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1970 - 2012

"Staying Within the Lines . . . Making Your Employee Handbook Work for You."

- What policies are required by state and federal law;
- Leave of absence policies in compliance with state and federal law;
- The NLRB attack on employee handbook policies that violate the NLRA.

July, 2014

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Certification Institute.*

"The use of this seal is not an endorsement by the HR Certification Institute of the quality of the program. It means that this program has met the HR Certification Institute's criteria to be pre-approved for recertification credit."

The attached material must not be considered legal advice. The sample forms and policies are for educational purposes only. We strongly recommend that you consult with legal counsel before adopting or implementing any of the attached sample forms and policies so as to avoid potential liability.

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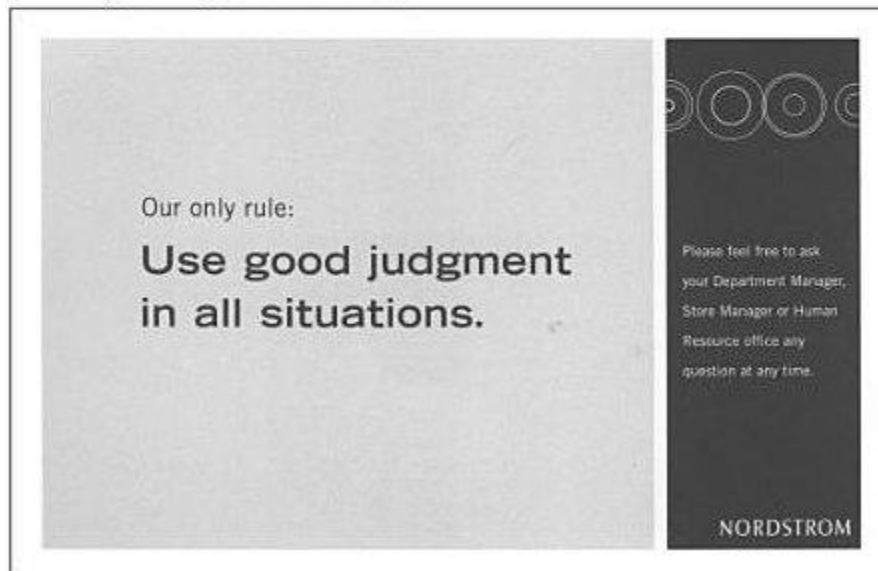
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SHORTEST EMPLOYEE HANDBOOK:

Take example of Nordstrom, the 200+ location department store chain. For years, their Employee Handbook was a single 5-by-8-inch grey card with just 75 words:



(Turning over the card)



Nordstrom's Employee Handbook

"Welcome to Nordstrom

We're glad to have you with our Company. Our number one goal is to provide outstanding customer service. Set both your personal and professional goals high. We have great confidence in your ability to achieve them.

Nordstrom Rules: Rule #1: Use best judgment in all situations. There will be no additional rules.

Please feel free to ask your department manager, store manager, or division general manager any question at any time."

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Introduction to the Company's Employee Handbook

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EMPLOYEE STATEMENT

1. I acknowledge receipt of my copy of the Company Employee Handbook. I have read and understand its contents, including the Company policies and rules governing my conduct, wages and working conditions as an employee. I have had the opportunity to ask questions about the Company's policies and rules. I agree to abide by these policies and rules during my employment and understand the consequences if I do not.

2. I understand that this Employee Handbook, and the Company's policies, rules and benefits may be changed at any time at the sole discretion of the President. I further understand that my employment is "at will", that either I or the Company may terminate the employment relationship at any time, that I may be disciplined, including demoted any time, at the discretion of the Company, and that the Employee Handbook is not a contract of employment. I further acknowledge that there are no express or implied agreements which contradict this provision of at-will employment, that the only person empowered to modify or alter this provision of at-will employment is the Company President, and that any agreement to modify the at-will status of my employment must be in writing and fully executed by the President and myself. I further understand that this acknowledgment supersedes all previous agreements, written or oral.

3. I will observe strict secrecy as to the accounts of all customers and as to all the transactions of the Company of whatever description with its customers, Company employees and officers or stockholders and I will not divulge any of said matters, nor the status of any of said accounts, nor the number of shares held by any person or persons, nor the nature of any interest that any person or customer may have in the affairs of the Company and I will not divulge any of the credit information of any person, company or corporation which I may acquire as an employee or use any information of whatsoever kind or character which I may receive as an employee for any purpose other than for the advancement of the interests of the Company and I will at no time divulge any such information to any person not entitled thereto.

4. I further promise that I will honestly and faithfully conduct myself, and duly and diligently perform all the duties assigned to me while in the employ of the Company, and I will truly and faithfully account for and deliver to the Company all moneys, securities and other property belonging to the Company which I may receive for, from or on account of the Company, and that upon termination of my employment, I will at once deliver to the Company, all books, documents, money, securities or other property belonging to the Company or for which the Company is liable to others, which shall be, or which ought to be, in my charge of custody, and I will in all other respects honestly and faithfully perform all my duties as an employee of the Company.

