COUNTY OF INYO
EMPLOYEE APPLICATION FOR PAID FAMILY LEAVE BENEFITS

Employee's Name____ **Home/Cell Phone #**____________________

Mailing Address____

Dates of Leave Requested: From______________________**through**_________________________________

Name and Relationship of Family Member you will provide care for: __________________________________

If family member is your son or daughter, date of birth_________________**or date of adoption or foster care placement (attach supporting documentation)** ______________**.**

Describe care you will provide to your family member____

____

I declare, under penalty of perjury, that the foregoing statements are true, complete and correct to the best of my knowledge. I agree that a photocopy of this release shall be as valid as the original.

______________________________________ ______________________________________
Employee's Signature **Date**

Employee's Name__________________________
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TREATING PHYSICIAN'S CERTIFICATION

RE:____________________________________ **Date illness/condition commenced**______________________
Patient's Name

Dates of family care needed: From____________**through**______________ **(can be an estimate; these fields must be completed).**

I certify that the serious health condition of my patient named above makes care by a family member necessary during the dates listed above.

____ ____
Physician's Signature **Date**

Physician's Name (Please Print)____

Type of Practice/Medical Speciality____

Telephone (______)_________________________ **Fax (____)**________________________________

RETURN TO: INYO COUNTY PERSONNEL DEPARTMENT
P.O. Box 249
Independence, CA 93526
Phone: (760) 878-0377
FAX: (760) 878-0465