DESIGNATION NOTICE
FAMILY AND MEDICAL LEAVE ACT (FMLA), CALIFORNIA FAMILY RIGHTS ACT (CFRA), AND CALIFORNIA PREGNANCY DISABILITY LEAVE LAW (PDLL)

To: __________________________ Date: __________________________

We have reviewed your request for Family and Medical Leave (FML) and any supporting documentation that you have provided.

We received your most recent information on __________________________ and decided:

PART A: To Be Completed if FML Request is Approved

☐ Your FML request is approved. All leave taken for this reason will be designated as FML.

For block leaves:
Start date: ____________ Anticipated End Date: ____________ Return to Work Date: ____________

For Reduced schedule leaves or leaves on an intermittent basis:
Start date: ____________ Anticipated End Date: ____________

You are required to notify the University as soon as practicable if the dates of your scheduled leave change or are extended. If there was no firm end date for your leave, you should notify the University as soon as a firm end date is established. 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 FML 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 FML leave entitlement: ____________ Weeks ____________ Days ____________ Hours.

If any portion of your leave is for Pregnancy Disability, the following number of hours, days or weeks will be counted against your PDLL leave entitlement: ____________ Weeks ____________ Days ____________ Hours.

Please note that the following portion of your Pregnancy Disability leave will be counted against your FML leave entitlement and has been included in the amount indicated above: ____________ Weeks ____________ Days ____________ Hours.

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 FML leave entitlement at this time. You have the right to request this information once in a 30-day period.

Please be advised (check if applicable):

☐ You have requested to use paid leave during your FML. Any paid leave taken for this reason will count against your FML leave entitlement.

☐ We are requiring you to substitute or use paid leave during some or all of your FML.

☐ You will be required to provide the enclosed Return to Work certification to be restored to employment. If the job description is attached, the Return to Work certification must address your ability to perform those essential functions that you were unable to perform as a result of your serious health condition.

PART B: To Be Completed if FML Request Is Not Approved

Your FML request is Not Approved because:

☐ Your leave is not for an FML-qualifying reason.

☐ You have not provided the necessary information to support your request for FML.

☐ You have exhausted your FML leave entitlement in the applicable 12-month period.

DEPARTMENT SIGNATURE
NAME (PRINT) __________________________ Date: __________________________

RETURN TO WORK DATE ON DOCTOR’S NOTE

COMPLETE PART A IF FML IS APPROVED

1. FML is max. 12 weeks from start of leave. For the type of leave applicable after FML, see the employee’s CBA, PPSM or APM.

2. For “BLOCK LEAVE” input the number of weeks, and/or days off work.

3. For a "REDUCED SCHEDULE" or "INTERMITTENT LEAVE" – Input the number of hours NOT worked.

4. For “EPISODIC FLARE-UPS” choose this option.

5. Does employee want to use sick pay or other paid leave? And do they have that option under their CBA, PPSM or APM?

6. What paid leave (e.g. sick, vacation) is the employee required to use? Check the employee’s CBA, PPSM or APM.

7. Choose this box if FML is for employee’s serious health condition or Pregnancy Disability Leave (if not followed by Parental Leave). Provide the Return to Work Certification.

8. Choose this box if 7 is checked. Provide the job description.