

FAMILY AND MEDICAL LEAVE ACT (FMLA) DESIGNATION NOTICE

To: _____

Date: _____

We reviewed your request dated _____ and supporting documentation dated _____, for leave under the FMLA. Our decision is indicated below:

- Your request for FMLA leave is approved to start on _____. It is scheduled to end on _____. All leave taken under this request will be designated as FMLA leave.

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

For consecutive FMLA requests:

- Per your FMLA request, the following estimated number of hours, days, or weeks will be counted against your leave entitlement: _____. **Note:** If you deviate from your anticipated leave schedule, these amounts may change.

For Intermittent FMLA requests:

- Because the leave requested will be unscheduled, it is not possible to estimate the hours, days, or weeks that will be counted against your FMLA entitlement at this time. You have the right to request this information once in a 30 day period (if leave was taken in the 30 day period).

Per your request, your leave will: Run concurrently with ___ Sick or ___ Annual Leave Be Unpaid

Other: _____

Per UAP #3440 FML policy, an employee returning to work following a leave of absence due to his or her own serious health condition must submit a physician's statement certifying that the employee can return to work and can perform the essential functions of the job, with or without reasonable accommodations. The University may request the employee provide the physician's statement up to five (5) workdays in advance of the employee's anticipated return date.

Note: Applicable workers' compensation, catastrophic leave, or disability will count against your FMLA leave entitlement.

Please be advised: (Check one)

- The certification submitted was **not complete or sufficient to determine whether FMLA applies**. You must provide further information no later than _____ (**7 calendar days**) or your leave may be delayed or denied. Information needed to make the certification complete or sufficient is:

Based on the information you provided, your request for FMLA leave is being **disapproved** because FMLA does not apply to your leave request.

You have exhausted your FMLA leave entitlement in the applicable 12-month period.

We are exercising our right to have you obtain a second or third opinion at our expense. We will provide you with further information within five (5) business days.

By signing below, I signify that I have approved/disapproved the request for FMLA and I have given a copy of this form to the employee. If FMLA has been approved, a copy of the position class description has been attached.

Supervisor Signature: _____

Date: _____