

Employee Letter - PDL Only

Date _____

Dear _____,

_____ (the Company) has received medical certification indicating that you are disabled because of pregnancy as of _____ (date). Under state law, you are entitled to pregnancy disability leave of up to a maximum of 17 1/3 weeks (693 hours) per pregnancy, if you are disabled because of pregnancy, childbirth, or other related medical condition. If you work less than 40 hours per week, leave is calculated on a pro rata or proportional basis. You previously have used _____ (days/hours) of pregnancy disability leave and thus the total remaining pregnancy disability leave available to you is _____ (days/hours).

According to the medical documentation, you should be able to return to work on _____ (date). Please notify us of your return date as soon as possible. If you have not been released by your doctor on that date, you will need to provide us with further medical documentation of your need for continued leave.

During your pregnancy disability leave, you may take any accrued and unused vacation hours. You currently have _____ hours available to you. Please advise _____ (name) if you wish to use any of your vacation time during your pregnancy disability leave.

Company policy _____ (allows/requires) use of paid sick leave during pregnancy disability leave. You currently have _____ hours of accrued sick leave. The sick time _____ (may/will) be paid out beginning on your first day of absence. If you are eligible for state disability insurance (SDI), your SDI benefits and sick leave pay will be coordinated so that your SDI/sick leave payments do not exceed your normal rate of pay.

Your medical benefit coverage will continue during your pregnancy disability leave for up to four months in a 12-month period per pregnancy commencing on the date the leave begins. If you currently contribute to the payment of benefits, you must continue to do so while on leave.

Remember that 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 after the prior certification expires).

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

Representative

Company Name

Address

City

State

Zip