



COUNTY OF RIVERSIDE
Human Resources Department

Designation Notice

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

TO:

Employee Name (Last, First, Middle)

Employee ID Number

FROM:

Department

Date

CONTACT:

Department Representative

Contact Phone

LEAVE APPROVAL

Your leave request is approved on a continuous / intermittent basis from: _____ through: _____

All leave taken for this reason will be designated as (check all that apply):

FMLA CFRA PDL

For the following reason:

Your own serious health condition Care of family member Other reason: _____

Care of a "designated person": _____

You must 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 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, CFRA, and/or 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).

Please be advised (check if applicable):

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

We are requiring you to substitute or use paid leave during your leave.

Other:

RETURN TO WORK (check if applicable)

You will be required to present a return-to-work certification in order to return to work. If such certification is not timely, your return to work may be delayed until certification is provided.

Your continuous leave will expire on _____ and you are expected to return to work on your next normally scheduled work day. Failure to do so may lead to discipline or an automatic resignation from County service. If you are unable to return by this date, you must request additional leave time and provide a medical certification or other proof of a qualifying reason prior to the expiration of the date noted above.

If you plan on using additional protected leave time in order to bond with your newborn child, you must submit the Request for Family/Medical Leave form to your Department Designee prior to the above expiration date.

Your intermittent leave will expire on _____. If you require additional leave time, you must submit a request and provide a medical certification or other proof of a qualifying reason to your Department Designee prior to the above expiration date.

Your bonding leave will expire on _____, and you are expected to return to work on your next regularly scheduled work day. If you need additional time off to bond with your newborn child, you must submit the Request for Family/Medical Leave form to your Department Designee prior to the expiration of your leave.

Your protected leave entitlement is due to exhaust on _____. The remainder of your leave from _____ through _____ will be managed by the Disability Access Office. It is important to note that approval of additional leave as a reasonable accommodation is not automatic.

Employee Name (Last, First, Middle):

Employee ID Number:

ADDITIONAL INFORMATION NEEDED

Additional information is needed to determine if your FMLA, CFRA, and/or PDL leave request can be approved:

- The certification you have provided is not complete and sufficient to determine whether the FMLA, CFRA, and/or PDL regulations apply to your leave request. You must provide the following information from your Health Care Provider within 7 calendar days or your leave may be denied. If it is not practicable under the particular circumstances to meet this deadline despite your diligent good faith efforts, you must notify your Department Representative prior to the expiration of the 7 days.
We need the following:

- We are exercising our right to have you obtain a second or third opinion medical certification at our expense, and we will contact you to provide further details.

LEAVE DENIAL

Check all that apply:

- Your: FMLA CFRA PDL FMLA Military Caregiver leave request is **not** approved.
- The applicable leave regulations do not apply to your request.
- Complete and sufficient certification was not provided in the required time period.
- Other/Comment:

Department Representative Signature

Date