DESIGNATION NOTICE
FAMILY AND MEDICAL LEAVE ACT (FMLA), CALIFORNIA FAMILY RIGHTS ACT (CFRA), AND CALIFORNIA PREGNANCY DISABILITY LEAVE LAW (PDLL)

To: ____ Date: ______________________________

We have reviewed your request for Family and Medical Leave (FML) and any supporting documentation that you have provided.

We received your most recent information on ________________________ and decided:

PART A: To Be Completed if FML Request is Approved.

☐ Your FML request is approved. All leave taken for this reason will be designated as FML.

For block leaves:

Start date: ____|____|____ Anticipated End Date:____|____|____ Return to Work Date: ___|___|___

For Reduced schedule leaves or leaves on an intermittent basis:

Start date: ____|____|____ Anticipated End Date:____|____|____

You are required to notify the University as soon as practicable if the dates of your scheduled leave change or are extended. If there was no firm end date for your leave, you should notify the University as soon as practicable when a firm end date is established. 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 FML 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 FML leave entitlement: ______ Weeks ______ Days ______ Hours.

☐ If any portion of your leave is for Pregnancy Disability, the following number of hours, days or weeks will be counted against your PDLL leave entitlement: ______ Weeks ______ Days ______ Hours.

Please note that the following portion of your Pregnancy Disability leave will be counted against your FML leave entitlement and has been included in the amount indicated above: ______ Weeks ______ Days ______ Hours.

☐ 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 FML leave 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 FML. Any paid leave taken for this reason will count against your FML leave entitlement.

☐ We are requiring you to substitute or use paid leave during some or all of your FML.

☐ You will be required to provide the enclosed Return to Work certification to be restored to employment. If such certification is not timely received, your return to work may be delayed until certification is provided. If the job description is attached, the Return to Work certification must address your ability to perform those essential functions that you were unable to perform as a result of your serious health condition.

☐ A job description listing the essential functions of your position is attached to the Return to Work Certification.

PART B: To Be Completed if FML Request Is Not Approved

Your FML request is **Not Approved** because:

☐ Your leave is not for an FML-qualifying reason.

☐ You have not provided the necessary information to support your request for FML.

☐ You have exhausted your FML leave entitlement in the applicable 12-month period.

DEPARTMENT SIGNATURE

NAME (PRINT)	
SIGNATURE	DATE