5. I shall be bound by all the rules and regulations of the Company now in force, and by all such other rules and regulations as may be hereinafter called to my notice and I will faithfully observe and abide by the same.

6. I agree that while employed by the Company, I will accept no other employment, either full or part-time, for compensation without prior written consent of the Company.

Dated: _____

Employee's Signature

Please return the Employee Statement when you have completed reading this booklet.

EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- for incapacity due to pregnancy, prenatal medical care or child birth;
- to care for the employee's child after birth, or placement for adoption or foster care;
- to care for the employee's spouse, son, daughter or parent, who has a serious health condition; or
- for a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness*; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness.*

***The FMLA definitions of "serious injury or illness" for current servicemembers and veterans are distinct from the FMLA definition of "serious health condition".**

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months*, and if at least 50 employees are employed by the employer within 75 miles.

***Special hours of service eligibility requirements apply to airline flight crew employees.**

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and

a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- interfere with, restrain, or deny the exercise of any right provided under FMLA; and
- discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulation 29 C.F.R. § 825.300(a) may require additional disclosures.



For additional information:
1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627
WWW.WAGEHOUR.DOL.GOV

U.S. Department of Labor | Wage and Hour Division



WHD Publication 1420 · Revised February 2013



It is unlawful for an employer to discriminate in terms of compensation, conditions, or privileges of employment because of pregnancy.



If a voluntary settlement cannot be reached, and there is sufficient evidence to establish a violation of the law, DFEH may issue an accusation and litigate the case before the Fair Employment and Housing Commission or in civil court. If the Commission or court decides in favor of the complaining party, remedies may include reinstatement, back pay, reasonable attorney's fees, damages for emotional distress, and administrative fines.

For more information, call toll free at
(800) 884-1684
Sacramento area & out-of-state at
(916) 478-7200
TTY number at (800) 700-2320
or visit our Web site at www.dfeh.ca.gov

In accordance with the California Government Code and ADA requirements, this publication can be made available in Braille, large print, computer disk, or tape cassette as a reasonable accommodation for an individual with a disability.

To request a copy of this publication in an alternative format, please contact DFEH at the numbers above.



State of California
Department of Fair Employment & Housing

DFEH-186 (07-07)

Pregnancy Leave

The Fair Employment and Housing Act (FEHA) contains provisions relating to pregnancy leave. These provisions cover all employers with five or more employees. It is unlawful for an employer to discriminate in terms of compensation, conditions, or privileges of employment because of pregnancy. In addition, there are certain leave and transfer protections and guarantees provided under the FEHA and the *California Family Rights Act (CFRA)*.

All employers must provide information about pregnancy leave rights to their employees and post this information in a conspicuous place where employees tend to gather. Employers who provide employee handbooks must include information about pregnancy leave in the handbook.

Leave Requirements

- An employee disabled by pregnancy is entitled to up to four months disability leave. If the employer provides more than four months of leave for other types of temporary disabilities, the same leave must be made available to women who are disabled due to pregnancy, childbirth, or a related medical condition.
- Leave can be taken before or after birth during any period of time the woman is physically unable to work because of pregnancy or a pregnancy-related condition. All leave



The mission of the Department of Fair Employment and Housing is to protect the people of California from unlawful discrimination in employment, housing and public accommodations, and from the perpetration of acts of hate violence.

taken in connection with a specific pregnancy counts toward computing the four-month period.

- Pregnancy leave is available when a woman is actually disabled. This includes time off needed for prenatal care, severe morning sickness, doctor-ordered bed rest, childbirth, recovery from childbirth, or any related medical condition.

- If an employee is disabled as the result of a condition related to pregnancy, childbirth, or associated medical conditions and requests reasonable accommodation upon the advice of her health-care provider, an employer must provide reasonable accommodation.

- As an accommodation, and with the advice of her physician, an employee can request transfer to a less strenuous or hazardous position for the duration of her pregnancy.

- Employees are entitled to take pregnancy disability leave in addition to any leave entitlement they might have under CFRA. For example, an employee could take four months pregnancy disability leave for her disability, and 12 weeks CFRA leave to bond with the baby; to bond with an adopted child; or to care for a parent, spouse, or child with a serious health condition. CFRA leave may also be taken for the employee's own serious health condition. For more information, see DFEH-188 "California Family Rights Act."

- If possible, an employee must provide her employer with at least 30 days advance notice of the date for which the pregnancy disability leave is sought or transfer begins and the estimated duration of the leave.

- If 30 days advance notice is not possible due to a change in circumstances or a medical emergency, notice must be given as soon as practical. The leave may be modified as a woman's changing medical condition dictates. If a woman desires to return earlier than agreed, an employer must reinstate her within two business days of her notice.

Salary and Benefits During Leave

- Employers who provide health insurance coverage for employees who take leave for non-pregnancy-related, temporary disabilities must provide coverage for employees who take leave for pregnancy, childbirth or related medical conditions.
- An employer may require an employee to use her accrued sick leave during any unpaid portion of her pregnancy disability leave. The employee may also use vacation leave credits to receive compensation during an otherwise unpaid portion of her pregnancy disability leave. An employer may not require an employee to use vacation leave or other accrued time off during pregnancy disability leave.

