ANNL LV FIRE - 40 HR
F5	FMLA-ANNL LV FIRE 56 JUL
F7	FMLA-ANNL LV FIRE 56 AUG
FU	FMLA-ANNL FMGT 56 JUL
YX	FMLA-ANNL LEAVE NONEXEMPT
F2	FMLA-ANNL EXEMPT NONSAFET
FO	FMLA-ANNUAL LV - O&M 2008
YQ	FMLA-ANNL ASSTDH/MV/PP
YY	FMLA-ANNL LV OVER MAX
FC	FMLA - COMP TIME - 100%
FT	FMLA - COMP TIME - 150%
FJ	FMLA - HOLIDAY
FK	FMLA - HOLIDAY FLOATER
F0	FMLA - SCEA SPEC LEAVE
1F	FMLA - SPOA SPEC LEAVE
FD	FMLA - MGT LEAVE - POL40
FG	FMLA - FURL POL 08-09
FH	FMLA - FURL POL 09-10
FI	FMLA - FURL POL 10-11
FN	FMLA - FURL POL 11-12
PF	FMLA - FURL POL 12-13
QF	FMLA - FURL POL 13-14
FX	FMLA - FURL 62 HRS
25	FMLA LEAVE - WITHOUT PAY
FW	FMLA-WORK COMP
FZ	FMLA LEAVE - CATAS PAY
FR	FMLA LEAVE - CATAS RECEIP