

**DESIGNATION NOTICE**  
Family and Medical Leave Act

To: \_\_\_\_\_

Date: \_\_\_\_\_

We reviewed your request and supporting documentation, dated \_\_\_\_\_, for leave under the FMLA. Our decision is indicated below:

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**Your request for FMLA leave is approved effective \_\_\_\_\_ . It is scheduled to end on \_\_\_\_\_ . All leave taken under this request will be designated as FMLA leave.**

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

Per your FMLA request, the following estimated number of hours, days, or weeks will be counted against your leave entitlement: \_\_\_\_\_. Please note that if you deviate from your anticipated leave schedule, these amounts may change.

Because the leave requested will be uncheduled, it is not possible to estimate 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).

Applicable workers' compensation, catastrophic leave, or disability will count against your FMLA leave entitlement.

Other: \_\_\_\_\_

If this request is due to your own serious health condition, you will be required to present a fitness-for-duty certificate 5 days prior to return. Your return to work may be delayed until certification is provided. The fitness-for-duty certificate must address your ability to perform the essential functions listed in your **attached position class description**.

**Please be advised:**

The certification submitted was **not complete or sufficient to determine whether FMLA applies**. You must provide further information no later than \_\_\_\_\_ (7 days) or your leave may be delayed or denied. Information needed to make the certification complete or sufficient is:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

We are exercising our right to have you obtain a second or third opinion at our expense. We will provide you with further information within five (5) working days.

Based on the information you provided, your request for FMLA leave is being disapproved because FMLA does not apply to your leave request.

**By signing below I signify that I have approved/disapproved the request for FMLA and I have given a copy of this form to the employee. If FMLA has been approved a copy of the position class description has been attached.**

Supervisor signature \_\_\_\_\_

Date \_\_\_\_\_