Human Resources

DESIGNATION NOTICE
(Family and Medical Leave Act)

Leave covered under the Family and Medical Leave Act (FMLA) must be designated as FMLA-protected and the employer must inform the employee of the amount of leave that will be counted against the employee's FMLA leave entitlement. In order to determine whether leave is covered under the FMLA, the employer may request that the leave be supported by a certification. If the certification is incomplete or insufficient, the employer must state in writing what additional information is necessary to make the certification complete and sufficient.

DATE: _____ EMPL ID: _____

TO: _____
(Employee's Name)

FROM: _____ DEPT #/NAME #: _____
(Supervisor Name/Designated Leave Coordinator)

On _____, you informed us that you needed FMLA leave beginning on _____ with an anticipated end date of
(MM/DD/YY) (MM/DD/YY)

_____ (not to exceed FMLA leave entitlement) as a ☐ continuous, ☐ intermittent, and /or ☐ reduced work schedule leave.
(MM/DD/YY)

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:
(MM/DD/YY)

☐ **Your FMLA leave request is approved and 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):

- ☐ You are eligible for paid time benefits, as applicable (ie., sick time, vacation time, paid parental leave, and, for non-exempt employees, compensatory time), any paid time used will be counted against the FMLA leave entitlement.
- ☐ Your FMLA leave (or a portion of) will be unpaid because you are not eligible for accrued paid time or have you exhausted or will exhaust your balance of accrued paid time.
- ☐ While on leave, you will be required to furnish us with periodic reports of your status and intent to return to work every _____. (Indicate interval of periodic reports as appropriate for the particular leave situation.)
- ☐ 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 _____, unless it is not practicable under the particular
(Provide at least seven calendar days) - (MM/DD/YY)
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.

(The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to a request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.)

☐ Your FMLA Leave request is **Not Approved.**

☐ The FMLA does not apply to your leave request.

☐ You have exhausted your FMLA leave entitlement in the applicable 12-month period.

DATE: _____
(MM/DD/YY)

_____ _____
Supervisor/Designated Leave Coordinator Contact #/Email

FORM ROUTING

Supervisor/Designated Leave Coordinator:

Original completed form to Employee
Maintain copy of form in confidential department file
Copy to Human Resources

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