SAN JOAQUIN COUNTY
Greatness grows here.

Designation Notice
•Family and Medical Leave Act (FMLA) •California Family Rights Act (CFRA) •California Pregnancy Disability Act (PDL)

To: _____ **Employee ID Number:** _____

Address: _____

Sent to primary email: _____

From: _____ **Date:** _____

We have reviewed all supporting documentation that you have provided regarding your leave that ☐ began on/ ☐ will begin on _____ and have decided the following: *(Check all boxes that apply)*

1. ☐ Your leave request for ☐ FMLA ☐ CFRA ☐ PDL leave is **NOT** approved because:

- ☐ The applicable leave regulations do not apply to your leave request.
- ☐ You have not submitted a complete and sufficient certification in the required time period.
- ☐ You exhausted your ☐ FMLA ☐ CFRA leave entitlement in the applicable 12-month period on: _____
- ☐ Other/Comment:

☐ Your leave request is **APPROVED** as a ☐ continuous leave or ☐ intermittent leave. All leave taken for this reason will be designated as: *(Check all boxes that apply)*

☐ FMLA and CFRA leave ☐ FMLA leave only ☐ CFRA leave only ☐ FMLA and PDL leave ☐ PDL leave only

2. The FMLA/CFRA/PDL requires that you notify us as soon as practicable if the dates of your scheduled leave change or were initially unknown. Based on the information you have provided to date, we are providing the following information on the amount of time that will be counted against your leave entitlement: *(Check only one of the boxes)*

☐ Provided there is no deviation from your anticipated leave scheduled to end on _____, the following number of hours, days, or weeks will be counted against your leave entitlement:

FMLA: _____ CFRA: _____ PDL: _____

☐ Because the leave you need will be unscheduled, it is not possible to provide the hours, days, or weeks that will be counted against your FMLA/CFRA/PDL 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).

3. You are required to use a minimum amount of available paid leave accruals per pay period during your protected leave before taking leave without pay following the appropriate policy/MOU/Board resolution, to the extent permitted by state and federal law. However, if you are receiving wage replacement benefits, such as State Disability Insurance (SDI) or Paid Family Leave (PFL), you are not required to use paid leave accruals during your protected leave. Based on information obtained, you are required to use one of the following: *(Leave coordinators/payroll personnel refer to Quick Reference Guide for Use of Accrual) Leave)*

☐ You have informed us that you have applied, or intend to apply, wage replacement benefits, and request to use _____ hours of available paid leave accruals each pay period while on leave so as not to exceed 100% of your normal salary.

☐ You have informed us that you have applied, or intend to apply, for wage replacement benefits, and do not wish to supplement those benefits with available paid leave accruals while on an approved, protected leave.

☐ You have informed us that you do not intend to apply for wage replacement benefits, or you have not communicated your plans to apply for wage replacement benefits. For this reason, you are required to use _____ hours paid leave accruals before taking leave without pay.

4. Return to Work Release

☐ You will be required to provide a return to work release certification from your health care provider at least two (2) business days prior to your expected return to work date of _____.

☐ You will not be required to provide a return to work release certification at this time. However, the County may require a return to work release at a later time if your current leave request is extended or changes occur.

5. Additional information is required to determine if your leave request can be approved under FMLA/CFRA/PDL. *(Check only one box)*

☐ The certification you have provided is not complete and sufficient to determine whether the FMLA/CFRA/PDL applies to your leave request. You must provide the following information no later than _____ (provide at least seven (7) calendar days).

Specify information needed to make certification complete and sufficient:

1.
2.
3.

☐ We are exercising our right to have you obtain a second opinion on your medical certification at our expense. We will contact you to provide further details.

If you have any questions about the contents of this notice, please contact _____ at _____.

cc: Supervisor *(if designation notice was not originated by employee's supervisor)*
Department E-Pad/Payroll Specialist
Human Resources, Position Control Unit