Print Clear all fields

COLLEGE OF MARIN

F5.18 – UPM/AFT

Request for Employee/Family Care Leave and Medical Certification

TO BE COMPLETED BY EMPLOYEE

Employee Name _____

A. Sections 1-5 must be completed by the employee for all employee/family care leave requests

1. Patient/Child's Name _____

2. Patient's/Child's Relationship to Employee _____

3. Date of Injury/Illness/Event _____

4. Probable Duration of Injury/Illness/Event _____

☐ (a) Continuous for _____ weeks.

☐ (b) Intermittent. This is my proposed work schedule:

5. Does the patient require inpatient care in a hospital or residential health care facility?

☐ Yes ☐ No

_____

PRINT EMPLOYEE NAME

_____

EMPLOYEE SIGNATURE

B. If you are requesting leave due to the **birth or adoption of a child or placement of a foster child**, sign the following declaration:

I declare under penalty of perjury of law that my request for leave under the College of Marin Employee/Family Care Leave Policy is based on the birth of my child, the adoption of a child by me, or the placement of a foster child with me.

_____

PRINT EMPLOYEE NAME

_____

EMPLOYEE SIGNATURE

Print | Clear all fields

COLLEGE OF MARIN

F5.18 – UPM/AFT

Request for Employee/Family Care Leave and Medical Certification

TO BE COMPLETED BY HEALTH CARE PROVIDER

C. Complete this sectionif the employee is **requesting leave due to the serious health condition of a family member**. Skip to Section D if the employee is requesting leave on account of his/her own serious health condition.

1. Does the patient require assistance for: (please check all applicable)

- ☐ basic medical care
- ☐ hygiene
- ☐ nutritional needs
- ☐ safety
- ☐ transportation

2. Is the employee's presence necessary or would it be beneficial to the care of the patient?
☐ Yes ☐ No

3. Estimate amount of time the employee's care is necessary or would be beneficial to the patient.

4. Dates of planned medical treatments or visits if it is medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal schedules of hours per day or days per week.

5. Additional comments

D. Complete this section if the employee is requesting leave due to the employee's own serious health condition.

1. I have reviewed the attached description of job duties and I certify that because of the employee's serious health condition, the employee is unable to perform the essential functions of his/her position.
☐ Yes ☐ No

2. Dates of planned medical treatments or visits if it is medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal schedules of hours per day or days per week.

_____

3. Anticipated return to work date: _____

4. Additional comments

Print | Clear all fields

COLLEGE OF MARIN

F5.18 – UPM/AFT

Request for Employee/Family Care Leave and Medical Certification

E. Declaration by health care provider

I certify under penalty of perjury of law that the information I have provided is true and accurate.

NAME/TITLE (PLEASE PRINT)

ADDRESS (number and street)

PHONE DATE

FOR HUMAN RESOURCES DEPARTMENT USE ONLY

Employee meets all requirements: ☐ Yes ☐ No

If "no" please explain:

Manager notified of request: (check)

Approval/Disapproval:

HUMAN RESOURCES DEPARTMENT DATE

SUPERINTENDENT DATE