APPENDIX T2
APPLICATION FOR FAMILY MEDICAL LEAVE
Foothill-De Anza Community College District

NAME: _____ DIVISION: _____

CWID #: _____ CAMPUS: _____

Beginning Date of Leave:_____ Ending Date of Leave:_____

Reason for Leave (check one):

_____ a) birth or adoption of a child, or the receipt of a child into foster care, within one year of such birth or placement, or

_____ b) the employee's own serious health condition that makes it impossible to perform essential job functions, or

_____ c) a serious health condition of an employee's eligible child, spouse, parent or member of the immediate household, which requires the employee to care for the family member.

Explanation (if necessary):_____
_____
_____
_____
_____

A leave request based on an employee's serious health condition or the serious health condition of an employee's spouse, child, parent or member of the immediate household must be accompanied by a verifying medical certification from a physician.

I hereby authorize the Foothill-De Anza Community College District, Office of Human Resources to contact my physician to verify the reason for my requested leave or for any other information concerning my requested Family Medical Leave.

I concur with the terms and conditions of the leave and understand that it will be my obligation to return to District employment on the working day following the ending date of the leave. I am aware that failure to return from leave may be construed as abandonment of my position.

_____ _____
Signature of Employee Date

APPROVED BY:

_____ _____
Administrator Vice Chancellor or Director of Human Resources

_____ _____
Date Date