**DESIGNATION NOTICE**

**FMLA and/or CFRA**

**(Except for Pregnancy Disability Leave)**

<Employee Name> <Date>

<Employee Email or Address>

RE: Designation Notice – Family and Medical Leave Act and/or California Family Rights Act

Date Leave of Absence requested:<date>

Leave requested for: <reason>

Dear <name>:

We have reviewed your request for Family and Medical Leave and any supporting documentation you have provided on <date>.

**Based on the information you provided, your leave request is approved.**

You are qualified for leave under:

 Family and Medical Leave Act (“FMLA”) and/or

 California Family Rights Act (“CFRA”).

All leave taken for this reason will be designated as FMLA/CFRA leave.

Should you fail to return to work at the end of your leave or fail to provide certification of your need for additional leave, we cannot guarantee reinstatement to your prior position, or that any job will be available for you upon your return to work. As of the date of this letter <or as of XX date>:

You have <XX> work weeks/ <XX> days/<XX> hours of FMLA leave available.

You have <XX> work weeks/<XX> days/<XX> hours of CFRA leave available.

The law requires that you notify us as soon as practicable if the dates of your scheduled leave change or are extended or were initially unknown.

Based on the information you have provided to date, and provided there is no deviation from your anticipated leave schedule, the following number of hours, days, or work weeks will be counted against your leave entitlement:

Hours: <XX>

Days: <XX>

Work weeks: <XX>

Your approved leave period will begin on <date> through <date>.

If you require intermittent leave, we will provide you with the leave your health care provider indicates is necessary to the extent required by law. However, we reserve the right to reassign you to a position with equivalent pay and benefits during your leave if another position is better suited to your new temporary schedule. We will notify you if a temporary reassignment will be made. Please follow the organization’s regular call-in procedures to report any absence related to any requested intermittent leave.

If the leave you will need will be unscheduled, it is not possible to provide the hours, days, or work weeks that will be counted against your FMLA/CFRA entitlement at this time. You have the right to request this information once in a 30-day period (if leave was taken in the 30-day period).

Information about State Disability Insurance <(“SDI”) and/or Paid Family Leave Insurance (“PFLI”)> benefits are enclosed with this letter. It is your responsibility to apply for such benefits through the Employment Development Department. Any accrued, unused sick leave, <vacation or PTO> you use will be coordinated with any <SDI or PFLI> benefits you receive so your leave payments do not exceed your normal pay.

**Please be advised**:

 You may request to use accrued, unused paid leave (such as vacation, PTO or PSL) during your leave. Any paid leave taken for this reason will count against your FMLA/CFRA leave entitlement. Please contact <title> to use this accrued, unused paid leave.

 We are requiring you to substitute or use accrued time off during your qualified leave unless you are receiving wage replacement benefits such as SDI, PFLI or workers’ compensation. Currently, as of <date>, you have the following accrued hours available:

 supplemental sick leave hours: <XX>

 vacation hours: <XX>

 PTO hours: <XX>

 To continue your health insurance and maintain your health benefits while you are on leave, the following options are available to you for payment of your premium:

* + - 1. As long as you receive a paycheck (for example, because you are using sick leave/PTO/vacation), you may use payroll deductions to pay your premium. If you choose this option, you must authorize this deduction through payroll; or
      2. You may send your premium payment to the <title> on a monthly basis to be received by the <date> of the month; or
      3. You may prepay the full amount of your portion of the medical premium owed of $<XX> to cover the entire leave of absence; or
      4. You may choose not to continue your health insurance coverage during your leave of absence.

 You will remain 100% responsible for premiums of other benefit plans you are participating in (such as life insurance, disability insurance), if you continue to participate. If we fail to receive payment within 30 days for the other benefits you are participating in, we will contact the insuring company advising them of your non-payment.

 Pursuant to our uniformly applied policy, you will be required to present a Return-to-Work Certification before returning to work. Your return may be delayed until certification is provided. A job description for your position is/is not attached to this letter. The Return-to-Work Certification must address your ability to perform the essential functions on the job description, if attached.

You will be required to return to work at the end of the approved leave period. If you do not return on that day or fail to submit a request for an extension with a recertification, we will assume you have voluntarily resigned your position.

Please sign and return where indicated below and return to <title> as soon as possible. If you have any questions, please contact <title> at <phone> or <email>.

Employer’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Employee’s Signature of Receipt\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

Enclosures: SDI and/or PFLI Pamphlet

Return to Work Certification

Job Description (if attached)

Please complete this page with your selection for health care insurance payment circled. Return to <name or title> before your leave begins.

To continue my health insurance and maintain my health benefits while I am on leave, I have checked the option from the list below for the payment of my premium:

* As long as I receive a paycheck, the Company may use payroll deductions to pay my premium. If I choose this option I authorize this deduction, by signing below, through payroll; or
* I will send my premium payment of $<XX>/mo. on a monthly basis to be received by the <date>of the month; or
* I will prepay the full amount of my portion of the health insurance premium owed of $<XX> to cover the entire leave of absence; or
* I choose not to continue my health insurance coverage during my leave of absence.

Employee’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Employee’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_