DESIGNATION NOTICE/EMPLOYER RESPONSE TO EMPLOYEE
FAMILY AND MEDICAL LEAVE

To:_____ Dept: _____
From:_____ Date: _____

Section I. Employer Designation Notice

On _____, we reviewed your **Request for Leave** under the FMLA and have determined that your leave ___ is approved/ ___ is provisionally approved/ _____ is not approved/ or _____ does not apply. Note: If the leave is not approved due to lack of proper medical certification, complete and sufficient certification is required within 15 calendar days from your request, or FMLA may not be approved.

Section II. Employer Response to Employee

On _____, you notified us of your need to take leave of absence for:

- ☐ The birth and care of your newborn child;
- ☐ Placement of a child with you for adoption or foster care;
- ☐ Your own serious health condition that renders you incapable of performing the functions of your job, including a work-related injury or illness;
- ☐ To care for your _____ spouse, _____ son or _____ daughter under age 18, or _____ Parent (___ mother, _____father), with a serious health condition;
- ☐ For a qualifying service member leave.

You notified us that you need this leave beginning on _____ and that you expect the leave to continue until on or about _____. If eligible, you have a right under the FMLA for up to 12 weeks of leave in a rolling 12-month period for the reasons listed above, except that you are entitled to up to 26 weeks of leave to care for an injured service member.

This is to inform you that:

1. You are ___ eligible, __ not eligible for leave under the FMLA. To be eligible you must have been employed by the agency for at least twelve (12) months and must have worked at least 1,250 hours during the twelve (12) month period immediately prior to the date when FMLA is scheduled to begin, work at a location where the county employs 50 or more Employees within a 75 mile radius, and have not exceeded 12 weeks leave over last reporting period.

2. If eligible, you have _____ (hours, days, weeks, etc.) of FMLA leave available in the applicable rolling 12-month period. If there is no deviation, your FMLA is approved for _____ (hours, days, weeks, etc.).

3. If eligible, the request for leave will be counted against your FMLA leave entitlement.

4. If the leave has been provisionally designated as FMLA, you must provide a complete and sufficient *certification* to your Employer by _____ (within 15 calendar days from date of this response). In the case of a condition exceeding 5 consecutive calendar days, you are required to provide a physician's statement specifying your inability to report to work and the probable date of recovery regardless of FMLA leave status.

5. Appropriate, available accrued paid leave shall be counted as part of your 12 week leave entitlement and must be exhausted prior to being granted unpaid leave and shall be taken concurrently

with FMLA leave, such that the total leave taken does not exceed 12 weeks.

6. When implemented, mandatory cost savings days will run concurrently with FMLA.

7. The Employer's portion of the County health care premium will be paid. If you normally pay a portion of the premiums for your health insurance, these payments must continue during the period of FMLA leave. If you do not return to work following FMLA leave for a reason other than the continuation, recurrence, or onset of a serious health condition or other circumstances beyond your control, you may be required to reimburse the agency for their share of health insurance premiums paid on your behalf during your FMLA leave

8. If the leave was for your own serious health condition, you will be required to present a fitness-for-duty certificate prior to being restored to employment. For return other than full duty, the *Attending Physician Statement* and the *Health Care Provider Information* forms are required. If such certification is not received, your return to work may be delayed until it is provided.

9. You ___ are or ____ are not a key Employee as described in the FMLA regulations. If you are a key Employee, restoration to employment may be denied following FMLA leave on the grounds that such restoration will cause substantial and grievous economic injury to us. As such, we _____ have or _____ have not determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic harm to us. *Explained:*_____

10. You _X__ will/ ____ will not be required to furnish us with periodic reports of your status and intent to return to work every 30 days while on FMLA leave.

11. You _X__ will/ ____ will not be required to furnish re-certification every 30 days relating to a serious health condition.

Please sign and return the original of this *Designation Notice,* and other documents if requested.

_____	_____
Employer's Signature	**Employee's Signature**
_____	_____
Date	**Date**

Attachment for Employees:

_____ Applicable *Certification* Form
_____ *Application for Leave* Form

And If For Your Own Serious Health Condition:

_____ *FMLA Attending Physician Statement* form
_____ *Health Care Provider Information* form
_____ Job Description
_____ Job Analysis – if available