{Insert Date}

SAMPLE PREGNANCY DESIGNATION LETTER

{Employee Name}
{Street Address}
{City, State ZIP}

RE: Family Medical Leave Act (FMLA) Designation

Dear *{Employee}:*

We have received the completed medical certification form, dated *{Insert date from Med Cert Form}* from your healthcare provider regarding your need for an FMLA designated leave of absence starting approximately *{Insert Beginning Date}*, and continuing through *{Insert Approximate End Date}*. Additionally, a need for periodical pre-natal visits beginning *{Insert Date Pre-Natal Visits begin}* has been indicated.

Based on the information provided at this time, Black Hawk County is designating this solid block leave of absence and pre-natal office visit request as being eligible for coverage under the Family Medical Leave Act (FMLA) and this letter provides you with notification as required by FMLA.

- Beginning date of the solid block leave: *{Insert Beginning Date}*
- Anticipated FMLA Expiration Date: *{Insert Ending Date}*(Note: This date will be adjusted to be reflective of the hours used for pre-natal office visits)
- Anticipated return to work date based on FMLA designation *{Date After End Date}* (Note: This date will be expiration of adjusted to be reflective of the hours used for pre-natal office visits)

Additionally, this notice is to advise you that an intermittent LOA program for periodical pre-natal office visits for two (2) hours in length have been approved with the following stipulations:

- You seek pre-approval for the all time absent from work by providing a schedule of pre-natal office visits.
- Appoints should be scheduled whenever possible during times (with an emphasis on utilizing non-scheduled work hours) that have the least impact on your ability to be present for your normal work schedule.
- The length of each absence shall be approved for two (2) hours for your office visit and transit time.
    - In the event the actual appointment (including waiting time in the office waiting room and transit time) exceeds two (2) hours, documentation must be provided that the office visit exceeded one (1) hour.
- Unless of an emergent nature, notification of your scheduled appointments for treatment should be provided as soon as the known appointment is made, but no less than the day before the scheduled appointment.
- In the event you find it necessary to be absent for more than as approved above due to your chronic health condition, it will be necessary to provide updated and supporting medical documentation.

Prior to returning to work, either on a full-time or reduced scheduled, we request the attached "Release to Work" form be completed by your treating healthcare practitioner. Your completed "Release to Work" form must be returned not less than two (2) days prior to your return to active work duties.

"The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services."

Everyone at Black Hawk County looks forward to your return to work. I encourage you to keep this letter as a resource and to contact me to discuss any questions. If you have any questions, please do not hesitate to contact me.

Sincerely

Supervisor's Name
Dept.

Cc: Human Resources

Black Hawk County

Medical Status/Release to Return to Work Form

PLEASE NOTE: THIS COMPLETED FORM MUST BE RETURNED TO THE EMPLOYEE'S SUPERVISOR.

Employee Name: _____

We encourage employees to continue to work or to return to work as quickly as possible. Thus, in support of the Family Medical Leave Act (FMLA) and the Americans with Disabilities Act (ADA), Black Hawk County will attempt to provide reasonable accommodations to any medically necessary limitation meeting ADA guidelines. We will also attempt to address short term limitations not meeting ADA or FMLA criteria.

In order to properly review and address the above named employee's ability to work under ADA or assess continued absences under FMLA, the following information is requested:

> ***Please Note:*** *"The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services."*

1. Has the health condition and/or treatment for which this leave was used changed? [ ] Yes, answer #1a [ ] No, answer #4

    a. If the condition will/has changed please describe these changes as they relate to the capabilities of our employee to perform the essential functions of the job.
    _____
    _____

2. Release to return to work:

    a. Is this employee released to return to work? [ ] Yes, answer 1c [ ] No, answer #4

    b. Are there are limitations/restrictions on what this employee can do? [ ] Yes, answer #3 [ ] No

    c. What date can this employee return to work? _____

3. If this employee's return to work has restrictions, please list the medically necessary restrictions/limitations required by this health condition/treatment that limits or impacts our employee's capabilities or work abilities?

    a. Please list the medically necessary restrictions (e.g., lifting maximum of 20 lbs., unable to hear normal voice tone, etc.)
    _____
    _____

    b. When will this employee be able to perform normal work duties without limitations/restrictions? (Give date or anticipated length of time the restrictions will be necessary) _____

    c. Is there other information related to work that we should be aware of to assist in a successful return to active employment?
    _____
    _____

4. If this employee is not able to return to work at this time in any capacity; when is it anticipated this employee will be able to return to work? (Give anticipated date of return to work or length of time it will necessary for the employee to be off work)

    a. Work with restrictions _____
    b. Work without restrictions? _____

5. Comments: _____
    _____
    _____

_____ _____ _____

Treating Healthcare Practitioner Signature | Treating Healthcare Practitioner Printed Name | Date