

**(DATE)**

**(NAME)**  
**(STREET ADDRESS)**  
**(CITY, STATE, ZIP CODE)**

Dear **(NAME)**:

The Business Office has been informed that it will be necessary for you to be absent from work for an extended period of time. Federal law guarantees you some safe guards for your health benefits during this time under the Family Medical Leave Act (FMLA). This legislation was enacted to guarantee health benefit coverage for employees up to twelve (12) weeks. **(SCHOOL DISTRICT/INTERMEDIATE SCHOOL DISTRICT)** will pay your health benefits according to the Family Medical Leave Act or the sick leave language in your contract, whichever is longer.

Enclosed is your information packet outlining the purpose and guidelines of the FMLA.

Please have the Certification of Health Care Provider form completed by your health care provider and returned to me. FMLA regulations require us to document the reasons for your leave. For your benefit, please return these forms by **(DATE OF 15 DAYS FROM LETTER)**.

If you have any questions, please feel free to contact me at **(Area Code) (Phone Number)**.

Sincerely,

(Name of Business Coordinator or Designated Contact)  
(Title)

Enclosures