FAMILY AND MEDICAL LEAVE DESIGNATION NOTICE

To: _____ Date: _____

We have reviewed your request for leave under the FMLA and any supporting documentation that you have provided.

We received your most recent information on _____ and decided:

☐ **Your FMLA leave request is approved. All leave taken for this reason will be designated as FMLA leave.**

The FMLA requires that you notify us as soon as practicable if dates of scheduled leave change or are extended, or were initially unknown. Based on the information you have provided to date, we are providing the following information about the amount of time that will be counted against your leave entitlement:

☐ Provided there is no deviation from your anticipated leave schedule, the following number of hours, days, or weeks will be counted against your leave entitlement:

_____

☐ Because the leave you will need will be unscheduled, it is not possible to provide the hours, days, or weeks that will be counted against your FMLA entitlement at this time. You have the right to request this information once in a 30-day period (if leave was taken in the 30-day period).

Please be advised (check if applicable):

☐ We are requiring you to substitute or use applicable paid leave during your FMLA leave before taking unpaid FMLA leave. Any leave (paid or unpaid) taken for this reason will count against your FMLA entitlement.

☐ You will be required to present a fitness-for-duty certificate to be restored to employment. If such certification is not timely received, your return to work may be delayed until certification is provided. A list of the essential functions of your position ☐ **is** ☐ **is not** attached. If attached, the fitness-for-duty certification must address your ability to perform these functions.

☐ **Additional information is needed to determine if your FMLA leave request can be approved:**

☐ The certification you have provided is not complete and sufficient to determine whether the FMLA applies to your leave request. You must provide the following information no later than _____ (provide at least 7 calendar days), unless it is not practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied.

_____

(specify information needed to make the certification complete and sufficient)

_____

☐ We are exercising our right to have you obtain a second or third opinion medical certification at our expense, and we will provide further details at a later time.

☐ **Your FMLA leave request is Not approved because:**

_____

_____

_____

_____ _____
Employee Signature Date

_____ _____
Human Resources Representative Date