Los Angeles Unified School District
Family and Medical Leave Act
California Family Rights Act
Pregnancy Disability Leave Act

DATE: _____

TO: _____ **EMPLOYEE ID #:** _____

FROM: _____

SUBJECT: DESIGNATION NOTICE – FMLA/CFRA/PDL APPROVED

RE: YOUR ABSENCE STARTING _____ **THROUGH** _____

Your current FMLA year is from _____ **to** _____

We have reviewed your request for leave under FMLA/CFRA/PDL and any supporting documentation that you have provided. Your protected leave request is approved. Protected time off entitles you to 1) continue your health insurance as if you were not on leave and 2) return to the same job (or one nearly identical to it).

FMLA/CFRA/PDL requires that you notify us as soon as practicable if dates of scheduled leave change are extended. 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 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 FMLA/CFRA/PDL 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/CFRA/PDL 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).

Reduced Schedule Leave (Part-time or Reduced Schedule Work Hours):

____ Hours per day; _____ Days per week; from _____ through _____

Time off for Medical Appointments or Treatment:

Frequency: _____ Times per: _____ Week(s) / or _____ Month(s)

Duration: _____ Hour(s) / or _____ Day(s) per episode

Intermittent Leave for Flare-ups:

Frequency: _____ Times per: _____ Week(s) / or _____ Month(s)

Duration: _____ Hour(s) / or _____ Day(s) per episode

This letter was delivered via:

- ☐ Hand-Delivered
- ☐ Regular postal mail
- ☐ Email
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