Leave Usage Options

Family Medical Leave Act (FMLA)

- To qualify: work 1250 hours in 12 months and a provide doctor's note.
- Quantity: 12 weeks - may be taken continuously or intermittently.
- Can be used for: birth/adoption, care for immediate family member with a serious health condition, or when employee has a serious health condition (in CA, pregnancy doesn't qualify - see PDL below).
- Unpaid leave; benefits continue.

California Family Rights Act (CFRA)

- To qualify: work 1250 hours in 12 months and provide a doctor's note.
- Quantity: 12 weeks - may be taken continuously or intermittently.
- CFRA is used for the same reasons as FMLA (except for pregnancy) and runs concurrently with FMLA.
- Unpaid leave; benefits continue.

Pregnancy Disability Leave (PDL)

- To qualify: must be pregnant and work for an employer who has more than 5 employees.
- Quantity: Up to 4 months (16 weeks) depending on doctor's note; can be taken intermittently.
- Duration of this leave depends on the doctor's note. This could be used prior to or after the birth.
- Employees may use sick, vacation and half-sick leave concurrently with PDL. If all leave is exhausted, time is unpaid; benefits continue.

"NOTICE B"

FAMILY CARE AND MEDICAL LEAVE AND PREGNANCY DISABILITY LEAVE

- Under the California Family Rights Act of 1993 (CFRA), if you have more than 12 months of service with your employer and have worked at least 1,250 hours in the 12-month period before the date you want to begin your leave, you may have a right to an unpaid family care or medical leave (CFRA leave). This leave may be up to 12 workweeks in a 12-month period for the birth, adoption, or foster care placement of your child or for your own serious health condition or that of your child, parent or spouse.

- Even if you are not eligible for CFRA leave, if disabled by pregnancy, childbirth or related medical conditions, you are entitled to take pregnancy disability leave (POL) of up to four months, or the working days in one-third of a year or 17½ weeks, depending on your period(s) of actual disability. Time off needed for prenatal or postnatal care; doctor-ordered bed rest; gestational diabetes; pregnancy-induced hypertension; preeclampsia; childbirth; postpartum depression; loss or end of pregnancy; or recovery from childbirth or loss or end of pregnancy would all be covered by your POL.

- Your employer also has an obligation to reasonably accommodate your medical needs (such as allowing more frequent breaks) and to transfer you to a less strenuous or hazardous position if it is medically advisable because of your pregnancy.

- If you are CFRA-eligible, you have certain rights to take BOTH POL and a separate CFRA leave for reason of the birth of your child. Both leaves guarantee reinstatement to the same or a comparable position at the end of the leave, subject to any defense allowed under the law. If possible, you must provide at least 30 days advance notice for foreseeable events (such as the expected birth of a child or a planned medical treatment for yourself or a family member). For events that are unforeseeable, you must to notify your employer, at least verbally, as soon as you learn of the need for the leave.

- Failure to comply with these notice rules is grounds for, and may result in, deferral of the requested leave until you comply with this notice policy.

- Your employer may require medical certification from your health care provider before allowing you a leave for:

    - your pregnancy;
    - your own serious health condition; or
    - to care for your child, parent, or spouse who has a serious health condition.

- See your employer for a copy of a medical certification form to give to your health care provider to complete.

- When medically necessary, leave may be taken on an intermittent or a reduced work schedule. If you are taking a leave for the birth, adoption or foster care placement of a child, the basic minimum duration of the leave is two weeks and you must conclude the leave within one year of the birth or placement for adoption or foster care.

- Taking a family care or pregnancy disability leave may impact certain of your benefits and your seniority date. Contact your employer for more information regarding your eligibility for a leave and/or the impact of the leave on your seniority and benefits.

This notice is a summary of your rights and obligations under the Fair Employment and Housing Act (FEHA). The FEHA prohibits employers from denying, interfering with, or restraining your exercise of these rights. For more information about your rights and obligations, contact your employer, visit the Department of Fair Employment and Housing's Web site at www.dfeh.ca.gov, or contact the Department at (800) 884-1684. The text of the FEHA and the regulations interpreting it are available on the Department's Web site.

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CERTIFICATION OF HEALTH CARE PROVIDER

For Pregnancy Disability Leave, Transfer and/or Reasonable Accommodation

EMPLOYEE NAME: _____

Please certify that, because of this patient's pregnancy, childbirth, or a related medical condition (including, but not limited to, recovery from pregnancy, childbirth, loss or end of pregnancy, or post-partum depression), this patient needs (check all appropriate category boxes):

☐ TIME OFF FOR MEDICAL APPOINTMENTS

When: _____ Duration: _____

☐ DISABILITY LEAVE *(Because of a patient's pregnancy, childbirth or a related medical condition, patient cannot perform one or more of the essential functions of patient's job or cannot perform any of these functions without undue risk to self, to successful completion of the pregnancy, or to other persons)*

Beginning (Estimate): _____ Ending (Estimate): _____

☐ INTERMITTENT LEAVE

Specify the intermittent leave schedule: _____

Beginning (Estimate): _____ Ending (Estimate): _____

☐ REDUCED WORK SCHEDULE

Specify the reduced work schedule: _____

Beginning (Estimate): _____ Ending (Estimate): _____

☐ TRANSFER/BE ASSIGNED TO A LESS STRENUOUS OR HAZARDOUS POSITION OR DUTIES

Specify the medically advisable position/duties: _____

Beginning (Estimate): _____ Ending (Estimate): _____

☐ REASONABLE ACCOMMODATION(S)

Specify (can include, but is not limited to, modifying lifting requirements, providing more frequent breaks, or providing a stool or chair): _____

Beginning (Estimate): _____ Ending (Estimate): _____

Health Care Provider Name (print): _____

Medical Health Care Specialty: _____ **License Number:** _____

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HEALTH CARE PROVIDER SIGNATURE DATE

Authority Cited: Government Code sections 12935, subd. (a), and 12945
Reference: Government Code sections 12940, 12945; FMLA, 29 U.S.C. §2601, et seq. and FMLA regulations, 29 C.F.R. § 825