## Leave of Absence Request Form – CFRA only Employers\*

**Employee Name** **Request Date**   
**Status** (check one) □ Full-Time □ Part-Time **Date of Hire** **Dept**

**Employee Statement** (to be completed by the employee)  
I, (name) , request a leave of absence to begin on (date)

and to end on (date) for the following reason (check which box applies):

□ Medical: Employee’s own serious health condition (other than pregnancy or a pregnancy-related condition)

□ Pregnancy: Employee’s disability due to pregnancy or a pregnancy-related condition

□ Family Member/Designated Person: To care for a family member or designated person with a serious health condition or injury/illness - family member relationship or name of designated person:

□ Bonding: To care for my newborn child or placement of child with me adoption/foster care (bonding leave)

□ Qualifying Exigency: Active Duty/Service member leave/qualifying exigency - family member relationship:\_\_\_\_\_\_\_\_

Specify the type of qualifying exigency: \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Other (please explain):

Are you or will you be applying for any type of wage replacement benefits such as State Disability Insurance, Paid Family Leave Insurance or Workers’ Compensation while on unpaid leave? □ yes □ no

*I have read the policies in my Company’s employee handbook regarding leaves of absence and will provide all documents required to establish my eligibility and entitlement to leave under the policies.*

Employee Signature Date

**All medical, pregnancy, and family/designated person leave requests require a statement from the treating health care provider within 15 calendar days of request verifying the dates of disability or serious health condition, showing the initial date of disability or serious health condition and expected return date. Additional certification may be required.**

*Note: Employees may not be eligible to accrue vacation/PTO, sick leave or holiday benefits while on an unpaid leave of absence. The provisions of the employee handbook will apply.*

**Employer Response** (to be completed by Human Resources and returned to the employee)

You have requested the following leave of absence:

□ Pregnancy □ Medical □ Family/Designated Person □ Bonding

□ Qualifying Exigency □ Other

**Determination (check all that apply)**

□ You meet the initial eligibility criteria for California Family Rights Act (CFRA). See attached Notice of Eligibility and Rights and Obligations. You will be notified of CFRA leave approval/denial via the Designation Notice within 5 business days of providing sufficient medical certification.

□ You are not eligible for CFRA leave. See the Notice of Eligibility and Rights and Obligations and Designation Notice.

□ You are approved for a non-CFRA leave of absence:□ **Medical** □ **Personal**

□ Leave not approved because \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Human Resources Representative Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

