PRINT

# RESPONSE TO EMPLOYEE REQUEST FOR FAMILY CARE AND MEDICAL LEAVE

DATE: _____

TO: _____

FROM: _____

On _____ , you notified us of your need to take FAMILY CARE AND MEDICAL LEAVE (FMLA) due to:

- ☐ the birth of your child, or the placement of a child with you for adoption or foster care; or
- ☐ a serious health condition that makes you unable to perform the essential functions of your job; or
- ☐ a serious health condition affecting your ☐ spouse, ☐ child, ☐ parent, for which you are needed to provide care.

You notified us that you need this leave beginning on _____ and that you expect leave to continue until on or about _____.

You notified us that you need INTERMITTENT leave beginning on (please be specific as to days, times, hours) _____

and that you expect this INTERMITTENT leave to continue until on or about _____.

Except as explained below, you have a right under the FMLA for up to 12 weeks of paid and unpaid leave in a 12 month period for the reasons listed above. Also, your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work and 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 leave. 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; or (2) 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.

This is to inform you that:

1. You are ☐ ELIGIBLE, ☐ NOT ELIGIBLE for leave under the FMLA.
2. The requested leave ☐ WILL, ☐ WILL NOT, be counted against your annual FMLA leave entitlement.
3. You are required to furnish a medical certification of a serious health condition by _____ (ATTENTION: must be at least 15 days after the employee has requested FMLA) or we may delay the commencement of your leave until the certification is submitted.
4. If you normally pay a portion of the premiums for you or your dependent(s) health insurance, you must continue the payments during the period of FMLA leave. PAYMENT ARRANGEMENTS MUST BE MADE WITH PERSONNEL PRIOR TO YOUR LEAVE OF ABSENCE.
5. While you are on a FMLA leave of absence, you have a 30-day grace period in which to make premium payments. IF PAYMENT IS NOT MADE IN A TIMELY MANNER, YOUR GROUP HEALTH INSURANCE WILL BE CANCELLED.
6. In the event of your own serious illness, you will be required to present a physician statement declaring your fitness-for-duty PRIOR to being restored to employment. IF SUCH A CERTIFICATION IS NOT RECEIVED PRIOR TO YOUR EXPIRATION OF LEAVE, YOUR RETURN TO WORK MAY BE DELAYED UNTIL THE CERTIFICATION IS PROVIDED.