FMLA DESIGNATION NOTICE

Department FMLA Leave Administrator to complete appropriate sections.

EMPLOYEE INFORMATION

Name:	PeopleSoft ID #:
Dates:	

1. ☐ Your Request for FMLA Leave as indicated on your certification is **approved** for the following period of time:

_____

According to the certification, the duration and frequency that is authorized for time away from work is:

_____

NOTE: *Should your need for time off exceed the frequency or duration shown above, or extend beyond the approval period, you will need to provide an updated certification or your FMLA may be denied.*

2. ☐ Your Request for FMLA is **not** approved because:

- ☐ You have not met the FMLA service requirement.
- ☐ You have exhausted your FMLA leave entitlement in the applicable 12-month period.
- ☐ Your request for leave is not covered by the Federal FMLA and/or Wisconsin FMLA. *Comment:*

_____

- ☐ ***Other:*** _____

3. ☐ Your request for FMLA leave is **pending** until additional information is received.

- ☐ The certification you have provided is not complete and sufficient to determine eligibility for FMLA. Please provide the information requested below no later than _____ *(at least 7 calendar days)* unless it is not practicable under the particular circumstances. Failure to provide information by the due date may result in FMLA denial.
- ☐ A second or third opinion medical certification at our expense is completed and we will provide further Instructions.

4. Return to Work Requirements:

- ☐ You will be required to present a return to work release from your health care provider to be restored to employment, listing any medical restrictions *(if applicable)*.
- ☐ A list of the essential functions of your job ☐ **is** ☐ **is not** attached. If attached, the release-to-duty certification must address your ability to perform these functions. If such certification is not received in a timely manner, your return to work may be delayed until certification is provided.
- ☐ You will be required to present a return to work release once every 30 days to be restored to employment following a period of intermittent leave if reasonable safety concerns exist regarding your ability to perform your duties.

↑ *Approving Officer's **Signature** (leave administrator)* ↑	*Approving Officer's Title*	*Date*

*Approving Officers' name **(printed)**:*

Employee Supervisor Name and Title:

Date

☐ Copy to Employee Supervisor ☐ Original to confidential Medical File
☐ Copy to Payroll File

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.