
Instructions

Leave covered under the Family and Medical Leave Act (FMLA) must be designated as FMLA-protected and the employer must inform the employee of the amount of leave that will be counted against the employee's FMLA leave entitlement.

This form is not for use if the employee is requesting pregnancy disability leave. Please use the *FMLA/PDL Designation Notice* form.

In order to determine whether leave is covered under the FMLA, the employer may request that the leave be supported by a certification (This requirement must be noted in your employer's family and medical leave policy).

If the certification is incomplete or insufficient, the employer must state in writing what additional information is necessary to make the certification complete and sufficient.

While use of this form is optional, completion of the form provides employees with the information required by 29 C.F.R. §§ 825.300(d), 825.301, and 825.305(c), which must be provided within five business days of the employer having enough information to determine whether the leave is for an FMLA-qualifying reason.

Section I – Employer

Indicate the most recent date you received a request, medical certification or other documentation of the employee's need for leave.

Indicate whether the leave is approved or denied, or if more information is needed.

Section II – Additional Information Needed

If needed, indicate any additional information needed to make a leave request determination.

Section III – FMLA Leave Approved

If leave beginning and ending dates are known, indicate those dates in the first check box. If the length or timing of leave is not known, use the second check box.

Indicate whether employee will be using other paid leave during FMLA.

For FMLA leave, you may not require employees to use paid leave if the employee is receiving money through a paid disability plan such as State Disability Insurance (SDI), Paid Family Leave (PFL), workers' compensation or an employer-provided short term disability plan. Employees can choose to supplement these wage replacement benefits with paid leave.

Use of State Disability Insurance (SDI)

Complete this section if the employee will receive SDI benefits and has requested to supplement unpaid leave with sick leave benefits.

Continued Health Benefits

Employees are entitled to continued health benefits during FMLA leave for a maximum of twelve (12) weeks.

Provide the amount of money the employee must pay, the due dates and the grace period for health benefits payment. Be sure to verify the grace period with your insurance carrier.

Return to Work

You may require medical certification of the employee's ability to return to work if the absence is for the employee's own serious health condition. In order to require such certification, you must have a uniformly-applied policy or practice for all similar situations. The medical certification can address the employee's ability to perform the essential functions of the employee's job. If the return to work certification contains this information, you must provide the employee with a list of the essential functions of his/her job, no later than with this designation notice.

Complete this section if you are requiring a release to return to work. Attach the essential functions of the employee's job if you want the health care provider to certify that the employee is able to perform the essential functions of his/her job upon return to work.

SECTION I - EMPLOYER

The employer is responsible in all circumstances for designating leave as FMLA-qualifying and giving notice to the employee. Once an eligible employee communicates a need to take leave for an FMLA-qualifying reason, an employer may not delay designating such leave as FMLA leave, and neither the employee nor the employer may decline FMLA protection for that leave.

From (Employer) _____ Date _____

To (Employee) _____

On _____ we received your most recent information to support your need for leave due to:

- ☐ The birth of a child, or placement of a child with you for adoption or foster care, and to bond with the newborn or newly-placed child.
- ☐ Your own serious health condition.
- ☐ The serious health condition of your spouse, child or parent.
- ☐ A qualifying exigency arising out of the fact that your spouse, child or parent is on covered active duty or has been notified of an impending call or order to covered active duty with the Armed Forces
- ☐ A serious injury or illness of a covered servicemember where you are the servicemember's spouse, child, parent or next of kin (*Military Caregiver Leave*).

We have reviewed information related to your need for leave under the FMLA along with any supporting documentation provided and decided that your leave request is: *(Select as appropriate)*

☐ **Approved.** (Go to Section III for more information)

☐ **Not Approved.** *(Select as appropriate)*

☐ The FMLA doesn't apply to your leave request.

☐ As of the date the leave is to start, you do not have any FMLA leave available to use.

