

FP MANAGER MANUAL

Section 8 – Leave of Absence

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Fresh Picks Cafe is a division of Café Services™

LEAVE OF ABSENCE

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Leave of Absence - Procedure



To allow for proper staffing, benefits management and payroll the need for leave needs to be communicated and approved in advance whenever possible. The need for a leave of absence must be communicated on a Leave of Absence (LOA) request form. If a leave does not qualify under FML or Military Leave then the leave must be approved by the District Manager, VP, HR Director and President/CEO. When the need is foreseeable a request for leave should be made a minimum of 30 days in advance.

Types of leave:

Personal Leave: A Personal Leave of Absence may be granted without pay with approval from the Company President and Director, Human Resources.

Military Leave: Employees serving in the reserve or National Guard may take unpaid military leave, as needed, to enable them to fulfill their obligations as reservists or Guard members.

Jury Duty: The Company supports an employees need to fulfill their civic duties. To that end, employees will be granted leave to serve on a jury, if summoned. Documentation of the summons must be presented.

Maternity/Paternity Leave: Café Services will approve leave time in accordance with the laws of the state in which the employee works.

FMLA - To be eligible, the employee must have worked at least 1,250 hours in the preceding 12 months and be employed at least 12 months. Additional FML documentation is required.

- Maternity/Paternity Leave: To care for the employee's child after birth, or placement for adoption or foster care.
- Caretaker Leave: To care for the employee's spouse, child, or parent who has a serious health condition.
- Medical Leave: A serious health condition making the employee unable to perform essential functions of their job.
- Federal Family Medical Leave Act (FMLA) – Employee, or their spouse, child or parent, has been called to active duty in the Armed Forces in support of a contingency operation or has incurred an injury or illness in the line of duty while on active duty.

Leave of Absence Request Form

The need for a leave of absence should be communicated at least 30 days in advance, when advance notice is possible. Supporting documentation regarding the need for leave must be attached to the Leave of Absence Request form. Upon receipt of this form HR will reach out to the employee to ensure they understand the process, to communicate any additional needs to qualify the leave and to discuss benefits and the use of paid time off when appropriate.

If an employee would like to discuss their need for leave and options prior to completing the request please have them contact Human Resources so we can answer any questions they may have.



Café Services, Inc.
Leave of Absence Request Form

Employee's Name	Location	Position
Work Schedule (Days and Shift)	Date of Hire	Contact Number
Type of Leave: Check One Below		
Date Leave Starts	Expected Return Date	
<input type="checkbox"/> Personal Leave – A Personal Leave of Absence may be granted without pay with approval from the Company President and Director, Human Resources. Each request for a leave of absence will be evaluated on an individual basis, taking into consideration length of service, work record, staffing needs, reason and length of the leave. During an unpaid leave of absence an employee participating in company sponsored benefits may be responsible for the full cost of the benefit.		
<input type="checkbox"/> Military Leave – Attach a copy of the military orders to the Leave of Absence Request Form.		
<input type="checkbox"/> Federal Family Medical Leave Act (FMLA) – To be eligible must have worked at least 1,250 hours in the preceding 12 months and be employed at least 12 months. Additional FML documentation is required.		
<input type="checkbox"/> Maternity of Paternity Leave: To care for the employee's child after birth, or placement for adoption or foster care.		
<input type="checkbox"/> Caretaker Leave: To care for the employee's spouse, child, or parent who has a serious health condition.		
<input type="checkbox"/> Medical Leave: A serious health condition making the employee unable to perform essential functions of their job.		
<input type="checkbox"/> Federal Family Medical Leave Act (FMLA) – Employee, or their spouse, child or parent, has been called to active duty in the Armed Forces in support of a contingency operation or has incurred an injury or illness in the line of duty while on active duty.		
Reason For Leave: Provide a detail explanation below. If intermittent, include proposed schedule.		
Is this an extension of a current leave? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, original dates were from _____ to _____		
Signatures: I have read and understand the Café Services policy concerning leave of absence and certify the above information is true and complete.		
Employee's Signature _____	Date _____	
Approval		
District Manager (Print)	(Signature)	Date
VP, Operations (Print)	(Signature)	Date
HR Director (Print)	(Signature)	Date
President/CEO <i>(for Personal LOA only)</i> (Print)	(Signature)	Date



FAMILY AND MEDICAL LEAVE ACT POLICY

The function of this policy is to provide employees with a general description of their FMLA rights. In the event of any conflict between this policy and the applicable law, employees will be afforded all rights required by law.

