



**STOCKTON UNIFIED SCHOOL DISTRICT**

**RISK MANAGEMENT**

56 S. Lincoln Street

Stockton CA 95203

Phone (209) 933-7110 • Fax (209) 933-6526

**FAMILY CARE & MEDICAL LEAVE/ CALIFORNIA FAMILY RIGHTS ACT LEAVE  
FMLA/CFRA REQUEST FORM (EMPLOYEES OWN MEDICAL CONDITION)**

Name: \_\_\_\_\_ SUSD ID #: \_\_\_\_\_

Address/City/State/Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Position: \_\_\_\_\_

Site: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Hours Worked: \_\_\_\_\_ Bargaining Unit: \_\_\_\_\_

I am requesting FMLA/CFRA for the period indicated:

Start Date: \_\_\_\_\_ Return to work date: \_\_\_\_\_

Reason for request of FMLA/CFRA:

*(If Intermittent Leave is needed, indicate in this area)*

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

**I understand that this leave shall run concurrent with any other leave, paid or unpaid, to which I am otherwise entitled, in compliance with Board Policy 4161.8/4261.8/4361.8.**

**I further understand that if I do not return at the conclusion of my FMLA/CFRA, I may be responsible to reimburse the District for the cost of medical benefits during my leave.**

**I understand that if I am on Unpaid FMLA/CFRA it will result in a pay deduction.**

**Risk Management Use Only:**

**Approved**       **Disapproved:**   
(12 months with SUSD and 1250 hours physically worked in the past 12 months)

**# of FMLA/CFRA days available:** 60 day  
**# of FMLA/CFRA days Used** \_\_\_\_\_

**Balance Available** \_\_\_\_\_

