

name
ADDRESS
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Dear _____:

Based on your telephone message to _____ on _____ that you were seeking medical treatment and would be away from your job for the "foreseeable future", _____ County is exercising their right to implement the Family Medical & Leave Act for your absence. Outlined below are the terms and conditions of your medical leave.

- You are entitled to 12 weeks leave during a 12-month period, which begins DATE, and ends DATE.
- Your 12 weeks leave, if taken all at once, will end approximately DATE.
- You will be required to use paid sick leave during the leave period. It is understood that for the duration of FMLA leave _____ County will maintain your health coverage with _____.
- _____ County may [or will??] require certification of your serious health condition by a health care provider. The certification should contain the necessary information to confirm the need for the leave. Your first certification documents (blanks enclosed) are due on _____. Also _____ County may require a second opinion at County expense.
- Subsequent re-certification during the leave is allowed on a reasonable basis, which is once every thirty days if _____ County so requests. Once your original certification, and any second opinion, we will notify you when a continuing certification is due. You will not accrue sick and vacation benefits during the leave.

If, as a result of the medical certification process, your leave is determined not to qualify for FMLA, we may notify you. In that case the County will reassess your employment status.