

## *Department Disability Notice / Paid Family Leave*

**Submitted By:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

Employee Name:

Employee Number:

Employee Job Title:

Home Department Coordinator:

Home Department Number:

Work Department Name:

Work Department Number:

Has the payline been adjusted?

Yes

No

Is the person full time or part time?

Full Time

Part Time

Salary as of the last completed payroll period,  
excluding overtime and other additional compensation

\$ \_\_\_\_\_

Per:  Month  Hour

If faculty, is pay based on a 9 or 12 month contract?

9

12

N/A

Salary/Wages paid on basis of:

Fiscal Year

Academic Year

Term

Other \_\_\_\_\_

Last day employee was physically at work \_\_\_\_\_(mm/dd/yyyy)

Through what day has employee been paid or  
will be paid wages or salary by department? \_\_\_\_\_(mm/dd/yyyy)

Has employee terminated?  Yes  No If yes, Date of Termination \_\_\_\_\_

Has sick leave been paid since employee was last physically at work?  Yes  No

From: \_\_\_\_\_(mm/dd/yyyy) Thru: \_\_\_\_\_(mm/dd/yyyy)

Has vacation leave been paid since employee was last physically at  
work?  Yes  No

From: \_\_\_\_\_(mm/dd/yyyy) Thru: \_\_\_\_\_(mm/dd/yyyy)

What is the employee's anticipated schedule for PFL?

Is this PFL a continuation from Maternity Leave without a break?  Yes  No

Is the employee eligible for FMLA and/or CFRA  Yes  No

Has the employee been on PFL in the past 12 months?  Yes  No

If yes, how many days and hours? Days \_\_\_\_\_ Hours \_\_\_\_\_

Comments:

*- If you should have any questions regarding this form please contact Elizabeth Palma at (213)740-5875  
- Upon completion please fax copy to the attention of Elizabeth Palma at (213)740-7305*