DESIGNATION NOTICE FAMILY AND MEDICAL LEAVE ACT/PREGNANCY DISABILITY LEAVE

DATE: _____

TO: _____
[Employee's Name and Title]

FROM:_____
[Department Manager]

We have reviewed your request for leave under the Family and Medical Leave Act ("FMLA") / Pregnancy Disability Leave Law ("PDL") and any supporting documentation you have provided. In your request, you asked for FMLA/PDL for your being disabled due to pregnancy, childbirth, or related medical conditions.

We have received your most recent information. Based on that information and the other information you provided, we have made the following determinations:

Your ☐ PDL and/or ☐ FMLA leave request is approved. All leave taken for the specified reason will be designated as PDL leave.

☐ **Twelve weeks of your PDL leave will also be designated as FMLA leave.**
Should you fail to return to work at the end of your PDL and/or FMLA leave, or fail to provide continued 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.

If you require intermittent leave or leave on a reduced work schedule, we will provide you with the leave your health care provider indicates is necessary to the extent required by law. However, for the twelve weeks your leave may qualify as FMLA leave, and if your need for such leave is foreseeable based on planned medical treatment, 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. You will be required to follow your department's regular call-in procedures to report any absence related to any required intermittent leave or leave on a reduced work schedule.

Please 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, we are providing the following information about the amount of time that will be counted against your FMLA and/or PDL leave entitlement:

☐ You currently have _____ hours of PDL and/or _____ hours of FMLA leave available.

☐ Your leave will begin on _____ and end on _____

☐ Provided there is no deviation from your anticipated leave schedule, the following number of hours, days, or weeks will be counted against your Pregnancy Disability Leave entitlement:

_____

☐ Provided there is no deviation from your anticipated leave schedule, the following number of hours, days, or weeks will be counted against your FMLA leave entitlement:

_____

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

Please be advised:
If you have requested to use paid leave during your FMLA and/or PDL leave, any paid leave taken for this reason will count against your FMLA and/or PDL leave entitlement. You will be required to use your available paid sick leave during your Pregnancy Disability Leave and/or FMLA absence. In addition, you have the option, but are not required, to use vacation and other accrued leave balances. This means that you will receive your paid leave and the leave will also be considered protected Pregnancy Disability Leave and/or FMLA leave and counted against your Pregnancy Disability Leave and/or FMLA leave entitlement. However, you will not be required to use leave balances if you are receiving wage replacement benefits like state disability insurance (SDI), paid family leave insurance (PFL), or workers' compensation benefits. You may choose to coordinate these benefits with your leave balances. **Notify Payroll and your department immediately if you receive any wage replacement benefits and state whether or not you wish to coordinate your leave balances with these benefits.** Wage replacement benefits you receive in combination with any leave balances you coordinate with these benefits may not exceed your regular weekly wages.

Information about state disability insurance ("SDI") and paid family leave ("PFL) benefits are enclosed with this letter. It is your responsibility to apply for such benefits through the local Employment Development Department if you so choose. Please inform Payroll immediately if/when you receive SDI or PFL benefits so as to avoid any sort of overpayment that could occur as a result of your choosing to coordinate leave balances with SDI or PFL benefits. If you are not taking intermittent or reduced schedule leave, you will be required to present a Fitness-for-Duty Certification to be restored to employment. If such certification is not timely received, your return to work may be delayed until certification is provided. A list of the essential functions of your position is attached. The Fitness-for-Duty Certification must address your ability to perform these functions.

☐ (Check if Applicable) If you are taking intermittent or reduced schedule leave, you will be required to provide a Fitness-For-Duty Certification for such absences up to once every 30 days because it has been determined that reasonable safety concerns exist regarding your ability to perform your duties based on the condition for which you are taking such leave. "Reasonable safety concerns" means a reasonable belief of significant risk of harm to you or to others, taking into consideration the nature and severity of the potential harm and the likelihood that potential harm will occur. Under this provision, for each subsequent instance of intermittent or reduced schedule leave, you will be required to submit a Fitness-for-Duty Certification unless one has already been submitted within the past 30 days. A list of the essential functions of your position is attached. The Fitness-For-Duty Certification must address your ability to perform these functions.

Additional information is needed to determine if your FMLA and/or PDL leave request can be approved (check if applicable):

☐ The certification you have provided is not complete and/or sufficient to determine whether the PDL and/or FMLA apply to your leave request. You must provide the following information no later than _____ (at least seven calendar days), unless it is not practicable under the particular circumstances despite your diligent good faith efforts), or your leave may be delayed, denied, or not designated as PDL and/or FMLA leave:

_____

_____

_____

_____

In connection with FMLA leave (but not PDL Leave) we are exercising our right to have you obtain a second or third health care provider certification at our expense. We will provide further details at a later time.

_____

☐ Your FMLA Leave request is denied.

Reason denied:_____

☐ Your PDL Leave request is denied.

Reason denied:_____

☐ The FMLA does not apply to your leave request.

☐ The PDL does not apply to your leave request.

_____

All additional information should be directed to:

_____
[Department Contact]

Any questions about FMLA and/or PDL leave should be directed to County Personnel.

Attachment(s):

Essential Functions of Employee's Position
Information about State Disability Insurance and Paid Family Leave Benefits