The Family and Medical Leave Act ("FMLA") provides eligible employees the opportunity to take unpaid, job-protected leave for certain specified reasons.

Employee Eligibility - Employees of Café Services, Inc. are eligible for family and medical leave if they have at least 12 months of service, have worked at least 1,250 hours within the preceding 12-month period, and work at a worksite where there are at least 50 employees within a 75-mile radius. If eligible, an employee may be able to take up to 12 weeks of unpaid leave during a 12-month period.

Basic Leave Entitlement - FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements - Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Exigencies is defined as a pressing or urgent situation and may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Use of Leave - An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

FMLA and Workers Compensation - FMLA and worker's compensation leave will be applied concurrently, provided that the reason for the absence is due to a qualified job-related serious illness or injury and the employer properly notifies the employee in writing that the leave will be counted as FMLA leave.

Substitution of Paid Leave for Unpaid Leave - Employees must use any accumulated sick leave, vacation time, or paid time off (PTO) to the extent available during FMLA leave unless such leave is covered under workers' compensation, in which case the employee may use accumulated leave time only for the purpose of satisfying any waiting period. Absences in excess of these accumulated days will be treated as FMLA leave without pay.

Employee Responsibilities - Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities – As a covered employer, Café Services, must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, Café Services must provide a reason for the ineligibility.

Café Services must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If Café Services determines that the leave is not FMLA-protected, Café Services must notify the employee.

Benefits and Protections - During FMLA leave, Café Services must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Fitness for Duty Certifications - Because Café Services wishes to ensure the well-being of all employees, any employee returning from FMLA leave for his/her own serious health condition may need to provide a Fitness for Duty (FFD) certification signed by his/her health care provider. An employee who fails to provide an FFD certification upon request will be prohibited from returning to work until it is provided. An employee who fails to provide an FFD certification may lose FMLA restoration rights.

FFD certifications may be required when an employee returns from intermittent FMLA leave if serious concerns exist regarding the employee's ability to resume his/her duties safely.

Married Couples Who Work for Café Services, Inc - If an employee and his/her spouse both work for Cafe Services, they are both eligible for leave. The employee and employee spouse may be limited to a combined total of 12 weeks of FMLA leave in a 12-month period if the leave is taken for:

- The birth, adoption, or foster placement of a child;
- To care for and bond with such child who does not suffer from a serious health condition;
- To care for a parent with a serious health condition; or
- A combination of the above.

For military caregiver leave, the employee and employee spouse may be limited to a combined total of 26 weeks of leave in a 12-month period, including the types of leave listed above in this paragraph.



1 E Commons Dr., Unit 25
PO Box 1069
Londonderry, NH 03053

5/31/2012

Jane Doe
Somewhere St.
Londonderry, NH 03053

Dear: Jane

You meet the eligibility guidelines to potentially qualify for leave time under the Family Medical Leave Act. This letter and enclosed information regarding the Family and Medical Leave Act is to give you an overview of our responsibility as an employer and what is expected of you to certify your need for leave and while on leave.

Enclosed please find:

- **Café Services' FMLA policy**
- **Notice of Eligibility and Rights**
- **Certification of Health Care Provider – *This form must be returned to us within 15 days***
- **Health Insurance Premium breakdown**

Please review and keep for your records, our FMLA policy, the Notice of Eligibility and Rights form and the Health Insurance Premium breakdown.

The Certification of your Health Care Provider form will need to be given to your health care provider for completion and *sent back to Café Services by you or the certifying health care provider*. Please be sure that this completed form is returned to us within 15 days following this notice. Failure to provide certification may result in a denial of commencement of your leave (please see our FMLA policy for further information). All medical information received for FMLA leave is considered confidential and shall be disclosed only to those involved in the FMLA leave determination.

After receipt and review of the forms, we will make a determination on if your circumstances qualify and will be designated as FMLA leave. If you have any questions or would like more information on FMLA leave, please contact Human Resources at 603.437.0200.

