

EMPLOYEE PREGNANCY DISABILITY LEAVE, FML AND MLOA REQUEST FORM

I request leave for the following reason (check one):

- Birth, adoption, foster care placement of a child (expected date: _____)
- Care for spouse, parent, child, or domestic partner with serious medical condition
- Own serious medical condition (non-pregnancy)
- Own disability due to pregnancy

Leave period requested (dates): from _____ to _____

Please specify whether you are requesting to take leave as:

- Full absence during leave period
- Reduced work schedule during leave period
- Intermittent absences during leave period

If anything other than full absence, please describe the schedule you are requesting:

 Your available accrued vacation and personal holiday time may be applied during FML, however, this will not extend the length of FML. If your leave request is due to pregnancy disability, you may elect to apply vacation and personal holiday time during your pregnancy disability. Electing to apply vacation will not extend the amount of any leave time available.

Please Note: Use of vacation, sick and paternity/maternity leave will be coordinated with SDI/PFL payments. Normally, SDI/PFL payments are 60 to 70 percent (depending on income). Therefore, the Corporation will coordinate the additional XX% in order to total 100% of employee's salary. Please notify Corporation HR if your SDI/PFL payments are different than what is stated.

- I request that vacation: be applied during disability leave vacation hrs. _____
 Begins on _____ and ends on _____
- not be applied during leave

You **may** use any available sick leave for your own serious medical condition or for a pregnancy disability.

- I request that sick pay: be applied during disability leave sick hrs. _____
 Begins on _____ and ends on _____
- not be applied during leave
- I request leave without pay: leave hrs. _____
 Begins on _____ and ends on _____

I HAVE READ THE NOTICE ON THE OTHER SIDE OF THIS FORM.

The required certification to support this leave request **must** be attached, if possible; otherwise, certifications must be provided within 15 days.

Employee Name (Please Print): _____

Signature: _____ Date: _____

FOR OFFICE USE ONLY

LEAVE Rejected Approved (dates) from _____ to _____

Supervisor Signature: _____ Date: _____

University Corporation at Monterey Bay

PREGNANCY DISABILITY, FAMILY AND MEDICAL LEAVE, MEDICAL LEAVE OF ABSENCE NOTICE

Notice to the employee: If the leave you are requesting meets the federal Family and Medical Leave Act and state of California Family Rights Act (hereinafter referred to as “FML”) requirements, you should be aware of the following rights and obligations:

- The period of this leave will be counted as FML in determining your future eligibility for additional FML.
- If your leave is due to a serious health condition (either your own, your spouse’s, parent’s, child’s, or domestic partner), you must provide medical certification. Approval of your leave may be withheld until you comply with certification requirements. Prior to returning to work, you will be required to present a physician’s certification of your ability to return to work if the leave is due to your own health condition.
- Your accumulated vacation time and personal holiday will be applied before placing you on unpaid leave of absence. If appropriate, accumulated sick leave may be used as provided by policy. Use of such paid time will not extend the amount of leave available.
- For the period of FML, up to a maximum of 12 weeks in a 12 month period, Corporation at Monterey Bay, will continue to pay its portion of your medical, dental and vision premiums. You will be required to pay any employee premiums (if applicable) during unpaid leave. If you wish to discontinue medical, dental and vision coverage during the unpaid leave, you may reinstate it upon return.
- If you do not return from FML, University Corporation at Monterey Bay may require you to reimburse it for medical premiums it paid on your behalf during the unpaid portion of your leave. However, no reimbursement will be required if you do not return because of a serious health condition or if you are unable to return due to circumstances, which are outside of your control.
- Upon your return to work, you have the right to reinstate the same position or another position with equivalent benefits, pay and conditions of employment. If your job is unavailable due to, for example, a temporary or indefinite layoff. You have no greater right to reinstatement than if you were actively at work rather than on leave. Leave of absence will only be used for the period of disability resulting from a medical condition. If you do not return to work at the end of, or before, the completion of the period granted, or accept employment elsewhere while on leave, Corporation at Monterey Bay will consider this to be a voluntary resignation of your Corporation job.
- Time spent on a medical leave will count toward the 12 weeks, in a 12 month period (beginning with initial FML eligibility), allowed under the FML.
- The Corporation cannot guarantee any position beyond four (4) months and it may be replaced due to business necessity at that time. Medical leaves due to pregnancy disability are up to four months, which do not run concurrently with the California Family rights Act. Therefore, in certain cases, reinstatement may be granted up to seven (7) months.
- Insurance coverage by Corporation will cease for time exceeding the paid period of disability (or FML, i.e., 12 weeks) unless payment of the premiums is made on a monthly basis by the employee.
- **Please note:** should this policy conflict with current prevailing law, prevailing law will apply.

*To request leave, submit the form on the back of this notice,
Along with medical certification, to Corporation Human Resources.*