CITY & COUNTY OF HONOLULU

FAMILY LEAVE APPLICATION

Instructions: Complete this application and FORM DF-88, and submit them to your Department Personnel Office.

Part I – EMPLOYEE INFORMATION

1. EMPLOYEE NAME (LAST) (FIRST) (MIDDLE INITIAL)		2. BARGAINING UNIT	
3. MAILING ADDRESS (NUMBER, STREET, APT. NO. OR P.O. BOX)		4. HOME PHONE	5. WORK PHONE
6. DEPARTMENT/DIVISION	7. POSITION TITLE		

SPECIFY THE REASON FOR THE FAMILY LEAVE: (*Check the appropriate space*)

STATE FAMILY LEAVE (SFL):

___ A. The birth of a child of the employee.
___ B. The adoption of a child of the employee.
___ C. To care for the employee's child, spouse, reciprocal beneficiary, parent (includes a biological, foster, or adoptive parent, a parent-in-law, a stepparent, a legal guardian, a grandparent, or a grandparent-in-law) with a serious health condition.
D. Are you taking leave intermittently? ___Yes ___No

FEDERAL FAMILY AND MEDICAL LEAVE (FMLA):

___ A. The birth and care of a newborn child (must conclude within 12 months of the birth).
___ B. Placement of a child with you for adoption or foster care (must conclude within 12 months of placement).
___ C. A serious health condition that makes you unable to perform the essential functions for your job.
___ D. A serious health condition affecting your spouse, child (under 18 or over 18 if incapable of self-care.) and parent (not parent-in-law), for which you are needed to provide care.
E. Are you taking leave intermittently? ___Yes ___No

_____ (FIRST & LAST NAME OF FAMILY MEMBER)

_____ (RELATIONSHIP TO EMPLOYEE)

Part II – Request for paid and/or unpaid leaves for duration of family leave. Indicate the dates/hours of the various family leave options and whether it is for SFL and/or FMLA.

_____sick leave_____ vacation leave _____ unpaid leave

Except as explained below, you have a right under the FMLA for up to 12 weeks of unpaid leave and under SFL for up to 4 weeks paid and/or unpaid leave in a calendar year for the reasons listed above. The 4 weeks of SFL shall run concurrently with the 12 weeks of FMLA, when applicable. Also, your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work, and you must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from leave.

If family leave is being taken for birth/adoption of a child, please attach medical/legal documentation to substantiate the request.

If family leave is being taken to care for a qualified family member or employee with a serious health condition, please attach the Family Leave Certification of Health Care Provider form (HR-LRT 8).

Part IV – EMPLOYEE SIGNATURE:

The information contained in this form may be subject to verification by the employer. I certify that the above information is true and accurate.

_____ Signature of Employee Date

_____ Appointing Authority or Designee Date