



Family Medical Leave Request Form (FMLA/CFRA/PDL)

Instructions:

Please ensure the form is filled out entirely. Each of the following sections should be filled out accordingly:

- I. Employee Section—Page 1: to be completed by Employee.
- II. Certification of Healthcare Providers for Family Medical Leave—Page 2: to be completed by Healthcare Provider.
 - a. Section A—Page 2: to be completed by Health Care Provider if leave is Pregnancy-related.
 - b. Section B—Page 3: to be completed by Health Care Provider if leave is Intermittent or Continuous.
- III. Healthcare Provider’s Information and Signature—Page 3: to be completed by Healthcare Provider.

I. Employee Information (Completed by Employee)	
Employee Name (Last, First)	Employee ID #
Job Title and Union (if applicable)	Phone Number
Email	Supervisor Name and Contact #

Leave Requested		
Type of Leave (Check All that Apply)		
<input type="checkbox"/> Intermittent	<input type="checkbox"/> Continuous	
Leave Request is for (Check One)	Protected Leave	Name (First and Last Name)
<input type="checkbox"/> Self (Employee)	FMLA/CFRA/PDL	
<input type="checkbox"/> Child	FMLA/CFRA	
<input type="checkbox"/> Spouse	FMLA/CFRA	
<input type="checkbox"/> Domestic Partner	CFRA	
<input type="checkbox"/> Parent	FMLA/CFRA	
<input type="checkbox"/> Parent-in-law	CFRA	
<input type="checkbox"/> Grandparent	CFRA	
<input type="checkbox"/> Grandchild	CFRA	
<input type="checkbox"/> Sibling	CFRA	
<input type="checkbox"/> Designated Person (Must Provide Designation Form)	CFRA	
Leave Request Reason is (Check One)	Protected Leave	
<input type="checkbox"/> Serious Health Condition	FMLA/CFRA	
<input type="checkbox"/> Child Bonding (Must Provide Temporary Birth Certificate)	FMLA/CFRA	
<input type="checkbox"/> Pregnancy Disability	FMLA/PDL	
<input type="checkbox"/> Qualifying Exigency	FMLA	
<input type="checkbox"/> Military Caregiver	FMLA	
<input type="checkbox"/> Organ Donor	AB 1223	
<input type="checkbox"/> Bone Marrow Donor	AB 1223	

Return to employee. You may also email this certification to HRDP@BART.gov or fax to 510-464-7511.

Revised 5/14/2025



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II. Certification of Healthcare Provider for Family Medical Leave (COMPLETED BY HEALTHCARE PROVIDER)

Employee Name: _____	Employee ID#: _____
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I am the Health Care Provider of the (Check One):

Employee (named above)

Employee's Relative or Designated Person. Please indicate the Full Name and Relationship to the Employee:

Reason for Leave (Please Check ALL that Apply)

Serious Health Condition (Including but not limited to)

- Conditions requiring an overnight stay in a hospital or other medical care facility;
- Conditions that incapacitate the employee/family member/Designated Person (for example, unable to work or attend school) for more than three consecutive days and have ongoing medical treatment (either multiple appointments with a health care provider, or a single appointment and follow-up care such as prescription medication);
- Chronic conditions that cause occasional periods when you or your family member or Designated Person are incapacitated and require treatment by a health care provider at least twice a year; and
- Conditions that resulted from domestic violence.
- An illness, injury (including, but not limited to, on-the-job injuries), impairment, or physical or mental condition of the employee or a child, parent, or spouse, or Designated Person of the employee that involves either inpatient care or continuing treatment, including, but not limited to, treatment for substance abuse.

Pregnancy (including prenatal medical appointments, incapacity due to morning sickness, and medically required bed rest)

Child Bonding (including bonding with a newborn child or a child placed for adoption or foster care)

Qualifying Exigencies

Military Caregiver

Time Needed for Leave *Please fill out at least ONE (A and/or B) section below*

SECTION A: Pregnancy-Related

Expected Due Date: _____

Is the employee unable to perform any of his/her essential job functions? Yes No

Is it medically advisable to transfer the employee to a less strenuous/hazardous position or provide a reasonable accommodation? Yes No

If yes, please specify restrictions and dates.