☐ Other: _____

☐ **Additional information** is needed to determine if your leave request qualifies as FMLA leave. *(Go to Section II for the specific information needed. If your FMLA leave request is approved and no additional information is needed, go to Section III.)*

SECTION II - ADDITIONAL INFORMATION NEEDED

We need additional information to determine whether your leave request qualifies under the FMLA. Once we obtain the additional information requested, we will inform you **within 5 business days** if your leave will or will not be designated as FMLA leave and count towards the amount of FMLA leave you have available. **Failure to provide the additional information as requested may result in a denial of your FMLA leave request.**

If you have any questions, _____ at _____
please contact: Name of Employer Representative Contact Information

Incomplete or Insufficient Certification

The certification you have provided is incomplete and/or insufficient to determine whether the FMLA applies to your leave request. *(Select as applicable)*

- ☐ The certification provided is incomplete and we are unable to determine whether the FMLA applies to your leave request. *"Incomplete" means one or more of the applicable entries on the certification have not been completed.*
- ☐ The certification provided is insufficient to determine whether the FMLA applies to your leave request. *"Insufficient" means the information provided is vague, unclear, ambiguous or non-responsive.*

Specify the information needed to make the certification complete and/or sufficient:

You must provide the requested information no later than *(provide at least seven calendar days)* _____, unless it is not practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied.

Second and Third Opinions

- ☐ We request that you obtain a (☐ second / ☐ third opinion) medical certification at our expense, and we will provide further details at a later time. *Note: The employee or the employee's family member may be requested to authorize the health care provider to release information pertaining only to the serious health condition at issue.*

SECTION III - FMLA LEAVE APPROVED

As explained in Section I, your FMLA leave request is approved. All leave taken for this reason will be designated as FMLA leave and will count against the amount of FMLA leave you have available to use in the applicable 12-month period. The FMLA requires that you notify us as soon as practicable if the 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 the **total amount of FMLA leave** you have available to use in the applicable 12-month period: *(Select as appropriate)*

- ☐ Provided there is no change from your **anticipated FMLA 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 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 all that apply)*

- ☐ **Some or all of your FMLA leave will not be paid.** Any unpaid FMLA leave taken will be designated as FMLA leave and counted against the amount of FMLA leave you have available to use in the applicable 12-month period.
- ☐ **Based on your request, some or all of your available paid leave (e.g., sick, vacation, PTO) will be used during your FMLA leave.** Any paid leave taken for this reason will also be designated as FMLA leave and counted against the amount of FMLA leave you have available to use in the applicable 12-month period.
- ☐ **We are requiring you to use some or all of your available paid leave (e.g., sick, vacation, PTO) during your FMLA leave.** Any paid leave taken for this reason will also be designated as FMLA leave and counted against the amount of FMLA leave you have available to use in the applicable 12-month period.
- ☐ **Other:** _____

(e.g., Short- or long-term disability, workers' compensation, etc.) Any time taken for this reason will also be designated as FMLA leave and counted against the amount of FMLA leave you have available to use in the applicable 12-month period.

Use of State Disability Insurance (SDI)

☐ If you're eligible for state disability insurance (SDI), you may elect to have your sick leave pay supplement your disability plan benefits. Your SDI benefits and sick leave pay will be coordinated so that your SDI/sick leave payments do not exceed your normal rate of pay.

Continued Health Benefits

Under federal family and medical leave, you're eligible for continued health benefits during your FMLA leave for a maximum of twelve (12) weeks.

Your continuation of health benefits will begin on _____ (date). If you currently contribute to the payment of benefits, you must continue to do so while on leave.

Your payment in the amount of _____ is due on or before: _____
(date, e.g. 15th of each month)

Option: The Company's health plan has a grace period for late payments. If your payment is more than _____ days late, your benefits will cease.

Please send the payment to:

Representative

Company Name

Address

City, State and Zip Code

Your medical benefit coverage will end on _____ (date). You may be eligible for continued COBRA coverage.

If your FMLA leave is to care for an ill or injured servicemember, health benefits will continue for a maximum of 26 weeks, after which time you will be eligible for COBRA.

Return to Work Requirements

To be restored to work after taking FMLA leave, you (☐ will be / ☐ will not be) required to provide a certification from your health care provider that you are able to resume work. This request for a return-to-work certification is *only* with regard to the particular serious health condition that caused your need for FMLA leave. **If such certification is not timely received, your return to work may be delayed until the 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 the essential job functions.

Form adapted for California use from U.S. Department of Labor WH-382 June 2020 (OMB Control Number 1235-0003 Expires 6/30/2026).

Employees should retain a copy of this disclosure in their records for three years. DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.