FMLA First Notice: *Notice of Eligibility and Rights & Responsibilities*

Must be provided within five business days of employee's request or receipt of information that leave may qualify under FMLA.

Name: _____ Department: _____

Part A: Notice of Eligibility

On _____/_____/_____, this office/department was notified of your need to take FMLA leave beginning on _____/_____/_____for:

- ☐ The birth of a child, or the placement of a child for adoption or foster care.
- ☐ Your own serious health condition
- ☐ Because you are needed to care for your [ ] spouse, [ ] son or daughter, or [ ] parent due to his/her serious health condition.
- ☐ Because of a qualifying exigency arising out of the fact that your [ ] spouse, [ ] son or daughter, or [ ] 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, or [ ] 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 below for Rights and Responsibilities)
- ☐ You are not eligible for FMLA leave because (only one reason need be checked):
  - ☐ You have not met the FMLA's 12-month length of service requirement. As of the first date of leave requested, you will have worked approximately _____ months towards this requirement.
  - ☐ You have not met the FMLA's 1,250 hours worked requirement.

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

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 this calendar year. However, in order for us to determine whether your absence qualifies as FMLA leave, you must return the following information to us by _____/_____/_____. (Minimum of at least 15 calendar days from receipt of this notice.) If sufficient information is not provided in a timely manner, your leave may be denied, or you may be subject to disciplinary action (e.g. insubordination).

- ☐ 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. See employee website for forms, if not enclosed, www.co.wood.oh.us/employee under the forms section.
  - ☐ Certification of Health Care Provider for Employee's Serious Health Condition (attach job classification)
  - ☐ Certification of Health Care Provider for Family Member's Serious Health Condition
  - ☐ Certification of Qualifying Exigency for Military Family Leave
  - ☐ Certification for Serious Injury or Illness of Covered Service Member for Military Family Leave
  - ☐ Equivalent documentation in the case of an adoption/foster care.
- ☐ 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 (check those that apply):

☐ You will be required to use your available paid leave, provided the need for leave meets the statutory requirement (e.g. adoption and qualifying exigency do not meet the definition of sick leave).

Available balances as of _____/_____/_____ paydate:

Sick Leave Hours _____ Vacation Leave Hours _____

Compensatory Time Hours _____ Personal Leave Hours _____

☐ This means that you will receive your available paid leave and the leave will be considered protected FMLA leave and counted against your FMLA leave entitlement. If you do not meet the requirements for taking paid leave, you remain entitled to take unpaid FMLA leave.

☐ 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).

☐ You will be required to present a fitness-for-duty certification prior to your return to duty.

☐ Contact your insurance group representative 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. Effective _____/ 1 /_____ you will be required to self pay your insurance premium by the last day of the month prior to coverage. Checks are payable to the Wood County Treasurer and shall be submitted to your insurance group representative. You have a minimum 30-day 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. See the Plan Document for additional reporting requirements (e.g., completing application to add dependent).

If the circumstances of your leave change, and you are able to return to work earlier than scheduled, 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 leave from January 1 through December 31.
- 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.

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.

Employer Representative: _____ Phone_____

Date Notice Provided to Employee: _____ ☐ Mailed ☐ Hand Delivered

cc: Employee's FMLA file Insurance Group Rep Department Payroll Officer Supervisor (if not completing this form)