

TULARE COUNTY

DESIGNATION NOTICE (FMLA/CFRA/PDL)

To: (Employee's Name) _____

From: (Name of Employer Representative) _____

Date: _____

Phone: _____

We have reviewed your request for leave under the Family and Medical Leave Act (FMLA), California Family Rights Act (CFRA), and/or Pregnancy Disability Leave (PDL) and any supporting documentation that you have provided. We received your most recent information on (DATE) and decided:

- ☐ Your leave requested is approved. All leave taken for this reason will be designated as:
 - ☐ FMLA leave only ☐ CFRA leave only ☐ FMLA and CFRA leave
 - ☐ PDL leave only ☐ PDL and FMLA leave
- ☐ Your leave request is not approved, under one or more of above leave time protections:
 - ☐ Neither the FMLA, CFRA nor PDL apply to your leave request.
 - ☐ You have exhausted your FMLA leave entitlement in the applicable 12-month period.
 - ☐ You have exhausted your CFRA leave entitlement in the applicable 12-month period.
- ☐ Additional information is needed to determine if your leave can be approved:
 - ☐ The information you provided is insufficient to determine whether your leave request qualifies under one or more of the applicable leave time protections. You must provide the following information no later than DATE (provide at least seven calendar days) , unless it is not practical under the particular circumstances despite your diligent good faith efforts. If the following is not received by the date specified your leave may be denied. **(HR/Payroll Representative: Please specify information needed to make the certification complete and sufficient).**
 - ☐ We are exercising our right to obtain a second or third opinion medical certification at our expense, and we will provide further details at a later time.

INFORMATION FOR APPROVED FMLA/CFRA LEAVE

It is required that you notify us as soon as practicable if dates of scheduled leave change, 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: _____
- ☐ You are required to use applicable accruals during your leave.
- ☐ You will be required to present a medical release to return to work. If such certification is not timely received, your return to work may be delayed until medical release is provided.

For further information, contact: (Name/Title) _____

Department: _____

Phone Number: _____