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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) _____ (Employee ID Number)

FROM: _____ (Department) _____ (Date)

CONTACT: _____ (Department Representative) _____ ( ) (Contact Phone)

LEAVE APPROVAL

☐ **Your leave request is approved on a** ◯ **continuous** ◯ **intermittent basis from:** _____ **to:** _____ .

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

◯ **FMLA** ◯ **CFRA** ◯ **PDL** ◯ **FMLA Military Caregiver**

For the following reason:

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

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.

☐ 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. A list of the essential functions of your position ◯ **is** ◯ **is not** attached. If attached, the return-to-work certification must address your ability to perform these functions.

☐ Other: _____

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 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.
- ☐ You have exhausted your leave entitlement in the applicable 12-month period.
- ☐ Other/Comment: _____

_____ (Department Representative Signature) _____ (Date)

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