

**FAMILY & MEDICAL LEAVE ACT (FMLA)**  
**Employer Notification to Employee**

Date: \_\_\_\_\_  
To: \_\_\_\_\_  
(Employee's name)  
From: \_\_\_\_\_  
(Name of appropriate employer representative)

You are being notified that your absence qualifies for a maximum of twelve (12) weeks of family/medical leave between the twelve (12) month period beginning \_\_\_\_\_ and ending \_\_\_\_\_ due to:  
(beginning date) (ending date)

- \_\_\_\_\_ 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, or parent for which you are needed to provide care.

You have a right under the FMLA for up to twelve (12) weeks of unpaid leave in a twelve (12) month period for the reasons listed above. Your health benefits will be maintained during the FMLA leave under the same conditions as if you continued to work, and you will be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your timely 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 health insurance premiums paid on your behalf during the FMLA leave.

This is to inform you that:

1. The leave \_\_\_\_\_ will \_\_\_\_\_ will not be counted against your annual FMLA leave entitlement.
2. You \_\_\_\_\_ will \_\_\_\_\_ will not be required to furnish medical certification of a serious health condition. If required, you must furnish certification within fifteen (15) days after you are notified of this requirement.
3. We will require that you substitute accrued paid leave for unpaid FMLA. If paid leave will be used the following conditions will apply:
  - a. If you normally pay a portion of the premiums for your health insurance, these payments will continue during the period of FMLA leave. You will need to make premium payments as follows:
  - b. If required you have a minimum thirty (30) day grace period in which to make premium payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least fifteen (15) days before the date that your health coverage will lapse, or, at our option, we may pay your share of the premiums during FMLA leave, and recover these payments from you upon your return to work. We \_\_\_\_\_ will \_\_\_\_\_ will not pay your share of health insurance premiums while you are on leave.
  - c. We \_\_\_\_\_ will \_\_\_\_\_ will not do the same with other benefits (e.g., life insurance, disability insurance, etc.) while you are on FMLA leave. If we do pay your premiums for other benefits, when you return from leave you \_\_\_\_\_ will \_\_\_\_\_ will not be expected to reimburse us for the payments made on your behalf.
4. You will be required to present a fitness-for-duty certificate prior to being restored to employment. Your return to work may be delayed until the certification is provided.
5. While on leave, you \_\_\_\_\_ will \_\_\_\_\_ will not be required to furnish us with periodic reports every \_\_\_\_\_ days of your status and intent to return to work unless the health care provider certifies that the condition will last longer than 30 days, in which case you must provide status reports immediately after the period your health care provider has specified is over. If the circumstances of your leave change and you are able to return to work earlier than the date indicated on this form, you will be required to notify us at least two (2) work days prior to the date you intend to report to work.

I \_\_\_\_\_ voluntarily and freely give my consent for the District's health care provider to contact my health care provider to provide clarification and authenticity for any medical documentation.

Dated: \_\_\_\_\_

\_\_\_\_\_  
(Employee Signature)

\_\_\_\_\_  
(District Representative Signature)

Should you have any questions please telephone (Area Code) (Phone Number) to speak with the Business Coordinator or contact your Administrator whom will put you in touch with the Business Coordinator.

Please sign and return one complete copy of this document.