City and County of San Francisco
Micki Callahan
Human Resources Director

Department of Human Resources
Connecting People with Purpose
www.sfdhr.org

CITY AND COUNTY OF SAN FRANCISCO

FML4: Leave Expiration Notice

Employee Name: _____ **DSW:** _____ **Phone:** _____

Address: _____ **Email:** _____

Dept.: _____ **Classification:** _____ **Title:** _____

According to our records, your: ☐ **FML** ☐ **CFRA** ☐ **PDL** is scheduled to end on (date) _____.

As of the scheduled end date, your unused leave balances (in hours) will be as follows:

_____ FMLA Hours _____ CFRA Hours _____ PDL Hours

If you need to request an extension of your FMLA, CFRA or PDL Leave, you must complete another Request for Leave and Leave Protections form and submit it to our Department's Personnel Office at least two (2) business days prior to the end of your scheduled leave. Failure to do so could delay granting the leave extension.

You must also submit a new Certification of Health Care Provider *(FML 2)* form, if required. This form must be submitted to our Department's Personnel Office within fifteen (15) calendar days of your receipt of this correspondence. While you may be eligible to extend your leave, if the Certificate of Health Care Provider form fails to confirm that the extension is for an FMLA/CFRA/PDL qualifying reason, the City will not continue designating your leave as FMLA/CFRA/PDL protected. Similarly, if you fail to submit the Certification, and cannot provide a reasonable explanation for the delay, the City may not designate your leave as FMLA/CFRA/PDL protected.

If you are returning to work at the end of your leave of five (5) days or more, and the leave was due to your own serious health condition, 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 the certification is provided.

If you have any questions, please contact your departmental Human Resource office or your Department of Human Resources client services representative at _____.

_____ _____
Preparer Signature Date

_____ _____
Printed Name Telephone Number

Enclosed:
☐ Request for Leave and Leave Protections
☐ Certification of Health Care Provider (DHR FML 2) Return Date: _____

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