# CITY AND COUNTY OF SAN FRANCISCO

Notice of Determination under the Family and Medical Leave Act (FMLA), California Family Rights Act (CFRA), and Pregnancy Disability Leave Act (PDL)

**FML 3**

**Employee Name: _____ DSW: _____ Dept.: _____**

We have reviewed your Request for Leave and Leave Protections under the FMLA, CFRA and/or PDL and any supporting documentation that you have provided. We received your most recent information on _____ and decide:

## DESIGNATE

**Your leave request is approved on a ☐ Continuous ☐ Intermittent ☐ Reduced Schedule basis. All leave taken for this reason will be designated as (check all that apply):**

**☐ FMLA ☐ CFRA ☐ PDL**

The FMLA and CFRA require that you notify us as soon as practicable if dates of scheduled leave change, are extended, or were initially unknown. Based on the information you have provided to date, we are designating the following regarding 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 will be counted against your leave entitlement: _____ Hours from (date): _____ through _____
- ☐ Because the leave you need will be unscheduled and intermittent, it is not possible to provide the weeks, days, or hours that will be counted against your FMLA/CFRA/PDL leave entitlement at this time. You have the right to request the number of leave hours designated by the City once in a 30-day period (if leave was taken in the 30-day period). Your leave is approved as:
  - Frequency: _____times per (circle): week/month/year
  - Duration: _____ (circle) hours/days per episode/occurrence
  - Flare-ups/Treatment/Care for family member may occur from (date): _____ through:_____

If you are absent more than 5 days because of your own illness or injury, you must provide your supervisor or the Department's Personnel Office with a medical release to return to work. You will be required to present this medical certification to be returned to work. If such certification is not timely received, your return to work may be delayed until such certification is provided.
**IMPORTANT NOTE: You must tell your supervisor each time you take intermittent leave for your approved FMLA/CFRA/PDL qualifying condition, or your leave will not be designated as such.**

## SECOND OPINION

- ☐ We are exercising our right to have you obtain a second opinion by a neutral health care provider at the City's expense. We will provide further details at a later time; however, your leave is conditionally approved.

## USE OF ACCRUED TIME

Please be advised (check if applicable):

- ☐ You have requested to use accrued ☐ SP ☐ VAC ☐ CTO ☐ FH during your FMLA/CFRA/PDL leave. For any FMLA/CFRA/PDL leave taken you will be compensated with your accrued leave.
- ☐ You are required to use accrued ☐ SP ☐ VAC ☐ CTO ☐ FH leave during your unpaid FMLA/CFRA/PDL.

## DELAY

**Additional information is needed to determine if your FMLA/CFRA/PDL leave request can be approved.**

- ☐ The certification you have provided is incomplete or insufficient to determine whether the FMLA/CFRA/PDL applies to your leave request. You must provide the following information no later than_____ (at least 7 days from the current date), unless it is not practicable under the particular circumstances, despite your diligent good faith efforts, or your leave may be denied: (Specify information needed to make the certification complete and sufficient)

_____

_____

## DENY

Your FMLA, CFRA, PDL leave request is not approved for the following reason(s):

- ☐ FMLA/CFRA/PDL (circle one or more) does not apply to your leave request.
- ☐ Unable to verify serious health condition or medical necessity for leave requested under FMLA/CFRA/PDL.

Department Representative: _____ Signature _____ Date _____

Delivered Via: ☐ Regular Mail ☐ Certified Mail ☐ Email ☐ Hand Delivery cc: Leave/Medical File