Return Rights

- After a pregnancy disability leave or transfer, employees are guaranteed a return to the same position and can

request the guarantee in writing.

- If her same position is no longer available, such as in a layoff due to plant closure, the employer must offer a position that is comparable in terms of pay, location, job content, and promotional opportunities, unless the employer can prove that no comparable position exists.

Filing a Complaint

If you believe you are a victim of illegal discrimination, you can explore filing a complaint with the Department of Fair Employment and Housing (DFEH) by following these steps:

- Contact DFEH by calling the toll-free number at (800) 884-1684 to schedule an appointment or use our online appointment system at www.dfeh.ca.gov
- Be prepared to present specific facts about the alleged discrimination or denial of leave.
- Keep records and provide copies of documents that support the charges in the complaint, such as paycheck stubs, calendars, correspondence and other potential proof of discrimination.

Complaints must be filed within **one year** of the last act of discrimination.

DFEH will conduct an impartial investigation. We are not an advocate for either the person complaining or the person complained against. We represent the State of California. DFEH will, if possible, try to assist both parties to resolve the complaint.

**"NOTICE A"****YOUR RIGHTS AND OBLIGATIONS AS A PREGNANT EMPLOYEE**

If you are pregnant, have a related medical condition, or are recovering from childbirth, **PLEASE READ THIS NOTICE.**

- California law protects employees against discrimination or harassment because of an employee's pregnancy, childbirth or any related medical condition (referred to below as "because of pregnancy"). California also law prohibits employers from denying or interfering with an employee's pregnancy-related employment rights.
- Your employer has an obligation to:
 - reasonably accommodate your medical needs related to pregnancy, childbirth or related conditions (such as temporarily modifying your work duties, providing you with a stool or chair, or allowing more frequent breaks);
 - transfer you to a less strenuous or hazardous position (where one is available) or duties if medically needed because of your pregnancy; and
 - provide you with pregnancy disability leave (PDL) of up to four months (the working days you normally would work in one-third of a year or 17 $\frac{1}{3}$ weeks) and return you to your same job when you are no longer disabled by your pregnancy or, in certain instances, to a comparable job. Taking PDL, however, does not protect you from nonleave related employment actions, such as a layoff.
 - provide a reasonable amount of break time and use of a room or other location in close proximity to the employee's work area to express breast milk in private as set forth in Labor Code section 1030, et seq.
- For pregnancy disability leave:
 - PDL is not for an automatic period of time, but for the period of time that you are disabled by pregnancy. Your health care provider determines how much time you will need.
 - Once your employer has been informed that you need to take PDL, your employer must guarantee in writing that you can return to work in your same position if you request a written guarantee. Your employer may require you to submit written medical certification from your health care provider substantiating the need for your leave.
 - PDL may include, but is not limited to, additional or more frequent breaks, time for prenatal or postnatal medical appointments, doctor-ordered bed rest, "severe morning sickness," gestational diabetes, pregnancy-induced hypertension, preeclampsia, recovery from childbirth or loss or end of pregnancy, and/or post-partum depression.

Notice A
YOUR RIGHTS AND OBLIGATIONS AS A PREGNANT EMPLOYEE
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- PDL does not need to be taken all at once but can be taken on an as-needed basis as required by your health care provider, including intermittent leave or a reduced work schedule, all of which counts against your four month entitlement to leave.
- Your leave will be paid or unpaid depending on your employer's policy for other medical leaves. You may also be eligible for state disability insurance or Paid Family Leave (PFL), administered by the California Employment Development Department.
- At your discretion, you can use any vacation or other paid time off during your PDL.
- Your employer may require or you may choose to use any available sick leave during your PDL.
- Your employer is required to continue your group health coverage during your PDL at the level and under the conditions that coverage would have been provided if you had continued in employment continuously for the duration of your leave.
- Taking PDL may impact certain of your benefits and your seniority date; please contact your employer for details.

Notice obligations as an Employee:

- Give your employer reasonable notice: To receive reasonable accommodation, obtain a transfer, or take PDL, you must give your employer sufficient notice for your employer to make appropriate plans – 30 days advance notice if the need for the reasonable accommodation, transfer or PDL is foreseeable, otherwise as soon as practicable if the need is an emergency or unforeseeable.
- Provide a Written Medical Certification from Your Health Care Provider. Except in a medical emergency where there is no time to obtain it, your employer may require you to supply a written medical certification from your health care provider of the medical need for your reasonable accommodation, transfer or PDL. If the need is an emergency or unforeseeable, you must provide this certification within the time frame your employer requests, unless it is not practicable for you to do so under the circumstances despite your diligent, good faith efforts. Your employer must provide at least 15 calendar days for you to submit the certification. See your employer for a copy of a medical certification form to give to your health care provider to complete.
- PLEASE NOTE that if you fail to give your employer reasonable advance notice or, if your employer requires it, written medical certification of your medical need, your employer may be justified in delaying your reasonable accommodation, transfer, or PDL.

This notice is a summary of your rights and obligations under the Fair Employment and Housing Act (FEHA). For more information about your rights and obligations as a pregnant employee, 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.

