

Archdiocese of Los Angeles

**Family and Medical Leave
Designation Notice**

Employee's Name _____ Location _____ Date _____

We have reviewed your leave of absence request that you provided on _____(date) and decided that:

_____ **Your FMLA leave request is approved. All leave taken for this reason will be designated as FMLA leave.**

- If you take leave, as requested, from _____(date) to _____(date), then _____ (hours, days, weeks, or months) will be counted against the maximum FMLA leave available to you. Please advise your supervisor of any changes in your scheduled leave dates.
- You may use paid leave (vacation, sick pay) or apply for disability benefits, where applicable per Archdiocesan leave policy, but this paid leave will count against your FMLA leave entitlement.
- In order to return to work, all employees returning from medical leave must present a doctor's note fully releasing them to return to work. If your doctor releases you to return to work **with any restrictions**, a decision about your return to work will be evaluated based on the list of essential job duties. You must present the doctor's full release confirming your fitness for duty and ability to perform the essential job functions before you can return to work.

_____ **Additional information is needed to determine if your FMLA request can be approved, specifically:** _____.

_____ **Your FMLA Leave Request is not approved because:**

_____ The FMLA does not apply to your leave request.

_____ You have exhausted all FMLA leave available to you within the last 12 months.

Designation Authorized by: _____ Title: _____

Location: _____ Date: _____