Sincerely,

Human Resources

Notice of Eligibility and Rights & Responsibilities
(Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division



OMB Control Number: 1235-0003
Expires: 2/29/2012

In general, to be eligible an employee must have worked for an employer for at least 12 months, have worked at least 1,250 hours in the 12 months preceding the leave, and work at a site with at least 50 employees within 75 miles. While use of this form by employers is optional, a fully completed Form WH-381 provides employees with the information required by 29 C.F.R. § 825.300(b), which must be provided within five business days of the employee notifying the employer of the need for FMLA leave. Part B provides employees with information regarding their rights and responsibilities for taking FMLA leave, as required by 29 C.F.R. § 825.300(b), (c).

[Part A – NOTICE OF ELIGIBILITY]

TO: _____
Employee

FROM: _____
Employer Representative

DATE: _____

On _____, you informed us that you needed leave beginning on _____ for:

- The birth of a child, or placement of a child with you for adoption or foster care;
- Your own serious health condition;
- Because you are needed to care for your _____ spouse; _____ child; _____ parent due to his/her serious health condition.
- Because of a qualifying exigency arising out of the fact that your _____ spouse; _____ son or daughter; _____ parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves.
- Because you are the _____ spouse; _____ son or daughter; _____ parent; _____ next of kin of a covered servicemember with a serious injury or illness.

This Notice is to inform you that you:

- Are eligible for FMLA leave (See Part B below for Rights and Responsibilities)
- Are **not** eligible for FMLA leave, because (only one reason need be checked, although you may not be eligible for other reasons):
 - You have not met the FMLA's 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately _____ months towards this requirement.
 - You have not met the FMLA's 1,250-hours-worked requirement.
 - You do not work and/or report to a site with 50 or more employees within 75-miles.

If you have any questions, contact _____ or view the FMLA poster located in _____.

[PART B-RIGHTS AND RESPONSIBILITIES FOR TAKING FMLA LEAVE]

As explained in Part A, you meet the eligibility requirements for taking FMLA leave and still have FMLA leave available in the applicable 12-month period. **However, in order for us to determine whether your absence qualifies as FMLA leave, you must return the following information to us by _____.** (If a certification is requested, employers must allow at least 15 calendar days from receipt of this notice; additional time may be required in some circumstances.) If sufficient information is not provided in a timely manner, your leave may be denied.

- Sufficient certification to support your request for FMLA leave. A certification form that sets forth the information necessary to support your request _____ is/_____ is not enclosed.
- Sufficient documentation to establish the required relationship between you and your family member.
- Other information needed: _____

No additional information requested

If your leave does qualify as FMLA leave you will have the following responsibilities while on FMLA leave (only checked blanks apply):

Contact _____ at _____ to make arrangements to continue to make your share of the premium payments on your health insurance to maintain health benefits while you are on leave. You have a minimum 30-day (or, indicate longer period, if applicable) 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 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.

You will be required to use your available paid _____ sick, _____ vacation, and/or _____ other leave during your FMLA absence. This means that you will receive your paid leave and the leave will also be considered protected FMLA leave and counted against your FMLA leave entitlement.

Due to your status within the company, you are considered a "key employee" as defined in the FMLA. As a "key employee," restoration to employment may be denied following FMLA leave on the grounds that such restoration will cause substantial and grievous economic injury to us. We _____ have/_____ have not determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic harm to us.

While on leave you will be required to furnish us with periodic reports of your status and intent to return to work every _____. (Indicate interval of periodic reports, as appropriate for the particular leave situation).

If the circumstances of your leave change, and you are able to return to work earlier than the date indicated on the reverse side of this form, you will be required to notify us at least two workdays prior to the date you intend to report for work.

If your leave does qualify as FMLA leave you will have the following rights while on FMLA leave:

- You have a right under the FMLA for up to 12 weeks of unpaid leave in a 12-month period calculated as:
 - _____ the calendar year (January – December).
 - _____ a fixed leave year based on _____.
 - _____ the 12-month period measured forward from the date of your first FMLA leave usage.
 - _____ a "rolling" 12-month period measured backward from the date of any FMLA leave usage.
- You have a right under the FMLA for up to 26 weeks of unpaid leave in a single 12-month period to care for a covered servicemember with a serious injury or illness. This single 12-month period commenced on _____.
- Your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work.
- You must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA-protected leave. (If your leave extends beyond the end of your FMLA entitlement, you do not have return rights under FMLA.)
- 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; 2) the continuation, recurrence, or onset of a covered servicemember's serious injury or illness which would entitle you to FMLA leave; or 3) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave.
- If we have not informed you above that you must use accrued paid leave while taking your unpaid FMLA leave entitlement, you have the right to have _____ sick, _____ vacation, and/or _____ other leave run concurrently with your unpaid leave entitlement, provided you meet any applicable requirements of the leave policy. Applicable conditions related to the substitution of paid leave are referenced or set forth below. If you do not meet the requirements for taking paid leave, you remain entitled to take unpaid FMLA leave.