###



Fast facts about Paid Family Leave

- Provides benefits but does not provide job protection or return rights.
- Provides eligible workers partial wage replacement when taking time off work to care for a parent, child, spouse, registered domestic partner or to bond with a new child.
- Covers employees who are covered by SDI (or a voluntary plan in lieu of SDI).
- Offers up to 6 weeks of benefits in a 12-month period.
- Provides benefits of approximately 55 percent of lost wages.
- Paid Family Leave benefits are considered taxable income.

In California, it's the law. **Paid Family Leave** Benefits

The time to care. 1-877-238-4373

To apply online or for more information, visit:

www.edd.ca.gov/disability

1-877-238-4373 (English)
1-877-379-3819 (Español)
1-866-692-5595 (Cantonese)
1-866-692-5596 (Vietnamese)
1-866-627-1567 (Armenian)
1-866-627-1568 (Punjabi)
1-866-627-1569 (Tagalog)
1-800-445-1312 (TTY)

EDD is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. Requests for services, aids, and/or alternate formats need to be made by calling 1-877-238-4373 (voice), or TTY 1-800-445-1312.

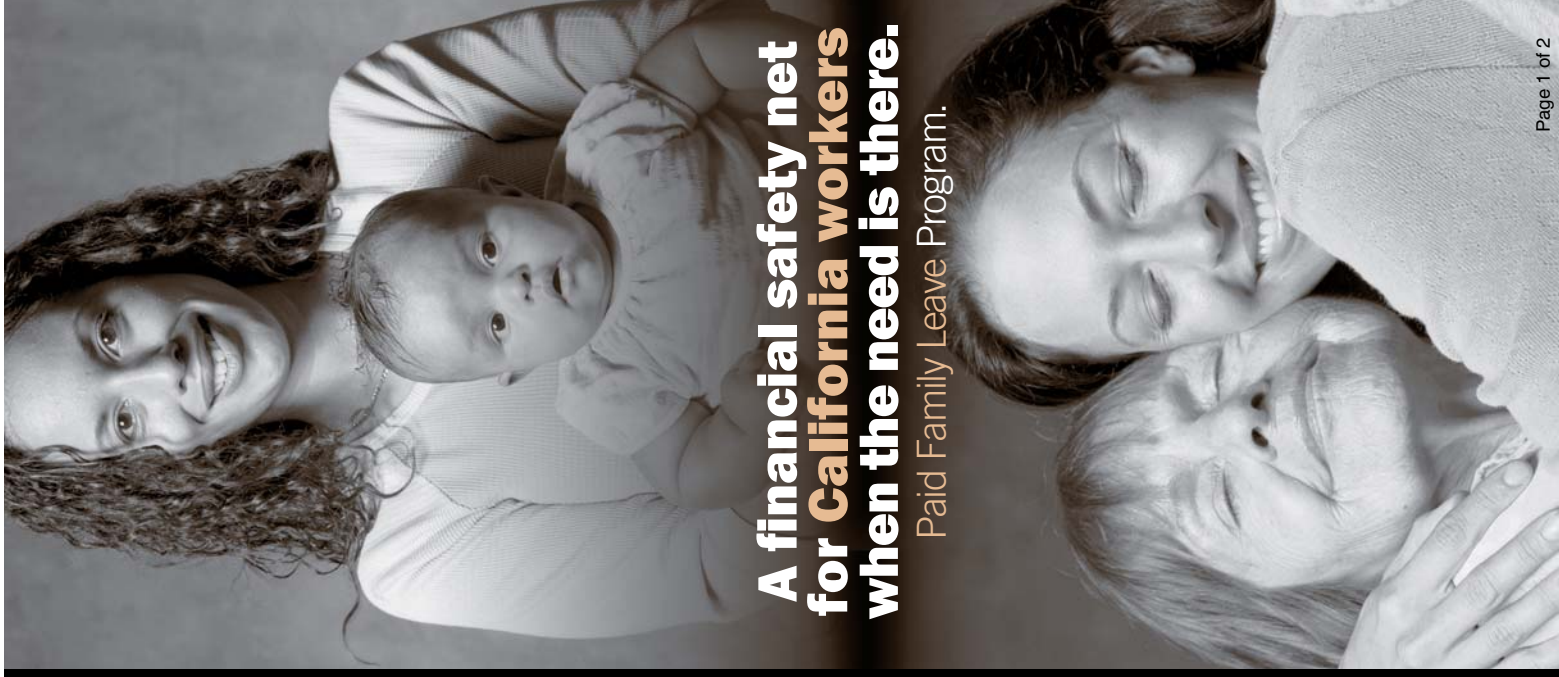
This pamphlet is for general information only and does not have the force and effect of law, rule or regulation.

State of California



**A financial safety net
for California workers
when the need is there.**

Paid Family Leave Program.



Paid Family Leave benefits for California workers

There may be times in the life of a working person when they need to care for a loved one. Whether it's a working parent bonding with a newborn, or an employee caring for a seriously ill parent, child, spouse, or registered domestic partner, California's Paid Family Leave program was created for these times (**Note:** Registered domestic partners must meet requirements and register with the California Secretary of State to be eligible for benefits).



