

Contra Costa Community College District

**REQUEST FOR
FAMILY AND MEDICAL LEAVE ACT
or
PREGNANCY DISABILITY LEAVE**

To: District Office, Human Resource Department

From:

Employee Name (Print) Location

Dates of Requested Leave

Under the Family and Medical Leave Act of 1993 (FMLA) and the California Family Rights Act of 1993 (CFRA), if you have at least 12 months of service with the District and have worked at least 1,250 hours in the 12-month period before the date you are requesting to begin your leave, you may have a right to an unpaid family care or medical leave. Please complete one of the sections below.

I. FMLA/CFRA Leave

Unpaid leave may be granted for *any* of the following reasons. Please indicate your reason(s) for requesting this leave.

- The birth, adoption, or foster care placement of your child;
- Your own serious health condition;
- To care for your child, parent or spouse who has a serious health condition.

Employee Signature

II. Pregnancy Disability Leave

Employee Signature

Contra Costa Community College District

**CERTIFICATION OF HEALTH CARE PROVIDER
FAMILY AND MEDICAL LEAVE ACT
OR
PREGNANCY DISABILITY LEAVE**

- 1. Employees Name _____
- 2. Patient's Name (if other than Employee) _____
- 3. Date medical condition or need for treatment commenced _____

[NOTE: THE HEALTH CARE PROVIDER SHOULD NOT DISCLOSE THE UNDERLYING DIAGNOSIS WITHOUT THE CONSENT OF THE PATIENT]

- 4. Probable duration of medical condition or need for treatment

- 5. Does the patient's condition qualify under any of the categories described on the attached page? If so, please circle the appropriate category.

(1) (2) (3) (4) (5) (6)

- 6. If the certification is for the serious health condition of the employee, please answer the following:

Yes No

___ ___ Is employee able to perform work of any kind?
(If no, skip next question.)

___ ___ Is employee unable to perform any one or more of the essential
functions of employee's position?

- 7. If the certification is for the care of the employee's family member, please answer the following:

Yes No

___ ___ Does (or will) the patient require assistance for basic medical,
hygiene, nutritional needs, safety or transportation?

___ ___ Does the condition warrant the participation of the employee? (This
participation may include psychological comfort and/or arranging for third-party
care for the family member.)

8. Estimate the period of time care is needed or during which the employee's presence would be beneficial:

9. Please answer the following question only if the employee is asking for intermittent leave or a reduced work schedule.

Yes No

_____ _____ Is it medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal work schedule in order to deal with the serious health condition of the employee or family member?

TO BE COMPLETED BY THE EMPLOYEE NEEDING FAMILY LEAVE.

10. Family care leave is needed to care for my seriously-ill family member. I will be providing the following for my family member: (Please estimate the time period during which this care will be provided, including a schedule if leave is to be taken intermittently or on a reduced work schedule:

Signature of employee

Date

TO BE COMPLETED BY THE HEALTH CARE PROVIDER

Name _____

Address _____

Phone _____

Health Care Provider Signature

Date

A serious health condition means an illness, injury, impairment, or physical or mental condition that involves one of the following:

1. **Hospital Care**

Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

2. **Absence Plus Treatment**

A period of incapacity of more than three consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:

(a) Treatment two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider, or

(b) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider.

3. **Pregnancy**

Any period of incapacity due to pregnancy, or for prenatal care.

[Note: An employee's own incapacity due to pregnancy is covered as a serious health condition under FMLA, but not under CFRA.

4. **Chronic Conditions Requiring Treatment**

A chronic condition which:

(a) Requires period visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;

(b) Continues over an extended period of time (including recurring episodes of a single underlying condition); and

(c) May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.)

5. **Permanent/Long-term Conditions Requiring Supervision**

A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

6. **Multiple Treatments** (Non-Chronic Conditions)

Any period of absence to receive multiple treatments (including any period of recovery there from) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.) severe arthritis (physical therapy), kidney disease (dialysis).

Substitution of Paid Leave:

An employee who requests leave because of his or her own serious health condition shall be required to substitute all accrued paid leave, including but not limited to sick leave and vacation for unpaid leave.

An employee who takes a leave for the reason of the birth, adoption, or placement of a child, or for the purpose of caring for a parent, child, or spouse with a serious health condition shall be required to substitute all accrued paid leave, except sick leave, for unpaid leave.

An employee who requests leave due to her disability resulting from pregnancy, childbirth, and related medical conditions shall be required to exhaust any accrued paid sick leave. An employee may elect, but is not required, to use vacation or other accumulated time off during the period of the pregnancy disability leave.

Advance Notice and Medical Certification:

In some circumstances you are required to provide advance notice of your need for leave and medical certification. Taking of leave may be denied if requirements are not met.

If possible, you must provide at least 30 days advance notice for foreseeable events (such as the expected birth of a child or planned medical treatment for yourself or a family member). For events that are unforeseeable, you must notify us, at least verbally, as soon as you learn the need for the leave. Failure to comply with these notice rules is grounds for, and may result in, deferral of the requested leave until you comply with this notice policy.

The District requires that you provide certification from your health care provider before the District makes a final decision as to whether to grant your request for leave for pregnancy or your own serious health condition. You may also be required to provide certification from the health care provider of your child, parent or spouse who has a serious health condition before you are permitted leave to take care of that family member. We may require second and third medical opinions (at our expense). A fitness for duty report is required before an employee who has been on leave for a serious health condition or for pregnancy disability is allowed to return to work.

When medically necessary, leave may be taken on an intermittent or reduced work schedule. If you are taking leave for the birth, adoption or foster care placement of a child, the minimum duration of the leave is two weeks, with limited exceptions, and you must initiate the leave within one year of the birth or placement for adoption or foster care.

Job Benefits and Protection:

For the duration of the FMLA, CFRA and/or pregnancy disability leave, the District will maintain your health coverage under our group health plans. You must continue to pay any required employee contribution for such coverage.

Upon return from FMLA, CFRA, and/or pregnancy disability leave, you must be restored to the same or equivalent position at the end of the leave, subject to any employer defense allowed by law.

Use of FMLA, CFRA, and/or pregnancy disability leave cannot result in the loss of any employment benefit that accrued prior to the start of your leave.