**RESPONSE TO REQUEST FOR FAMILY**

**OR MEDICAL LEAVE OF ABSENCE**

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| **Employee Name:** | **Date:** |
| **Department:** | **Title:** |

On [DATE] you notified us of your need to take family/medical leave due to:

* The birth of a child or the placement of a child for adoption or foster care; or
* A serious health condition that you need care for; or
* A serious health condition affecting your spouse/child/parent, for which you are needed to provide care.

You requested leave beginning [DATE] and ending on or about [DATE].

This is to inform you that (check appropriate boxes):

1. You are  eligible  not eligible for Family Responsibility leave.

2. The requested leave  will  will not be counted against your annual Family Responsibility Leave entitlement.

3. You  will  will not be required to furnish medical certification of a serious health condition. If required, you must furnish certification by [DATE] (must be within 15 days after you are notified of this requirement) or we may delay the commencement of your leave until the certification is submitted.

4. You may elect to substitute accrued annual paid leave for unpaid Family Responsibility Leave. We  will  will not require that you substitute accrued paid leave for unpaid FMLA leave. If paid leave will be used, the following conditions will apply:

5. You  will  will not be required to present a fitness-for-duty certificate prior to being restored to employment. If such certification is required but not received, your return may be delayed until such certification is provided.

6. You  will  will not be required to furnish us with periodic reports of your status and intent to return to work every [Number] days while on Family Responsibility leave.

7. You  will  will not be required to furnish recertification every [NUMBER] days relating to a serious health condition:

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| --- | --- |
| **Signature:** | **Date** |
| **Department:** | **Title:** |