A program benefiting you and your family

California leads the nation as the first state to make it easier for employees to balance the demands of the workplace and family care needs at home. Paid Family Leave (PFL) benefits are based on the claimant's (care provider's) past quarterly earnings. For more information regarding maximum benefit amounts paid, view the link to the *Disability Insurance (DI) & Paid Family Leave (PFL) Weekly Benefit Amounts in Dollar Increments* form, DE 2589 at www.edd.ca.gov/disability.

Paid Family Leave for California employees

Paid Family Leave benefits do not provide job protection or return rights. Job protection **may** be provided if your employer is subject to the federal Family Medical Leave Act and the California Family Rights Act. Notify your employer of the reason for taking leave in a manner consistent with your company's leave policy.

To qualify for Paid Family Leave benefits, you must meet the following requirements:

- Be covered by State Disability Insurance (SDI) (or a voluntary plan in lieu of SDI) and have earned at least \$300 in your base period from which deductions were withheld.
- Supply medical information supporting your claim that the care recipient has a serious health condition and requires your care.
- Submit your claim no earlier than 9 days, but no later than 49 days after the first day your family care leave began.
- Provide documentation to support a claim for bonding with a new biological, adopted, or foster child.
- Use up to two weeks of any earned but unused vacation leave or paid time off (PTO) if required by your employer prior to the initial receipt of benefits.
- Serve a 7-day unpaid waiting period before benefits begin for each different care recipient within the 12-month period.

You may not be eligible for benefits if:

- You are receiving Disability Insurance, Unemployment Insurance, or Workers' Compensation benefits.
- You are not working or looking for work at the time you begin your family care leave.
- You are not suffering a loss of wages.
- The need for care is not supported by the certificate of a treating physician or practitioner.
- You are in custody due to conviction of a crime.

You are entitled to:

- Know the reason and basis for decision affecting your benefits.
- Appeal decisions about your eligibility for benefits (Appeals must be sent to Paid Family Leave in writing.)

(INTERNET)



- A hearing of your appeal before an Administrative Law Judge (ALJ). Decisions may be further appealed to the California Unemployment Insurance Appeals Board and the courts.
- Privacy — Information about your claim will be kept confidential except for the purposes allowed by law.

Apply for benefits

Apply for Paid Family Leave benefits online at www.edd.ca.gov/disability. Employers and physicians/practitioners can submit claim information through SDI Online. You may also file a paper form. To request a claim form visit www.edd.ca.gov/disability.

If you are currently receiving SDI pregnancy-related benefits, it is not necessary to request a PFL claim form. PFL claim filing information will be sent through your SDI Online account or via mail when your pregnancy-related disability claim ends.

Contact Paid Family Leave

For questions about Paid Family Leave benefits, please visit www.edd.ca.gov/Disability/Paid_Family_Leave.htm.

1-877-238-4373 (English) **1-877-379-3819 (Español)**
1-866-692-5595 (Cantonese) **1-866-692-5596 (Vietnamese)**
1-866-627-1567 (Armenian) **1-866-627-1568 (Punjabi)**
1-866-627-1569 (Tagalog) **1-800-445-1312 (TTY)**

For more information, visit: www.edd.ca.gov/disability
 Claim forms should be mailed to Paid Family Leave at:
 P.O. Box 997017, Sacramento, CA 95799-7017

**“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 (PDL) 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 PDL.
- 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 PDL 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.

NOTICE B

FAMILY CARE AND MEDICAL LEAVE AND PREGNANCY DISABILITY LEAVE

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- 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.

###

REQUEST FOR LEAVE OF ABSENCE

Employee's Name: _____

Date of Request: _____

Employee's Position: _____

Department: _____

Date Leave is to Begin: _____

Date of Hire: _____

Anticipated Date of Return: _____

I request a leave of absence for the following reason:

☐ Personal ☐ Military ☐ Medical ☐ Jury Duty

☐ Pregnancy Disability ☐ Family Care (See attached pages)

☐ Other (Please explain): _____

BENEFITS

I have ☐ days of accrued vacation. I request to use this accrued time at the start of my leave. Any remaining time off will be unpaid.

I have ☐ days of accrued sick time. I request to use this accrued time at the start of my leave. Any remaining time off will be unpaid.

Medical insurance premiums will be paid by the Company through _____ for continuation of coverage under the same terms and conditions as if I were working full-time; after, I understand that I must pay one hundred percent (100%) of the premiums for continuation of coverage.

I understand that I am bound by the personnel policies governing leaves of absence as set forth in the Employee Handbook for the type of leave I have requested.

I understand that in order to maintain my leave status, I must notify my immediate supervisor on a regular basis as outlined in the Employee Handbook concerning the continuing status of my leave of absence and my anticipated date of return.

I also understand that:

- (1) I must notify the Company of my intent to return to work within 2 weeks of my anticipated date of return;
- (2) I must not accept outside employment without the Company's prior approval; and
- (3) I may be terminated if I have falsified the purpose of the leave.

