COUNTY OF RIVERSIDE **Human Resources Department**	**LEAVE FOLLOW-UP NOTIFICATION** •Family and Medical Leave Act (FMLA) •California Family Rights Act (CFRA) •California Pregnancy Disability Act (PDL)

Employee Name (Last, First, Middle):	Employee ID Number:	Date Provided/Sent to Employee:
Department:	Leave Begin Date:	Leave End Date:

You are currently on a (check all that apply):

○ Family and Medical Leave (FMLA)

○ California Family Rights Leave (CFRA)

○ California Pregnancy Disability Leave (PDL)

Check all that apply:

☐ Your medical certification 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 re-certification or other proof of a qualifying reason prior to the expiration of the date noted above.

☐ Your medical certification will expire on ____________________ and you are expected to return to work on your next normally scheduled work day. If you plan on using additional protected leave time in order to bond with your newborn child, please complete the enclosed Request for Family/Medical Leave form and submit it to your Department Designee prior to the above expiration dated.

Please Contact: ______________________________ at (   ) ____________________ by ____________________

☐ 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.

☐ We have attempted to notify you but have not received any response from you by phone or email regarding your leave and/or absence from work.

Please Contact: ______________________________ at (   ) ____________________ by ____________________

☐ You are required to provide a medical release statement from your health care provider prior to returning to work.

Comments:

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Department Head/Designee Printed Name:	Department Head/Designee Signature:	Date:	Phone Number: ( )