CALHR
CALIFORNIA DEPARTMENT OF HUMAN RESOURCES

NDI-FCL DESIGNATION FORM

California Department of Human Resources
State of California

NON-INDUSTRIAL DISABILITY INSURANCE FAMILY CARE LEAVE

Employee Information

Employee Last Name: ____________ Employee First Name: ____________ Department: ____________

Approval Begin Date: ____________ Approval End Date: ____________ Bargaining Unit: ____________

Supplementation: ____________ Reason for NDI-FCL: ____________

NDI-FCL Designation

NDI-FCL must be reported to your disability coordinator each month NDI-FCL is taken. Supplementation must remain the same for the entire duration of the claim. If there is not enough leave for the chosen supplementation level, supplementation will drop to no supplementation for the remainder of the claim.

1. Obtain approval from your immediate supervisor for NDI-FCL use for the pay period.
2. Mark the days that FCL was/will be taken in the pay period.
3. Submit the form with appropriate signatures to your HR office on or before the 15th day of the month.
   a. If your NDI-FCL Designation Form is not submitted by the 15th day, overpayments or underpayments may result.
   b. If your NDI-FCL designation changes after submission of this form, contact your disability coordinator immediately and submit a revised NDI-FCL Designation Form with supervisor approval. Overpayments or underpayments may result if changes occur after the 15th day.
   c. NDI-FCL days designated on this form should match the NDI-FCL days designated on your timesheet submitted at the close of the pay period.

Pay Period: ____________

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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Comments:

Employee Signature: ____________ Date: ____________

Supervisor Signature: ____________ Date: ____________

Supervisor Name: ____________