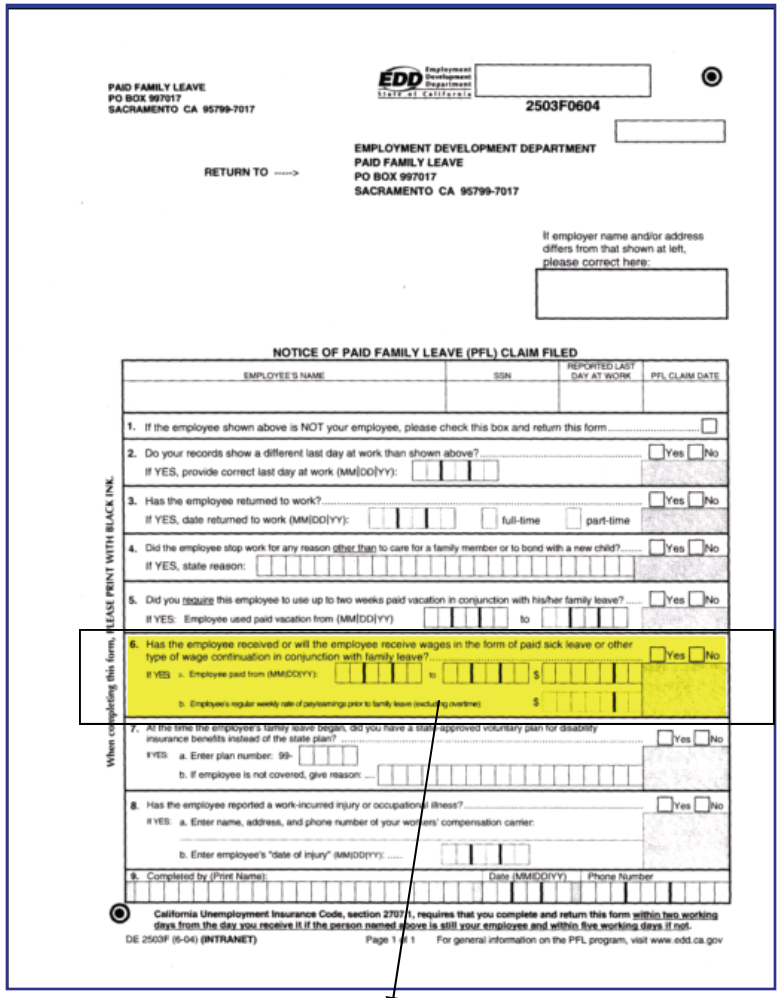
Sample DE 2503F, Question 6



PAID FAMILY LEAVE
PO BOX 997017
SACRAMENTO CA 95799-7017

EDD Employment Development Department State of California

2503F0604

RETURN TO ----->

EMPLOYMENT DEVELOPMENT DEPARTMENT
PAID FAMILY LEAVE
PO BOX 997017
SACRAMENTO CA 95799-7017

If employer name and/or address differs from that shown at left, please correct here:

NOTICE OF PAID FAMILY LEAVE (PFL) CLAIM FILED

EMPLOYEE'S NAME	SSN	REPORTED LAST DAY AT WORK	PFL CLAIM DATE

When completing this form, PLEASE PRINT WITH BLACK INK.

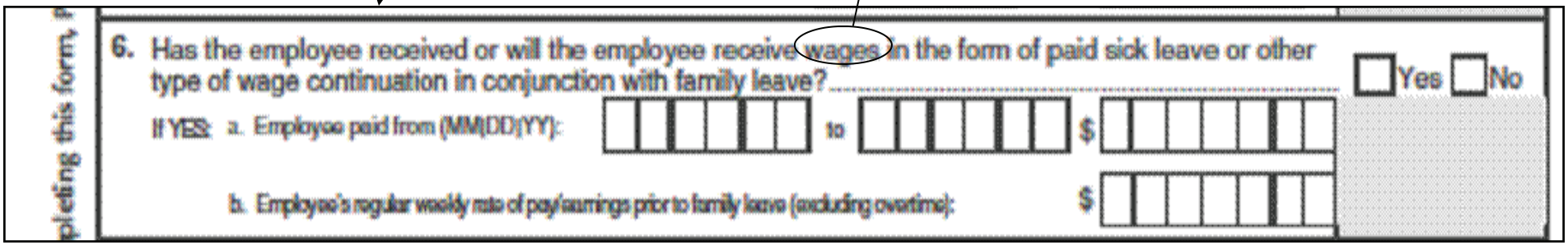
1. If the employee shown above is NOT your employee, please check this box and return this form ☐
2. Do your records show a different last day at work than shown above? ☐ Yes ☐ No
   If YES, provide correct last day at work (MM|DD|YY):
3. Has the employee returned to work? ☐ Yes ☐ No
   If YES, date returned to work (MM|DD|YY): ☐ full-time ☐ part-time
4. Did the employee stop work for any reason other than to care for a family member or to bond with a new child? ☐ Yes ☐ No
   If YES, state reason:
5. Did you require this employee to use up to two weeks paid vacation in conjunction with his/her family leave? ☐ Yes ☐ No
   If YES: Employee used paid vacation from (MM|DD|YY) to
6. Has the employee received or will the employee receive wages in the form of paid sick leave or other type of wage continuation in conjunction with family leave? ☐ Yes ☐ No
   If YES: a. Employee paid from (MM|DD|YY): to $
   b. Employee's regular weekly rate of pay/earnings prior to family leave (excluding overtime): $
7. At the time the employee's family leave began, did you have a state-approved voluntary plan for disability insurance benefits instead of the state plan? ☐ Yes ☐ No
   If YES: a. Enter plan number: 99-
   b. If employee is not covered, give reason:
8. Has the employee reported a work-incurred injury or occupational illness? ☐ Yes ☐ No
   If YES: a. Enter name, address, and phone number of your workers' compensation carrier:
   b. Enter employee's "date of injury" (MM|DD|YY):
9. Completed by (Print Name): Date (MM|DD|YY) Phone Number

California Unemployment Insurance Code, section 2707.1, requires that you complete and return this form within two working days from the day you receive it if the person named above is still your employee and within five working days if not.

DE 2503F (6-04) (INTRANET) Page 1 of 1 For general information on the PFL program, visit www.edd.ca.gov

NOTE FOR QUESTION 6:
Samples of wages received can be in the following form:

- **Paid Sick Leave**
- **Vacation**
- **Personal time off**
- **Holiday**
- **Bonus**
- **Commission**
- **Other**



6. Has the employee received or will the employee receive wages in the form of paid sick leave or other type of wage continuation in conjunction with family leave? ☐ Yes ☐ No

If YES: a. Employee paid from (MM|DD|YY): to $

b. Employee's regular weekly rate of pay/earnings prior to family leave (excluding overtime): $