***<DATE>***

***<NAME>***

***<ADDRESS>***

Dear ***<NAME>***,

The Department is in receipt of your medical certification dated ***<MED CERT DATE>***. Your covered family member’s need for ongoing medical treatment qualifies for intermittent leave under the Family Medical Leave Act (FMLA) and the California Family Rights Act (CFRA). Enclosed is the Notification of Eligibility of Family Medical Leave which designates your leave of absence as FMLA/CFRA. Your leave is also granted under the County’s Medical Leave Policy.

Your FMLA/CFRA leave days will be tracked to assist you in using this benefit. We ask that you inform your supervisor whenever your absence is related to your covered family member’s medical condition so that the time may be tracked as incremental leave under FMLA/CFRA.

If any changes to your leave return date occur, please provide **<XX>** days notice and a new medical certification.

If you have any questions about these forms or your leave, please contact me at ***<565-xxxx>*** or ***<Analyst Name, Disability Management Analyst>*** at ***<565-xxxx>***. More information and copies of the Medical Leave Policy, Disability and Reasonable Accommodation Policy, and the Temporary Transitional Duty Policy, can be found at:

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

Sincerely,

***<Dept Designee>***

Enclosures: Notification of Eligibility of Family Medical Leave form

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

 Confidential Medical File