



DOUGLAS COUNTY, NEBRASKA
DESIGNATION NOTICE
FAMILY AND MEDICAL LEAVE ACT

TO: _____

DATE: _____

We have reviewed your request for leave under the FMLA and any supporting documentation that you have provided. We received your most recent information on _____ and decided:

[] Your FMLA leave request is approved. All leave taken for this reason will be designated as FMLA 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: _____

[] Because the leave you will need will be unscheduled, it is not possible to provide 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).

Please be advised (check if applicable):

[] Per County policy we are requiring you to use your available paid sick leave, if applicable, during your FMLA leave. Once exhausted, you may use other paid leaves as indicated on your application.

[] 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. Per County policy, all sick leave must be used prior to vacation, comp, or unpaid time.

[] 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 [] is not attached. If attached, the fitness-for-duty certification must address your ability to perform these functions.

[] Additional information is needed to determine if your FMLA leave request can be approved:

[] The certification you have provided is not complete and sufficient to determine whether the FMLA applies to your leave request. You must provide the following information no later than (in following field provide at least seven calendar days)

_____, unless it is not practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied.

Specify information needed to make the certification complete and sufficient _____

[] We are exercising our right to have you obtain a second or third opinion medical certification at our expense, and we will provide further details at a later time.

[] Your FMLA Leave request is not approved.

[] The FMLA does not apply to your leave request.

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

Department Approval By: _____ Date: _____

HR Department Review By: _____ Date: _____