FMLA SAMPLE LETTER CONTENTS

Initial Letter of Preliminary Designation and Request for Certification

7/2013

Date

Name

Address

Dear………

Your circumstances may meet the requirements for coverage under the Family and Medical Leave Act (FMLA). To be eligible for FMLA, an employee must have been employed by the employer for at least 12 months AND have been at work for at 1,250 hours of service during the 12-month period immediately preceding the commencement of leave. As you have met those two requirements, a preliminary designation of FMLA coverage has been made. Leave time taken beginning (DATE) will be considered FMLA covered and will be counted toward the 12 weeks of leave available to you during a 12-month period.

Circumstances that qualify under FMLA include birth of the employee’s child or an adoption or foster care placement, care of a spouse, child or parents due to a serious health condition, or the employee’s own serious health condition.

Your coverage under FMLA does not guarantee that any or all of your leave will be paid. This is determined by the amount of leave you have earned and taken to date. You will be required to use your own leave for FMLA before going on unpaid FMLA leave. Also, please remember that all leave you take, whether paid or unpaid, must be requested and approved by your supervisor.

The State will pay its portion of your health care benefits throughout the FMLA approved absences under the same conditions as if you continued to work. You will be reinstated to the same or an equivalent job with the same pay, benefits, terms and conditions of employment on your return from leave.

Included with this letter is a Certification of Health Care Provider Form that is used to determine qualification for FMLA. If coverage is needed for yourself, please enter your name in Section 2 on the first page. If leave is needed to care for a family member, provide the information in Section 2 and sign the bottom of page one. Next give the form to your health care provider for completion. The completed form should be returned to me within 15 days (DATE). It may be hand-delivered, mailed or faxed to the address below. Failure to return a completed Certification may cause a delay or denial of your FMLA coverage.

( PUT ADDRESS, PHONE, FAX)

When we receive your Certification Form we will be able to make a final determination of your qualification. At that time we will provide more information concerning your rights and responsibilities under FMLA. In the event it is determined that your condition does not qualify for FMLA, you will be notified in writing that the preliminary designation of FMLA qualification has been withdrawn.

If you have any questions about FMLA or completing the Certification of Health Care Provider Form, please contact me at (phone number).

Sincerely,

Enclosure: FMLA Certification of Health Care Provider Form

cc: Director/Supervisor

File