FAMILY AND MEDICAL LEAVE
NOTICE OF ELIGIBILITY AND RIGHTS & RESPONSIBILITIES

PART A - NOTICE OF ELIGIBILITY

TO: _____ **FROM:** _____ **DATE:** _____
Employee Employer Representative

On _____ , you informed us that you needed leave beginning on _____ for:

☐ The birth of a child, or placement of a child with you for adoption or foster care;

☐ Your own serious health condition;

☐ Because you are needed to care for your ☐ spouse; ☐ child; ☐ parent due to his/her serious health condition.

☐ Because of a qualifying exigency arising out of the fact that your ☐ spouse; ☐ son or daughter; ☐ parent is on active duty or call to active duty status with the Armed Forces.

☐ Because you are the ☐ spouse; ☐ son or daughter; ☐ parent; ☐ next of kin of a covered servicemember with a serious injury or illness.

This Notice is to inform you that you:

☐ Are eligible for FMLA leave (See Part B below for Rights and Responsibilities)

☐ Are **not** eligible for FMLA leave, because (only one reason need be checked, although you may not be eligible for other reasons):

- ☐ You have not met the FMLA's 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately _____ months towards this requirement.
- ☐ You have not met the FMLA's 1,250-hours-worked requirement.
- ☐ You have exhausted your FMLA leave entitlement in the applicable 12-month period.

PART B - RIGHTS AND RESPONSIBILITIES FOR TAKING FMLA LEAVE

As explained in Part A, you meet the eligibility requirements for taking FMLA leave and still have FMLA leave available in the applicable 12-month period. **However, in order for us to determine whether your absence qualifies as FMLA leave, you must return the following information to us by _____.** (If a certification is requested, employers must allow at least 15 calendar days from receipt of this notice; additional time may be required in some circumstances.) If sufficient information is not provided in a timely manner, your leave may be denied.

☐ Sufficient certification to support your request for FMLA leave. A County Auditor's certification form that sets forth the information necessary to support your request **is** enclosed. ☐ 456A ☐ 456B ☐ 456C ☐ 456D

☐ Sufficient documentation to establish the required relationship between you and your family member.

☐ No additional information requested.

If your leave does qualify as FMLA leave you will have the following **responsibilities** while on FMLA leave (only checked blanks apply):

☐ Decide whether you want to continue benefits coverage for any period of unpaid FMLA leave. See County Auditor's Form 459, *Family and Medical Leave Insurance Coverage Statement for Continuous Unpaid FMLA*. You are responsible for your share of the premium payments on your health insurance while you are on unpaid leave. You have a minimum 30-day grace period in which to make premium payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse.

☐ You will be required to use your available ☐ compensatory time, ☐ sick leave, ☐ vacation leave during your FMLA absence. This means that you will receive your paid leave and the leave will also be considered protected FMLA leave and counted against your FMLA leave entitlement. (If you do not meet the requirements for taking paid leave, you remain entitled to take unpaid FMLA leave.)

☐ While on leave you will be required to furnish us with periodic reports of your status and intent to return to work every _____. You must make **oral** contact with _____ (name of person) at _____ (phone # or address, as appropriate) every _____ (must be filled in, day of week and frequency, i.e., "first Friday of the month" or "other Monday").

If the circumstances of your leave change, and you are able to return to work earlier than the date indicated on this form, you will be required to notify us at least two workdays prior to the date you intend to report for work.

If your leave does qualify as FMLA leave you will have the following **rights** while on FMLA leave:

- You have a right under the FMLA for up to 12 weeks of unpaid leave in a 12-month period calculated as the calendar year (January-December).

- You have a right under the FMLA for up to 26 weeks of unpaid leave in a single 12-month period to care for a covered servicemember with a serious injury or illness. This single 12-month period commenced on _____.
- Your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work.
- You must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA-protected leave. (If your leave extends beyond the end of your FMLA entitlement, you do not have return rights under FMLA.)
- If you do not return to work following FMLA leave for a reason other than: 1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; 2) the continuation, recurrence, or onset of a covered servicemember's serious injury or illness which would entitle you to FMLA leave; or 3) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave.
- Once we obtain the information from you as specified above, we will inform you, within 5 business days, whether your leave will be designated as FMLA leave and count towards your FMLA leave entitlement. If you have an questions, please do no hesitate to contact:

_____ at _____

I acknowledge receipt of the FMLA Notice of Eligibility and Rights & Responsibilities. I understand the Rights & Responsibilities as they have been explained herein.

_____ _____

Employee Signature Date

_____ _____

Human Resources Representative Date