REQUEST FOR LEAVE OF ABSENCE**Page 2**

Attached is my certification (physician placing me on disability leave, jury summons, military notice, etc.) verifying my need for the leave of absence. I understand that I must submit a physician's release to return to work upon the conclusion of my disability and upon the expiration of my leave of absence.

I understand that the granting of this leave is within the discretion of management unless otherwise provided by law. I also understand that extensions of this leave are at the sole discretion of management. I further understand that my reinstatement is governed by the leave of absence policy set forth in the Employee Handbook.

DATE: _____

By: _____
Employee Signature

☐ Approved ☐ Denied (If denied, see attached.)

DATE: _____

By: _____
Supervisor

DATE: _____

By: _____
Administrator

☐ Received physician's certification.

REQUEST FOR FAMILY AND MEDICAL CARE LEAVE OF ABSENCE

A. PURPOSE OF LEAVE:

☐ Self (Go directly to B)

☐ Spouse ☐ Registered Domestic Partner ☐ Child ☐ Parent
(If Spouse, Registered Domestic Partner, Child or Parent is marked, go directly to C)

☐ Newborn/Adopted Child (Go to D)

B.

- (1) Due to my own serious health condition¹, I am unable to work at all, or to perform any one or more of the essential functions of my position. (See definition of "Serious Health Condition" below).
- (2) Attached is the physician's certification stating (a) the date of the serious health condition commenced, (b) the probable duration of the condition, and (c) a statement that, due to my serious health condition, I am unable to work at all or I am unable to perform any one or more of the essential functions of the position.
- (3) Go to E.

C.

- (1) The Serious Health Condition of my spouse, registered domestic partner, parent, or child (designated above) warrants my participation to provide care during a period of treatment or supervision of the spouse, registered domestic partner, parent, or child.
- (2) Attached is the physician's certification stating (a) the date the serious health condition commenced, (b) the probable duration of the condition, (c) an estimate of the amount of time I will be needed to care for my family member, and (d) a statement that I am needed to care for my family member or that I must participate in the care and supervision of treatment of my family member.
- (3) Go to E.

¹ "Serious Health Condition" means an illness, injury, impairment, or physical or mental condition of the employee or a child, parent or spouse or registered domestic partner of the employee which involves either:

- (1) Inpatient care in a hospital, hospice, or residential health care facility, or
- (2) Continuing treatment or continuing supervision by a health care provider, as detailed in FMLA and its implementing regulations.

**REQUEST FOR FAMILY AND MEDICAL CARE
LEAVE OF ABSENCE**

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D.

- [] (1) The leave is requested in connection with the birth of my child or the placement of an adopted child or foster child.
- [] (2) Date of birth, adoption, or foster placement: _____
- (3) Go to E.

E.

- (1) If Family Care Leave is to be taken in conjunction with Pregnancy Disability Leave of Absence:

Date Pregnancy Disability Leave is to begin: _____

Date Pregnancy Disability Leave is to conclude: _____

Date Family Care Leave is to begin: _____

Date Family Care Leave is to conclude: _____

DATE: _____

By: _____
Signature of Employee

ATTENDING PHYSICIAN'S CERTIFICATE

To Accompany Request for Family Care Leave
For the *Employee's* Own Serious Health Condition

EMPLOYEE INFORMATION (to be completed by Employee):

Name: _____

Address: _____

I give my permission for this information concerning my medical condition to be provided to the employer from whom I am requesting a Family Care Leave.

DATE: _____

By: _____
Patient's Signature

PHYSICIAN INFORMATION (to be completed by Physician):

Name: _____

Address: _____

-
- ☐ I hold a physician's or surgeon's certificate issued pursuant to Article 4 of Chapter 5 of Division 2 of the Business and Professions Code.
- ☐ I hold an osteopathic physician's or surgeon's certificate issued pursuant to Article 4 of Chapter 5 of Division 2 of the Business and Professions Code.
- Note that one of the above certifications is required.

INFORMATION CONCERNING PATIENT CONDITION/STATUS

(to be completed by Physician):

Date on which the serious health condition commenced: _____

Probable duration of condition: _____

ATTENDING PHYSICIAN'S CERTIFICATE

To Accompany Request for Family Care Leave For the
Employee's Own Serious Health Condition

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Please answer the following question only if the employee is asking for intermittent leave or a reduced work schedule:

Yes No

☐ ☐ Is it medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal work schedule in order to deal with the serious health condition of the employee or family member?

If the answer is "yes," please indicate the estimated number of doctor's visits, and/or estimated duration of medical treatment, either by the health care practitioner or another provider of health services, upon referral from the health care provider: _____

► [NOTE] **THE HEALTH CARE PROVIDER IS NOT TO DISCLOSE THE UNDERLYING DIAGNOSIS WITHOUT THE CONSENT OF THE PATIENT.**

I hereby certify that due to the Employee's serious health condition², the Employee is unable to work at all or is unable to perform any one or more of the essential functions of his or her position.

