APPROVAL – FMLA/CFRA LEAVE AND RIGHTS AND RESPONSIBILITIES

To: ____

Date: ____

[Company Name] (the Company) has received information which indicates that you are absent for a reason that qualifies under state and federal law as family and medical leave. Effective the date of this notice, we are placing you on family and medical leave. Please note that state and federal family and medical leave run concurrently. You are entitled to up to twelve (12) weeks of family and medical leave in a 12-month period.

You previously have used ________ *(days/hours)* of family and medical leave during the current 12-month period and thus the total remaining family and medical leave available to you is ________ *(days/hours).*

According to the information received, you should be able to return to work on __________ *(date).* If you are unable to return to work at that time, you must contact _______________________ *(name)* at (___) ___-____ *(phone).*

During your family and medical leave, you may take any accrued and unused vacation/PTO hours. You currently have _____ hours available to you. Please advise your supervisor if you wish to use any of your vacation time during your leave.

Company policy __________ *(allows/requires)* use of paid sick leave during family and medical leave. You currently have _____ hours of accrued sick leave. The sick time _____ *(may/will)* be paid out beginning on your first day of absence. If you are eligible for state disability insurance (SDI), your SDI benefits and sick leave pay will be coordinated so that your SDI/sick leave payments to not exceed your normal rate of pay.

Under state and federal family and medical leave, you are eligible for continued health benefits 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, i.e. 15th of each month).*

Please send the payment to:

____
Representative

____
Company Name

____
Address

________________________ ________________ ____________
City State Zip Code

Your medical benefit coverage will end on __________ *(date).* If your FMLA/CFRA leave exceeds twelve (12) weeks, you will be eligible for COBRA and COBRA information will be sent to you at that time.

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Remember that if you are absent because of your own illness or injury, you must provide the Company with a medical release to return to work form or certification from your doctor of continued disability on or before __________ *(day after the prior certification expires)*.

When you return from a family and medical leave you will be reinstated to your previous position or to an equivalent position with equivalent benefits, pay, and terms and conditions of employment. However, you have no greater right to reinstatement than if you had been continuously employed rather than on leave. For example, if while on family and medical leave you would have been laid off had you not gone on leave, or if your job has been eliminated during the leave and there are no equivalent or comparable jobs available, then you would not be entitled to reinstatement. In addition, your use of family and medical leave will not result in the loss of any employment benefit that you earned or were entitled to before using family and medical leave.

Should you fail to return to work at the end of the approved FMLA/CFRA leave, or fail to provide continued medical certification of the need for additional leave (not to exceed twelve(12) weeks), the Company will not guarantee reinstatement to your prior position nor that a job will be available for you upon your return.

If you have any questions about FMLA/CFRA or other benefits, please contact:

Name: ____

Phone: ____

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