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
☐ 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
☐ Military Leve (circle one)

Qualifying Exigency
Care for Military Member

Employee Signature: _____________________________________ Date: ___________________

Supervisor Signature: _____________________________________ Date: ___________________

This leave will be taken in accordance with all applicable leave laws and will count towards an employee's 12 weeks of FMLA leave.