Designated Person Request Form (CFRA)

Name: _____ **Today's Date (Month/Day/Year):** _____

I, _____ am requesting to care for a "designated person" with a
(Name of Employee)
serious health condition, under the California Family Rights Act ("CFRA").

_____ _____
(Name of Designated Person) (Start Date of CFRA Leave)

Please describe the nature of your relationship:
_____
_____
_____

Please note the following:

- "Designated person" for CFRA leave is defined as any individual related by blood or whose association with the employee is the equivalent of a family relationship.
- You may identify your designated person at the time you request CFRA leave.
- You are limited to ***one*** **designated person per 12-month period** for CFRA leave.

By signing below, I acknowledge that my designated person meets the qualifications above, and that I am limited to one designated person in a 12-month period. If signing electronically, please type your full name, followed by "e-signed."

_____ _____
Employee's Signature Date

Administrative Use Only

☐ **Approved** ☐ **Denied**

Additional Notes:
_____
_____
_____
_____