**LEAVE DESIGNATION NOTICE**

**FAMILY AND MEDICAL LEAVE ACT (FMLA)**

**AND CALIFORNIA FAMILY RIGHTS ACT (CFRA)**

**TO: [Employee]**

**FROM: [District Representative]**

**DATE:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

We have reviewed your request for leave under the FMLA and/or CFRA and any supporting documentation that you have provided. We received your most recent information on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and determined:

**1. A. □** **Your leave request is approved under FMLA and CFRA. All leave taken for this reason will be designated as FMLA and CFRA leave.** Your current leave is approved for the following category of person(s):

□ self (non-pregnancy related)

□ spouse or registered domestic partner

□ minor child or disabled adult child over the age of 18 incapable of self-care

□ parent

**OR**

 **B. □ Your leave request is approved under CFRA only. All leave taken for this reason will be designated as CFRA leave only because it is for one of the following categories of persons:**

 □ child, age \_\_\_\_\_\_;

□ parent-in-law

□ grandparent

□ grandchild

□ sibling

□ designated person

**OR**

**C.** □ **Your leave request is approved as FMLA only. All leave taken for this reason**

**will be designated as FMLA only because it is or the following category of person and reason**:

□ Self (pregnancy related)

**The FMLA and/or CFRA require that you notify us as soon as practicable if 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 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 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 FMLA and/or 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).

 **Please be advised (check if applicable):**

 □ You have requested to use paid leave during your FMALA and/or CFRA leave. Any paid leave taken for this reason will count against your FMLA and/or CFRA leave entitlement.

 □ We are requiring you to substitute or use paid leave during your FMLA and/or CFRA leave.

 □ If the leave is for your own Serious Health Condition, in order to be restored to employment at the conclusion of your leave, you will be required to present a release to return-to-work from your health care provider stating you are able to resume work. If such release is not timely received, your return to work may be delayed until the release is provided. A list of the essential functions of your position □ is □ is not attached. If attached, the release to return-to-work must address your ability to perform these functions.

 □ If your FMLA and/or CFRA leave is due to the birth of your child and to care for the newborn child, or the placement of a child with you for adoption or foster care and to care for the newly placed child, and you have worked for the District for at least 12 months, you are eligible for Education Code parental leave for a maximum of 12 workweeks. You must exhaust all sick leave, including accumulated sick leave, to be eligible for differential pay of at least 50% of your salary for the remainder of the 12 workweeks. This parental leave will be protected leave and will run concurrently with your FMLA and/or CFRA leave.

**2. □** **Additional information is needed to determine if your FMLA and/or CFRA leave request can be approved.**

□The certification you have provided is not complete and sufficient to determine whether the FMLA and/or CFRA apply to your leave request. You must provide the following information no later than \_\_\_\_\_\_\_\_\_\_, which is a date at least seven calendar days from now, unless it is not practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied.

[Specify information needed to make the certification complete and sufficient.]

 □ We are exercising our right to have you obtain the opinion of a second or third health care provider at our expense. We will provide further details at a later time.

**3. □** **Your FMLA and/or CFRA leave request is not approved.**

 □ The FMLA and/or CFRA do not apply to your leave request.

 □ You have exhausted both your FMLA and CFRA leave entitlement in the applicable 12-month period.