**CFRA Denial - Not Complying with Medical Certificate Requests, ADA/FEHA Conditional Designation (CAA2303)**

Send Certified And Regular Mail

Certification # \_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE

NAME

ADDRESS

Dear NAME:

COMPANY has received information on DATE that indicates you were absent for a reason that may qualify as leave under California Family Right Act (CFRA) medical leaves. However, as of DATE [DATE MED CERT WAS DUE FROM 2nd REQUEST CONDITIONAL DESIGNATION LETTER] your request for FMLA/CFRA leave has been denied because we have not yet received the required certification by your health care provider indicating you qualify for the job and attendance protection under CFRA leave benefits.

As stated in our previous letter provided to you on [DATE LETTER MAILED/HAND DELIVERED], we requested that you provide COMPANY a medical certificate confirming your need for leave. You have neither provided us a medical certificate nor have you contacted us regarding these requests.

At this time:

☐ You have [NUMBER OF HOURS] available of accrued unused PTO/Vacation/Sick leave.

OR

☐ You do not have any PTO/Vacation/Sick leave available and your current leave is unpaid.

COMPANY policy says you must use/may use [VERIFY IN POLICY] PTO, sick and/or vacation prior to eligibility for an unpaid leave of absence [VERIFY]. If you are eligible for state disability insurance (SDI), your SDI benefits and PTO, sick and/or vacation leave pay can be coordinated so that your SDI/vacation leave payments do not exceed your normal rate of pay. Information about State Disability Insurance (SDI) benefits is enclosed with this letter. It is your responsibility to apply for such benefits through the local Employment Development Department (EDD).

If you are currently enrolled in healthcare benefits, and you are in an unpaid leave of absence, your benefits will end the first day of the month following the month in which the unpaid leave begins on, DATE. COBRA information will follow under a separate cover at that time. [DELETE THIS PARAGRAPH IF NOT APPLICABLE]

At this time, there are/there are no other options available to you under COMPANY’s policies. [BE SPECIFIC and SPELL OUT WHAT IS AVAILABLE OR WHAT THEY HAVE ALREADY UTILIZED]

**Although your benefits have been denied under the CFRA, you may be eligible for protection under the Americans with Disabilities Act (ADA) and the Fair Employment and Housing Act (FEHA). As a means of providing you full opportunity for protection under state and federal regulations, we are temporarily designating your leave as an ADA/FEHA leave accommodation, pending confirmation of your eligibility as a qualified individual with a disability.**

If you are either:

* Requesting the opportunity to continue a temporary leave of absences with the intention of returning to work at a designated date, as confirmed by your treating health care provider, or
* Requesting an accommodation which would allow you to perform the essential functions of your current job or an alternative position,

COMPANY requires additional documentation be provided to this office to determine your eligibility status as a qualified individual with a disability. Please have your health care provider utilize the enclosed job description in completing the enclosed FEHA/ADA - Essential Job Function Analysis - Health Care Provider Evaluation Form.

To allow us to confirm the ability of COMPANY in continuing to provide additional leave as an accommodation, please have your health care provider complete the enclosed Essential Function Job Analysis, Health Care Provider Evaluation and return it to our office on or before GFM DATE. Have your health care provider utilize the enclosed job description in completing the evaluation form.

We have scheduled a second Good Faith Interactive meeting with you, NAME, TITLE, COMPANY and [NAME OF ANY OTHERS ATTENDING THE MEETING], to discuss the ADA and FEHA eligibility and accommodation issues on:

Date and Time – DATE & TIME

Location – ADDRESS

Contact Phone – NAME, TITLE, PHONE NUMBER

Upon receipt of this letter, it is your responsibility to confirm your appointment time. You may return the FEHA/ADA - Essential Function Job Analysis - Health Care Provider Form on or before the meeting scheduled for DATE.

Remember that if you are absent because of your own illness or injury, you must provide COMPANY with a Certification of Health Care Provider for Employee Return to Work (RTW) form when you return to work (see enclosed).

If you have any questions, please feel free to contact me.

Name: HR/MEDICAL LEAVE ADMINISTRATOR CONTACT

Phone: TELEPHONE #

Enclosures: FEHA/ADA - Essential Job Function Analysis - Health Care Provider Evaluation

Authorization for Release of Medical Information

SDI Pamphlet

Job Description [Title of Job Description]

Certification of Health Care Provider for Employee to Return to Work Form