YOSEMITE COMMUNITY COLLEGE DISTRICT
Human Resources Operations
Benefits Office

APPLICATION FOR FAMILY MEDICAL LEAVE ACT/ CALIFORNIA FAMILY RIGHTS ACT LEAVE

NAME : _____ DIVISION:_____

COLLEAGUE #: _____CAMPUS:_____

Beginning Date of Leave: _____ Ending Date of Leave:_____

Reason for Leave (check one):

☐ (a) birth or adoption of a child, or the receipt of a child into foster care, within one year of such birth or placement, or

☐ (b) the employee's own serious health condition, or

☐ (c) a serious health condition of an employee's eligible child, spouse/domestic partner, parent or member of the immediate household, which requires the employee to care for the family member or during which the employee's presence would be beneficial.

A serious health condition means an illness, injury, impairment or physical or mental condition which involves either inpatient care of continuing treatment or supervision by a health care provider and does not include a cold or flu, as more fully described in the attached separate statement.
Explanation (if necessary): _____

A leave request based on an employee's serious health condition or the serious health condition of an employee's spouse/domestic partner, child, parent or member of the immediate household must be accompanied by a verifying medical certification from a physician.

I hereby authorize the Yosemite Community College District Office of Human Resources to contact my physician to verify that the reason for my requested leave is my own serious health condition, or that of my qualifying person. I understand the diagnosis will not be discussed.

I concur with the terms and conditions of the leave and understand that it will be my obligation to return to District employment on the working day following the ending date of the leave. I am aware that failure to return from leave may be construed as abandonment of my position.

_____ _____
Signature of Employee Date

REVIEWED BY:

_____ _____
Immediate Supervisor Date

_____ _____
Senior Director of Human Resources Date