DATE: _____

By: _____
Physician's Signature

² "Serious Health Condition" means an illness, injury, impairment, or physical or mental condition of the employee or a child, parent, spouse or registered domestic partner of the employee which involves either:

- (1) Inpatient care in a hospital, hospice, or residential health care facility, or
- (2) Continuing treatment or continuing supervision by a health care provider, as detailed in FMLA and its implementing regulations.

Please see the attached sheet for a further description of "Serious Health Condition."

ATTENDING PHYSICIAN'S CERTIFICATE
To Accompany Request for Family Care Leave To Care for the
Serious Health Condition of a *Spouse, Registered Domestic Partner, Child, or Parent*

EMPLOYEE INFORMATION (to be completed by Employee):

Name: _____

Address: _____

PATIENT INFORMATION (to be completed by Employee):

Name: _____

Address: _____

Relationship to employee: ☐ Parent ☐ Registered Domestic Partner

☐ Spouse ☐ Child

I give my permission for this information concerning my medical condition to be provided to the employer for whom my relative is requesting a Family Care Leave.

DATE: _____

By: _____
Patient's Signature (Or Guardian's signature if patient
is a minor)

PHYSICIAN'S INFORMATION (to be completed by Physician):

Name: _____

Address: _____

☐ I hold a physician's or surgeon's certificate issued pursuant to Article 4 of Chapter 5 of Division 2 of the Business and Professions Code.

☐ I hold an osteopathic physician's or surgeon's certificate issued pursuant to Article 4 of Chapter 5 of Division 2 of the Business and Professions Code.

► Note that one of the above certifications is required.

ATTENDING PHYSICIAN'S CERTIFICATE

To Accompany Request for Family Care Leave To Care for the
Serious Health Condition of a *Spouse, Registered Domestic Partner, Child, or Parent*

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INFORMATION CONCERNING PATIENT CONDITION/STATUS

(to be completed by Physician):

Date on which the serious health condition commenced: _____

Probable duration of condition: _____

Estimated length of time employee needs to care for patient: _____. (If an extension of this period results in an additional leave request from the employee, you will be asked to submit an update of the information provided on this form.)

Please answer the following question only if the employee is asking for intermittent leave or a reduced work schedule.

Yes No

☐ ☐ Is it medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal work schedule in order to deal with the serious health condition of the employee or family member?

If the answer is "yes," please indicate the estimated number of doctor's visits, and/or estimated duration of medical treatment, either by the health care practitioner or another provider of health services, upon referral from the health care provider: _____

▶ **[NOTE] THE HEALTH CARE PROVIDER IS NOT TO DISCLOSE THE UNDERLYING DIAGNOSIS WITHOUT THE CONSENT OF THE PATIENT.**

I hereby certify that the serious health condition³ suffered by the patient warrants the participation of the employee⁴ to provide care during a period of treatment or supervision of the individual requiring care. I certify that this patient requires the care of a family member during this period of treatment/supervision.

DATE: _____ By: _____
Physician's Signature

³ "Serious Health Condition" means an illness, injury, impairment, or physical or mental condition of the employee or a child, parent, spouse or registered domestic partner of the employee which involves either:

- (1) Inpatient care in a hospital, hospice, or residential health care facility, or
- (2) Continuing treatment or continuing supervision by a health care provider, as detailed in FMLA and its implementing regulations.

Please see the attached sheet for a further description of "Serious Health Condition."

⁴ "Warrants the Participation of the Employee" includes, but is not limited to, providing psychological comfort, and arranging "third party" care for the child, parent, spouse or registered domestic partner, as well as directly providing, or participating in, the medical care.

REQUEST FOR PREGNANCY DISABILITY LEAVE OF ABSENCE

A.

- (1) Due to my pregnancy disability, I am unable to work at all or I am unable to perform any one or more of the essential functions of my position without undue risk to myself, the successful completion of my pregnancy, or to other persons.
- (2) Attached is the physician's certification, stating (a) the date on which I became disabled due to pregnancy, (b) the probable duration of the period or periods of disability, and (c) a statement that, due to the disability, I am unable to work at all or I am unable to perform any one or more of the essential functions of my position without undue risk to myself, the successful completion of my pregnancy, or to other persons.
- (3) I have provided thirty (30) days advance notice of my need for Pregnancy Disability Leave, or Notice was provided as soon as practicable because I lacked sufficient knowledge of my need for Pregnancy Disability Leave in order to provide thirty (30) days notice thereof.

B.

- (1) If Family Care Leave will be taken immediately after the conclusion of the Pregnancy Disability Leave in order to care for the newborn child.

Date Pregnancy Disability is to end: _____

Date Family Care Leave is to begin: _____

Date Family Care Leave is to conclude: _____

DATE: _____

By: _____
Signature of Employee

ATTENDING PHYSICIAN'S CERTIFICATE

To Accompany Request for *Pregnancy Disability Leave*

EMPLOYEE INFORMATION (to be completed by Employee):

Name: _____

Address: _____

I give my permission for this information concerning my medical condition to be provided to the employer for the purpose of requesting a Pregnancy Disability Leave.

DATE: _____

By: _____
Patient's Signature

PHYSICIAN INFORMATION (to be completed by Physician):

Name: _____

Address: _____

Telephone: _____

[] I hold a physician's or surgeon's certificate issued pursuant to Article 4 of Chapter 5 of Division 2 of the Business and Professions Code.

