Pasadena Area Community College District
REQUEST FOR MEDICAL LEAVE
Family and Medical Leave Act
California Pregnancy Disability Act
California Family Rights Act

Employee information: Please provide **all** information requested below.			
Employee Name	Address		Contact Phone #
Job Title	Bargaining Unit	Department	Supervisor

Reason for leave request

____ Employee's own serious health condition resulting in more than three (3) calendar days incapacitation and/or continuing medical treatment
____ Disabled by pregnancy or childbirth
____ Bonding after child's birth or placement of child for adoption/foster care
____ To care for family member (parent, spouse, son, daughter, domestic partner) with serious health condition
____ To care for a covered service member with a serious injury or illness if the eligible employee is the service member's spouse, son, daughter, parent, or next of kin
____ Any qualifying exigency arising out of the fact that the employee's spouse, son, daughter, or parent is a covered military member on "covered active duty"

Date leave to begin:		**Date leave expected to end:**	

Provide details if leave requested is to be intermittent or reduced schedule (dates, period of time):

MEDICAL CERTIFICATION

I understand that I am required to submit a Certification of Health Care Provider within 15 workdays. I must complete Section II and my healthcare provider must complete Section III. I understand that if this information is not received in the required timeframe, my leave will be considered unauthorized. *Initial Here* _____

SUPPLEMENTAL LEAVE

I understand that FMLA, CFRA and PDL are leave without pay, and that my accrued paid leaves (sick, vacation, and personal leave) shall be paid to supplement my unpaid leave in accordance with FMLA, CFRA, and/or PDL policies, and according to the terms of my collective bargaining agreement. I understand that my paid leaves run concurrently with FMLA, CFRA, and PDL. *Initial Here* _____

I understand that I may become eligible for extended or differential sick leave when all of my sick leave is exhausted. By initialing here, I authorize payroll to supplement my extended or differential sick leave with other accrued leave I have available. *Initial Here* _____

DEDUCTION AUTHORIZATION

I understand that while on leave, my District's health insurance will continue. However, if I fail to return to work after my leave entitlement ends, the District will have the right to recover its share of my health plan premiums for the entire leave period. I understand that my voluntary non-health benefits will not be paid unless I make appropriate arrangements with the Payroll Department. By initialing here, I authorize payroll to make deductions from the income for payment of my non-health benefits. *Initial Here* _____

CERTIFICATION

I hereby request leave for the purpose indicated above. I understand that I must comply with PCC procedures for requesting such leave and that additional documents including medical certification may be required. I understand that I am responsible for notifying Human Resources immediately, in writing or by phone, of any changes in the leave period requested.

Print Name:	**Employee Signature:**	**Date:**