FMLA/CFRA Documentation Checklist - For Employer Use Only

_____
Company Name

_____
Number of employees, full-and/or part-time

_____
Employee Name

If employer has **50 full-and/or part-time employees**, employer is covered by FMLA and CFRA. FMLA/CFRA provides up to twelve weeks of family and medical leave and up to twelve weeks leave for a qualifying exigency relating to a family member's military service. FMLA also provides up to 26 week leave to care for an ill or injured covered service member. Employer should post the applicable federal and state notices available from HRCalifornia.com and also provide the notices to new employees at time of hire. Employer should publish its leave policy in its employee handbooks. Notify employees of the method you use to calculate the 12-month period in which the leave entitlement occurs.

*Use *PDL/FMLA Documentation Checklist* if the leave request involves pregnancy disability leave.

REQUEST FOR LEAVE

Yes	No	Date		
☐	☐	_____		Employee requested FMLA/CFRA. Request can be verbal and need not specifically mention FMLA/CFRA rights as long as it provides notice that the underlying reason for the FMLA/CFRA leave is for a qualifying reason.
☐	☐	_____		Employee's request was 30 days in advance as need for leave was foreseeable, or notice was given as soon as practicable if not foreseeable.
☐	☐	_____		Determine employee eligibility for FMLA/CFRA Leave. Has employee been employed for 12 months and 1,250 hours*? For purposes of FMLA only, does the employee work at a worksite where the employer employs 50 or more employees either at the worksite or within 75 miles? If not, the employee may still be eligible for CFRA leave. **Special hours of service eligibility apply to airline flight crew employees.*

Provide employee with the appropriate forms:

☐	☐	_____	(a)	*Request for Leave of Absence – FMLA/CFRA/PDL* (Optional and based on company policy)
☐	☐	_____	(b)	*CFRA Notice and CFRA/FMLA Designation (50 or More Employees)*: Provide this to employee to give them notice of their rights and obligations under CFRA.
☐	☐	_____	(c)	*FMLA – Notice of Eligibility and Rights and Responsibilities*: Provide to employee within **five business days** of the request for FMLA/CFRA leave. If employee is not eligible, advise employee of the reasons why.
☐	☐	_____	(d)	*Certification of Health Care Provider – Employee's or Family Member's Serious Health Condition*: You must give employee at least **15 calendar days** to respond.
☐	☐	_____	(e)	*Certification for Serious Injury or Illness of a Current Servicemember – for Military Family Leave (Family and Medical Leave Act)*: You must give employee at least **15 calendar days** to respond.
☐	☐	_____	(f)	*Certification for Serious Injury or Illness of a Veteran for Military Caregiver Leave- FMLA Only*: You must give employee at least **15 calendar days** to respond.
☐	☐	_____	(g)	*Certification of Qualifying Exigency for Military Family Leave*: You must give employee at least **15 calendar days** to respond.
☐	☐	_____	(h)	*Notice to Employee as to Change in Relationship*

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☐ ☐ _____ Receive forms from employee and process. Follow up if forms not received.

☐ ☐ _____ Designation of Leave: Use *CFRA Notice and CFRA/FMLA Designation (50 or More Employees)* to notify the employee that the leave is designated and will be counted as either FMLA only, CFRA only, or concurrent FMLA/CFRA leave. Provide this form within five business days of that determination. If more information is needed, you can use this form to inform the employee that additional information is needed. This form may also be used to inform the employee that the leave was denied.

☐ ☐ _____ If extension requested, obtain updated medical documentation from physician/practitioner

☐ ☐ _____ Track FMLA and/or CFRA time used.

☐ ☐ _____ Determine coordination of FMLA and/or CFRA time with any other forms of eligible paid leave (Vacation, Sick, PTO, Other)

Employee received pay for the following:

				# of Hours
☐	☐	_____	Sick leave	_____
☐	☐	_____	Vacation	_____
☐	☐	_____	Other _____	_____

Yes	No	Date	Employee Will:
☐	☐		Accrue seniority.
☐	☐		Participate in health plans.
		_____	If yes, date employee received notice of any payments to be made by employee.
☐	☐		Participate in other employee benefits. If yes, list:

_____

_____

_____

RETURN TO WORK

_____ If leave is for employee's own serious health condition, request employee to provide a *Certification of Health Care Provider for Employee to Return to Work*.

_____ Date employee may return to work.

_____ Employee returned to work within the time allowed by law.

_____ Date employee was reinstated to his/her prior position.