[] I hold an osteopathic physician's or surgeon's certificate issued pursuant to Article 4 of Chapter 5 of Division 2 of the Business and Professions Code.

► Note that one of the above certifications is required.

INFORMATION CONCERNING PATIENT CONDITION/STATUS

(to be completed by Physician):

Date on which Pregnancy Disability commenced: _____

Probable duration of condition: _____

ATTENDING PHYSICIAN'S CERTIFICATE

To Accompany Request for *Pregnancy Disability Leave*

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I hereby certify that due to the Employee's pregnancy disability, the Employee is unable to work at all or unable to perform any one or more of the essential functions of her position without undue risk to herself, the successful completion of her pregnancy, or to other persons.

DATE: _____

By: _____
Physician's Signature

REQUEST FOR PREGNANCY DISABILITY TRANSFER

1. Due to my pregnancy disability, my doctor has advised me that I must be transferred to a position that is less strenuous or hazardous, or that requires the performance of duties that are less strenuous or hazardous.
2. Attached is the physician's certification, stating (a) the date on which the transfer became advisable, (b) the probable duration of the period or periods of the need to transfer, and (c) an explanatory statement that, due to my pregnancy, the transfer is medically advisable.

Date Pregnancy Disability Transfer is to begin: _____

Date Pregnancy Disability Transfer is to end: _____

DATE: _____

By: _____
Signature of Employee

ATTENDING PHYSICIAN'S CERTIFICATE
To Accompany Request for *Pregnancy Disability Transfer*

EMPLOYEE INFORMATION (to be completed by Employee):

Name: _____

Address: _____

I give my permission for this information concerning my medical condition to be provided to the employer for the purpose of requesting a Pregnancy Disability Transfer.

DATE: _____

By: _____
Patient's Signature

PHYSICIAN INFORMATION (to be completed by Physician):

Name: _____

Address: _____

Telephone: _____

☐ I hold a physician's or surgeon's certificate issued pursuant to Article 4 of Chapter 5 of Division 2 of the Business and Professions Code.

☐ I hold an osteopathic physician's or surgeon's certificate issued pursuant to Article 4 of Chapter 5 of Division 2 of the Business and Professions Code.

► **Note that one of the above certifications is required.**

INFORMATION CONCERNING PATIENT CONDITION/STATUS

(to be completed by Physician):

Date on which Pregnancy Disability Transfer became medically advisable: _____

The probable duration of the period or periods of the need to transfer: _____

I hereby certify that due to the Employee's pregnancy, the transfer is medically advisable.

DATE: _____

By: _____
Physician's Signature

REASON FOR DENIAL (Pregnancy Disability)

- ☐ Leave request is not certified by attending physician.
- ☐ Attending physician is not properly certified.
- ☐ Need for the leave was foreseeable, and no reasonable advance notice of the leave was given.
- ☐ Employer is unable to accommodate the employee's need for leave due to business necessity⁵.

⁵ "Business Necessity" means that the requirement of non-pregnancy must have a manifest relationship to the employment in question. In order to qualify as a business necessity, the employment practice must predict or significantly correlate with, important methods of work behavior that comprise, or are relevant to, the job.

REASON FOR DENIAL (Family Care Leave)

- [] Employee has not completed one year of service.
- [] Employee does not have 1,250 hours of service in the previous twelve (12) month period.
- [] Leave request for illness of family member is not certified by attending physician.
- [] Employee is a salaried employee, is in the highest 10% of wage earners within 75 miles of employee's work site, whose subsequent reinstatement will cause substantial and grievous economic injury to the operations of the employer. Notice of intent not to reinstate has been provided, along with notice of reasonable opportunity to return to work.
- [] Attending physician is not properly certified.
- [] The need for leave was foreseeable, and no reasonable advance notice of the leave was given. (30 days' notice is required, unless impracticable).
- [] The validity of the physician's certification is in doubt. Employer will require that the employee obtain the opinion of a second health care provider, at the employer's expense, designated or approved by the employer.

SERIOUS HEALTH CONDITION

A "Serious Health Condition" means an illness, injury, impairment, or physical or mental condition that involves one of the following:

(1) **HOSPITAL CARE.**

Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

(2) **ABSENCE PLUS TREATMENT.**

(a) A period of incapacity of more than three consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:

(1) Treatment two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or

(2) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider.

(3) **PREGNANCY.**

► **NOTE:** An employee's own incapacity due to pregnancy is covered as a Serious Health Condition under FMLA but not under CFRA.]

Any period of incapacity due to pregnancy, or for prenatal care.

(4) **CHRONIC CONDITIONS REQUIRING TREATMENT.**

A chronic condition which:

(1) Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;

(2) Continues over an extended period of time (including recurring episodes of a single underlying condition); and

(3) May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.)

(5) PERMANENT LONG-TERM CONDITIONS REQUIRING SUPERVISION.

A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

(6) MULTIPLE TREATMENTS (NON-CHRONIC CONDITIONS).

Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).