_____ For a copy of conditions applicable to sick/vacation/other leave usage please refer to _____ available at: _____.

_____ Applicable conditions for use of paid leave: _____

Once we obtain the information from you as specified above, we will inform you, within 5 business days, whether your leave will be designated as FMLA leave and count towards your FMLA leave entitlement. If you have any questions, please do not hesitate to contact:

_____ at _____.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

It is mandatory for employers to provide employees with notice of their eligibility for FMLA protection and their rights and responsibilities. 29 U.S.C. § 2617; 29 C.F.R. § 825.300(b), (c). It is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 10 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.**

Certification of Health Care Provider for
Employee's Serious Health Condition
(Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division



OMB Control Number: 1235-0003
Expires: 2/29/2012

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

Employer name and contact: _____

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions: _____

Check if job description is attached: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: _____
First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: () Fax: ()

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

Probable duration of condition: _____

Mark below as applicable:

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

No Yes. If so, dates of admission:

Date(s) you treated the patient for condition:

Will the patient need to have treatment visits at least twice per year due to the condition? No Yes.

Was medication, other than over-the-counter medication, prescribed? No Yes.

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?

No Yes. If so, state the nature of such treatments and expected duration of treatment:

2. Is the medical condition pregnancy? No Yes. If so, expected delivery date: _____

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition: No Yes.

If so, identify the job functions the employee is unable to perform:

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___ No ___ Yes.

If so, estimate the beginning and ending dates for the period of incapacity: _____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ___ No ___ Yes.

If so, are the treatments or the reduced number of hours of work medically necessary?
___ No ___ Yes.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

Estimate the part-time or reduced work schedule the employee needs, if any:

_____ hour(s) per day; _____ days per week from _____ through _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ___ No ___ Yes.

Is it medically necessary for the employee to be absent from work during the flare-ups?
___ No ___ Yes. If so, explain:

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency : _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or ___ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

Signature of Health Care Provider

Date

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**



1 E Commons Dr., Unit 25
PO Box 1069
Londonderry, NH 03053

May 31, 2012

Jane Doe
Somewhere St.
Londonderry, NH 03053

Re: Payment of benefits

Dear Jane :

While on leave, your portion of the health insurance premiums will be your responsibility. Below please find a breakdown of your weekly benefit premium(s). Please contact Human Resources regarding schedule of payment for your portion of your insurance premiums while on leave.

The following rates are based on your weekly portion deducted from your paycheck:

- **Employee Medical** **\$69.23/week**
- **Employee Dental** **\$4.15/week**
- **Short Term Disability** **\$5.12/week**
- **Long Term Disability** **\$3.81/week**

Total amount per week: \$82.31

Should you have any questions, please contact Human Resources at 603.437.0200.

Thank you,

Human Resources



1 E Commons Dr., Unit 25
PO Box 1069
Londonderry, NH 03053

5/31/2012

«First_Name» «Last_Name»
«Street»
«City», «State» «Zip»

Dear «First_Name»:

You are currently on an approved FMLA leave; all leave taken for this reason will be designated as FMLA leave.

Date of Leave:

The FMLA requires that you notify us as soon as practicable if dates of scheduled leave change or are extended, or were initially unknown. Based on the information you have provided to date, we are providing the following information about the amount of time that will be counted against your leave entitlement:

Provided there is no deviation from your anticipated leave schedule, the following number of hours, days, or weeks will be counted against your leave entitlement: 12 weeks of continuous leave

Please be advised (check if applicable):

You have requested to use paid leave during your FMLA leave. Any paid leave taken for this reason will count against your FMLA leave entitlement.

We are requiring you to substitute or use paid leave during your FMLA leave.

You will be required to present a fitness-for-duty certificate to be restored to employment. If such certification is not timely received, your return to work may be delayed until certification is provided. A list of the essential functions of your position is attached is not attached. If attached, the fitness-for-duty certification must address your ability to perform these functions.

Anticipated Return Date:

If you have any questions or would like more information on FMLA leave, please contact Human Resources at 603.437.0200.

Sincerely,

Human Resources