



**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: _____



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)

Employee Name: _____

PART A: COVERED ACTIVE DUTY STATUS

Covered active duty or call to covered active duty in the case of a member of the Regular Armed Forces means duty during the deployment of the member with the Armed Forces to a foreign country. Covered active duty or call to covered active duty in the case of a member of the Reserve components means duty during the deployment of the member with the Armed Forces to a foreign country under a Federal call or order to active duty in support of a contingency operation pursuant to: Section 688 of Title 10 of the United States Code; Section 12301(a) of Title 10 of the United States Code; Section 12302 of Title 10 of the United States Code; Section 12304 of Title 10 of the United States Code; Section 12305 of Title 10 of the United States Code; Section 12406 of Title 10 of the United States Code; chapter 15 of Title 10 of the United States Code; or, any other provision of law during a war or during a national emergency declared by the President or Congress so long as it is in support of a contingency operation. 10 U.S.C. § 101(a)(13)(B).

An employer may require the employee to provide a copy of the military member's active duty orders or other documentation issued by the military which indicates that the military member is on covered active duty or call to covered active duty status, and the dates of the military member's covered active duty service. **This information need only be provided to the employer once, unless additional leave is needed for a different military member or different deployment.**

- (3) Provide the dates of the military member's covered active duty service: _____
- (4) Please check one of the following and attach the indicated written document to support that the military member is on covered active duty or call to covered active duty status:
- ☐ A copy of the military member's covered active duty orders
 - ☐ Other documentation from the military indicating that the military member is on covered active duty or has been notified of an impending call to covered active duty, such as official military correspondence from the military member's chain of command
 - ☐ I have previously provided my employer with sufficient written documentation confirming the military member's covered active duty or call to covered active duty status

PART B: APPROPRIATE FACTS

Under the FMLA, leave can be taken for a number of qualifying exigencies. 29 C.F.R. § 825.126(b). Complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes available written documentation which supports the need for leave such as a copy of a meeting announcement for informational briefings sponsored by the military, a document confirming the military member's Rest and Recuperation leave, or other documentation issued by the military which indicates that the military member has been granted Rest and Recuperation leave, or a document confirming an appointment with a third party (e.g., a counselor or school official, or staff at a care facility, a copy of a bill for services for the handling of legal or financial affairs). Please provide appropriate facts related to the particular qualifying exigency to support the FMLA leave request, including information on the type of qualifying exigency and any available written documentation of the exigency event.

- (5) Select the appropriate **Qualifying Exigency Category** and, if needed, provide additional information related to the event:
- ☐ Short notice deployment (*i.e.*, deployment within seven or fewer days of notice)
 - ☐ Military events and related activities (*e.g.*, official ceremonies or events, or family support and assistance programs):

 - ☐ Childcare related activities for the child of the military member (*e.g.*, arranging for alternative childcare):

Employee Name: _____

- ☐ Care for the military member's parent (*e.g., admitting or transferring the parent to a new care facility*):

- ☐ Financial and legal arrangements related to the deployment (*e.g., obtaining military identification cards*)
- ☐ Counseling related to the deployment (*i.e., counseling provided by someone other than a health care provider*)
- ☐ Military member's short-term, temporary Rest and Recuperation leave (R&R) (leave for this reason is limited to 15 calendar days for each instance of R&R)
- ☐ Post deployment activities (*e.g., arrival ceremonies, or reintegration briefings and events*): _____
- ☐ Any other event that the employee and employer agree is a qualifying exigency: _____

- (6) Available written documentation supporting this request for leave is (☐ attached / ☐ not attached / ☐ not available).

PART C: AMOUNT OF LEAVE NEEDED

Provide information concerning the amount of leave that will be needed. Several questions in this section seek a response as to the frequency or duration of the qualifying exigency leave needed. Be as specific as you can; terms such as "unknown" or "indeterminate" may not be sufficient to determine FMLA coverage.

- (7) List the approximate date exigency started or will start: _____ (mm/dd/yyyy)
- (8) Provide your best estimate of how long the exigency lasted or will last:
From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy)
- (9) Due to a qualifying exigency, I need to work a **reduced schedule**. Provide your **best estimate** of the reduced schedule you are able to work:
From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy)
I am able to work _____
(*e.g., 5 hours/day, up to 25 hours a week*)
- (10) Due to a qualifying exigency, I will need to be absent from work for a **continuous period of time**. Provide your **best estimate** of the beginning and ending dates for the period of absence:
From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy)

Employee Name: _____

- (11) Due to a qualifying exigency, I will need to be absent from work on an **intermittent basis** (periodically).

Provide your **best estimate** of the frequency (how often) and duration (how long) of each appointment, meeting, or leave event, including any travel time.

Over the next 6 months, absences on an **intermittent basis** are estimated to occur: _____ times per
(☐ day / ☐ week / ☐ month) and are likely to last approximately _____ (☐ hours / ☐ days) per episode.

- (12) My leave is due to a qualifying exigency that involves **Rest and Recuperation leave** (R & R) of the military member (leave for this reason is limited to 15 calendar days for each instance of R & R leave).

List the dates of the military member's R & R leave:

From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy)

PART D: THIRD PARTY INFORMATION

If applicable, please provide information below that may be used by your employer to verify meetings or appointments with a third party related to the qualifying exigency. Examples of meetings with third parties include: arranging for childcare or parental care, to attend non-medical counseling, to attend meetings with school, childcare or parental care providers, to make financial or legal arrangements, to act as the military member's representative before a federal, state, or local agency for purposes of obtaining, arranging or appealing military service benefits, or to attend any event sponsored by the military or military service organizations. This information may be used by your employer to verify that the information contained on this form is accurate.

Individual (e.g., name and title) or Entity / Organization: _____

Address: _____

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

Describe purpose of meeting: _____

Employee

Signature _____ 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. 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 DEPARTMENT OF LABOR.
RETURN FORM TO THE EMPLOYER.**



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