**<LETTERHEAD>**

**<DATE>**

**<NAME>**

**<ADDRESS and/or sent via email to xx>**

Dear **<NAME>,**

(Medical Self)

We have received your medical certification dated **<MED. CERT. DATE>**, which indicates a request for medical leave as stated by your doctor: **<DOCTOR’S STATEMENT/TIME OFF NEED>**.Your request for **<continuous> <intermittent> <reduced schedule>** medical leave has been approved under the County Medical Policy from **<START DATE>** to **<END DATE>**.

(Medical Caregiver)

We have received your **<FAMILY MEMBER/DESIGNATED PERSON’S RELATION>** medical certification dated **<MED. CERT. DATE**>, which indicates a request for caregiver leave as stated by their doctor: **<DOCTOR’S STATEMENT/TIME OFF NEED>**. Your request for **<continuous> <intermittent> <reduced schedule>** family medical leave for has been approved under the County Medical Policy from **<START DATE>** to **<END DATE>**.

(Intermittent/Reduced Schedule)

Your FMLA/CFRA leave hours will be tracked to help you use this benefit. Please let your supervisor and Department payroll clerk know when your absence is related to medical leave, so it can be recorded as FMLA/CFRA in your timecard.

If your return date changes, please provide an updated medical note as soon as reasonably possible, but in advance of **<scheduled return date>**.

(Subsequent notices)

We received notice of extension(s) to your leave on **<date>,** and **<date>**. Your request for **<regular, intermittent, reduced schedule>** medical leave has been approved from **<start date>** to **<end date>**. (Delete if not applicable)

(Remove for extensions of initial leave)

I’ve included a Notification of your Rights and Responsibilities under the Family Medical Leave Act (FMLA) and the California Family Rights Act (CFRA), as applicable. This document explains your eligibility and designates your leave as FMLA and/or CFRA.

FMLA and/or CFRA provides up to 12 weeks (usually 480 hours for a full-time employee) of unpaid job protected leave. These protections run concurrently if both apply. Your leave qualifies for **<both FMLA and CFRA or FMLA or CFRA>**.

In the last 12 months you **<HAVE/HAVE NOT>** used FMLA/CFRA. Your available CFRA hours are **<INSERT BAL>**, your available FMLA hours are **<INSERT BAL>** as of **<PPE DATE>**. Your estimated leave use for this period is **<INSERT ESTIMATED HOURS>.**

While you’re on leave, your available sick hours will be used as outlined in: **<INSERT LINK TO MOU>**

To continue your health benefits during leave, you will need to make payments for your share of health insurance premiums. You may need to repay the County for premiums paid on your behalf during your leave. Please contact **<Dept. Payroll Clerk>** at **<(707)565-xxxx>,** or HR Benefits at 707-565-2900 or Benefits@sonoma-county.orgfor more details. Additional information can be found in the “Notification of Federal and/or State Leave Entitlements” document, the medical leave policy, and applicable MOU or Salary Resolution.

If you have questions or your return date changes, please contact me at <**(707)565-xxxx>,** or **<Analyst Name**>, Disability Management Analyst at **<(707)565-xxxx>**.

You can find more information and copies of relevant policies at:

<https://sonomacounty.ca.gov/HR/Disability-Management/Policies/>

Sincerely,

**<Dept Designee>**

Enclosed: (update as needed) Notification of Rights & Responsibilities/Designation, LOA Form, Medical Leave Checklist

 Cc: **<DM Analyst Name>**, Disability Management Analyst

 Confidential Medical File