

Family and Medical Leave (FML) Notice and Request Form

Notice to the Employee: If the leave you are requesting meets federal and state Family and Medical Leave (FML) requirements, you should be aware of the following rights and obligations:

- The period of this leave will be counted as federal/ state Family and Medical Leave in determining your future eligibility for additional FML.
- If your leave is due to a serious health condition (either your own, your spouse's, parent's or child's), you must provide medical certification requirements. **Prior** to returning to work, you will be required to present a "fitness-for duty" certification if the leave is due to your own health condition.
- Unless you are covered by a bargaining agreement which states otherwise, your personal holiday and any accumulated vacation and CTO leave credits will be used prior to placing you on unpaid leave of absence. If appropriate, accumulated sick leave may be used as mutually agreed upon by you and the appropriate administrator.
- For the period of unpaid FML. The CSU will continue to pay its portion of your medical, dental and vision premiums. An accounts receivable will be established for any employee premiums required during unpaid leave. If you wish to discontinue medical coverage during the unpaid leave, you may reinstate it upon return.
- If you do not return from FML, the CSU will require you to reimburse it for medical, dental and vision premiums paid on your behalf during the unpaid portion of your leave. However, no reimbursement will be required if you do not return because of a serious health condition or if you are unable to return due to circumstances that are outside of your control.
- Upon your return to work, you have the right to reinstate to the same position or to another position with equivalent benefits, pay conditions of employment. However, you will have no different rights than if you were actively at work rather than on leave: this exception could affect your reinstatement in the case of layoffs, for example.

Employee Leave Request: I request FML for the following reason (check one):

_____ **Birth, adoption, foster care placement** – Arrival or Due Date: _____

Dates of FML: _____

_____ **Care for family member -- Relationship** _____

Dates of FML: _____

Last day worked: _____ Expected return to work date: _____

Dates of Intermittent Period: _____

_____ **Own illness**

Last day worked: _____ Expected return to work date: _____

Dates of FML: _____

Dates of Intermittent Period: _____

If FMLA is unpaid, please continue these insurance (circle yes or no for each plan):

Medical (Yes/ No)

Dental (Yes/ No)

Vision (Yes/ No)

Employee Name (Please print): _____

Signature: _____ Date: _____