

Please check one: Spouse³ Child⁴ Parent Individual who was in *loco parentis* when the employee was a child Parent-in-law or Parent of employee's registered domestic partner (OFLA leave only)
 Custodial parent Noncustodial parent Adoptive parent Stepparent Foster parent Grandparent (OFLA leave only) Grandchild (OFLA leave only).

Please state name and address of relation:

Name _____ Address _____

Does the condition render the family member unable to perform daily activities?

4. For a serious health condition which prevents me from performing my job functions. (District: Use GCBDA/GDBDA-AR(3)(A) Certification Form)

Describe _____

Leave to start _____ Expected return date _____

Regarding 3 or 4 above, request intermittent (reduced workday hours) or reduced leave (fewer workdays each workweek) schedule or alternate duty (if applicable, subject to employer's approval). Please describe schedule of when you anticipate you will be unavailable to work:

5. In order to care for a child with a condition requiring home care which does not meet the definition of serious health condition and is not life threatening or terminal (OFLA leave only).

6. A qualifying exigency arising from an employee's spouse, son, daughter, or parent who is a covered servicemember as defined in GCBDA/GDBDA-AR(1), or leave for the spouse of a military personnel per each deployment of the spouse when the spouse has either been notified of an impending call to active duty, has been ordered to active duty, or has been deployed or on leave from deployment. (District: Use GCBDA/GDBDA-AR(3)(C) Certification Form)

7. To care for a spouse, son, daughter, parent, or next of kin⁵ who is a covered servicemember with a serious illness or injury incurred in the line of duty or active duty in the armed forces. Has leave been taken for the same servicemember and the same injury? Yes No (District: Use GCBDA/GDBDA-AR(3)(D) Certification Form) If yes, when was the leave taken and for how many work days? _____

8. For the death of a family member (OFLA only).

I understand that I may use accrued paid leave, including personal and sick leave or accrued vacation leave for the family and medical leave period.

If my request for a leave is approved, it is my understanding that without an authorized extension when the need for an extension could be anticipated, I must report to duty on the first workday following the date my leave is scheduled to end. I understand that failure to do so will constitute unequivocal notice of my intent not to return to work and the district may terminate my employment. (A fitness-for-duty statement may be required.)

I authorize the district to deduct from my paychecks any employee contributions for health insurance premiums, life insurance or long-term disability insurance which remain unpaid after my leave, consistent with state and/or federal law.

³"Spouse" means individuals in a marriage including "common law" marriage and same-sex marriage. For OFLA, spouse also includes same-sex individuals with a Certificate of Registered Domestic Partnership.

⁴For FMLA, the age of the son or daughter at the onset of disability is not relevant in determining a parent's entitlement to FMLA leave.

⁵"Next of kin" means the nearest blood relative of the eligible employee.

I have been provided a copy of the district's family and medical leave policy and a copy of my rights and responsibilities under the Family Medical Leave Act leave request form.

Signature of Employee: _____ Date: _____