PREGNANCY DISABILITY LEAVE (PDL) - EMPLOYEE NOTICE

Employee Name: _____

Date: _____

We have reviewed your request for leave due to your pregnancy and any supporting documentation that you have provided. We received your most recent information on _____ (date) and determined (check one):

☐ Your Pregnancy Disability Leave (PDL) will run concurrently with FMLA. Please see the attached **FMLA/PDL Designation Notice** and **FMLA/CFRA Rights and Responsibilities** notifications for information regarding your leave.

☐ You are eligible for PDL, but not eligible for FMLA. Please see the information regarding PDL below.

You have informed us that you will be disabled because of pregnancy as of _____ (date) and an expected return to work date of _____.

If you are disabled because of pregnancy, childbirth or other related medication condition, you are eligible for up to four months of leave per pregnancy, not per year. A "four month leave" means time off for the number of days or hours you would normally work within four calendar months (one-third of a year or 17 1/3 weeks). For a full time employee who works 40 hours per week, “four months” means 693 hours of leave entitlement, based on 40 hours per week times 17 1/3 weeks. You are required to provide notification from your health care provider prior to your leave beginning and prior to your return to work. Your total available time off under PDL is based on your hours worked per week and is as follows:

# of hours worked per week	# of hours of Pregnancy Disability Leave
12	208
20	346.5
28	485
32	554.5
40	693
48	832

☐ We received notification from your doctor on _____ (date) of your need for PDL.

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_☐_ We have not received notification from your doctor regarding your need for PDL. Please provide this notification no later than _____ (date).

You previously have used _____ *(days/hours)* of pregnancy disability leave. Thus, the total remaining pregnancy disability leave available to you is _____ *(days/hours).*

During your pregnancy disability leave, you may use any accrued and unused vacation/PTO or sick leave hours. You currently have _____ hours of vacation/PTO available to you. You currently have _____ hours of paid sick leave available to you.

Please advise your supervisor if you wish to use any of your accrued time during your pregnancy disability leave.

Under state law, you are eligible for continued health benefits for the duration of your pregnancy disability leave. Your continuation of health benefits began on _____ *(date).* You have _____ *(time)* remaining. 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

If your pregnancy disability leave exceeds four months, or 17 1/3 weeks, you will be eligible for COBRA and COBRA information will be sent to you at that time.

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 the prior certification expires)*. When you are released to return to work you must give advance notice (48 hours minimum) by contacting:

Name:_____Phone: _____

Email:_____

Under most circumstances, upon submission of a medical certification that you are able to return to work from a pregnancy disability leave, you will be reinstated to the same position you held at the time the leave began or to an equivalent position, if available. However, when you return from a pregnancy disability leave you have no greater right to reinstatement than if you had been continuously employed rather than on leave. For example, if

while on pregnancy disability leave you would have been laid off had you not gone on leave, then you would not be entitled to reinstatement.

If you have any questions about pregnancy disability leave or other benefits, please contact:

Name:_____Phone: _____

Email_____

For the duration of leave, please provide details below regarding your preferred form of contact.

_____
Email Address

_____
Phone Number for Voice calls

_____
Phone Number for Texting

_____
Address

_____ _____-____
City State Zip