



CITY OF STOCKTON LEAVE REQUEST FORM

Employee Name: _____

Position/Title: _____

Department: _____

TYPE OF LEAVE REQUESTED

Date(s) of Leave: _____

Time of Leave: Number of Days: _____ Number of Hours: _____

Pregnancy Disability Leave (PDL) in conjunction with FMLA (if applicable)

Family Medical Leave (FMLA)/California Family Rights Act (CFRA)

check appropriate box:

Employee's Serious Health Condition

Placement of child due to adoption/foster care

Serious Health Condition of:

Child

Parent

Spouse or Domestic Partner

Birth of child or to care for a newborn

Military Leave (circle one)

Qualifying Exigency **OR** Care for Military Member

Care for a minor child if the child's school or place of childcare has been closed or is unavailable due to public health emergency.

Name of child AND school/care provider:

Son or Daughter. The term "Son or Daughter" has the meaning given such term in section 101 of the FMLA (29 U.S.C. 2611). Accordingly, the term means a biological, adopted, or foster child, a stepchild, a legal ward, or a child of a person standing *in loco parentis*, who is under 18 years of age; or 18 years of age or older who is incapable of self-care because of a mental or physical disability.

Employee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

Leave is not approved until Human Resources has notified you that your request has been approved. This leave will be taken in accordance with all applicable leave laws and will count towards an employee's 12 weeks of FMLA leave.