Start Date: _____ End Date: _____

Comments: _____



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SECTION B: Dates (with Frequency and Duration) of Leave-Serious Health Condition

INTERMITTENT LEAVE

Start Date: _____ End Date: _____

Frequency/Duration for each Episode/Appointment (Check and Fill One):

Example: 2 times per 1 month(s) for 4 hour(s)

- _____ times per _____ month(s) for _____ hour(s)
 week(s) day(s)
 year

OTHER: _____

Health Care Provider: If this is a revision/correction, please update then initial and date this box:	
_____ Initial	_____ Date

Is it medically necessary for the employee to work on a temporarily reduced work schedule during their intermittent leave? Yes No

The employee can work _____ hours in a day and _____ days in a week.

If dates differ from above, please indicate reduced work schedule dates.

Start Date: _____ End Date: _____

or CONTINUOUS LEAVE

Start Date: _____ End Date: _____

RESTRICTIONS: If the employee has any work restrictions, a separate request for a Reasonable Accommodation should be submitted along with supporting medical documentation. Please complete the Reasonable Accommodation Request Form and contact Leave Management at HRDP@bart.gov for further guidance.

III. Healthcare Provider's Information and Signature (COMPLETED BY HEALTHCARE PROVIDER)

Healthcare Provider's Additional Comments (if needed)

Healthcare Provider's Name (Print)	Healthcare Provider's Signature	Date Signed
Type of Practice (Field of Specialization)	State License #	
Address (Including City, State, and Zip Code)	Phone Number	

Return to employee. You may also email this certification to HRDP@BART.gov or fax to 510-464-7511.

Revised 5/14/2025



Family Medical Leave (FML) Pay Time Request Form

I. Employee will complete this section to request pay while on Family Medical Leave (FML).

Employee Name:	Union:	Employee ID:
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Please indicate which order (e.g., 1 to 5) you would like to use your available balances, if eligible. *If you do not complete this form, your balances will be used according to the order listed below.*

Order of Use	Leave (If available)
	Sick (FMSKN/CFSLN)
	Vacation (FMVCN/CFVCN)
	Floating Holiday (FMHLT/CFHLT)
	Compensatory Time (FMCTN/CFCTN)
	Unpaid Leave (FMNPN/CFNPN)

Comments: _____

Employee Signature: _____ Date: _____

Supervisor Name: _____ Supervisor Phone Number: _____

II. Supervisor/Manager/Dept will enter time as listed above while the employee is on Family Medical Leave (FML).

Non-Pregnancy Related Leave

Union	Leave Usage Order
AFSCME BPMA BPOA Non-Represented	1) Sick Leave, 2) Vacation (not required for self), 3) Floating Holidays, 4) Compensatory Time, 5) Unpaid Leave • To receive STD employees must first exhaust all Sick Leave • If on WC employees can coordinate using Sick Leave only
ATU SEIU	Sick Leave/Vacation/Floating Holidays/Compensatory Time or unpaid leave can be taken in any order; Sick Leave is the default option. • To receive STD employees must first exhaust all Sick Leave • If on WC employees can coordinate using Sick Leave only

Pregnancy/Child Bonding Related Leave

Leave	Union	Leave Usage Order
Pregnancy Leave	AFSCME Non-Represented	Sick Leave/Vacation/Floating Holidays/Compensatory Time or unpaid leave can be taken in any order; Sick Leave is the default option. If an employee is eligible for Short Term Disability (STD), then the following options are available: 1. Apply for STD and integrate Sick Leave only 2. Apply for STD and not integrate Sick Leave (Unpaid Leave), or 3. Use all Sick Leave and then apply for STD
	ATU SEIU	Employees must exhaust Sick Leave before using Vacation/Floating Holiday accruals, electing to take unpaid leave, or receiving STD.
	BPMA BPOA	Employees must exhaust Sick Leave. Employees then have the option to use Vacation/Floating Holidays/ Compensatory Time or unpaid leave while waiting for or before receiving Long Term Disability (PORAC).
Child Bonding	AFSCME Non-Represented	Sick Leave/Vacation/Floating Holidays/Compensatory Time can be taken in any order, but employees must exhaust all accruals before electing to take Unpaid Leave.
	ATU SEIU	Vacation/Floating Holidays/Compensatory Time can be taken in any order, but employees must exhaust all accruals before electing to use Sick Leave or electing to take Unpaid Leave.
	BPMA BPOA	Sick Leave can be used for the first two weeks from the birth of the baby. After the first two weeks from the actual date the baby is born, only Vacation/Floating Holidays/Compensatory Leave can be taken in any order, but employees must exhaust all leaves before Unpaid Leave.

Please send completed form by email to HRDP@bart.gov or fax to (510) 464-7511