

**MEMORANDUM**

**DATE:**

**TO:** (Employee's Name)

**FROM:** (Supervisor)

**SUBJECT:** Response to Request for Leave of Absence due to Reason Covered under the Family and Medical Leave Act of 1993

On \_\_\_\_\_, you notified us of your need to take family/medical leave due to:

\_\_\_\_\_ the birth of your child, or the placement of a child with you for adoption or foster care; or

\_\_\_\_\_ a serious health condition that makes you unable to perform the essential functions of your job; or

\_\_\_\_\_ a serious health condition affecting the following family member for whom you are needed to provide care:

\_\_\_\_\_ your spouse

\_\_\_\_\_ your child

\_\_\_\_\_ your parent

\_\_\_\_\_ other \_\_\_\_\_ (relationship).

You notified us that you need this leave to begin on \_\_\_\_\_, and that you expect to return to work on \_\_\_\_\_ as determined by medical certification.

Your request for a leave of absence has been approved pending our receipt of the medical certification form completed by the appropriate health provider. The requested leave will be counted towards your entitlement under the Family and Medical Leave Act. The following is a listing of your rights and responsibilities.

1. Sign two copies of this document and return them to me by (date).
2. Provide the following documentation to support the leave of absence within 15 calendar days from the date of this document:

\_\_\_\_\_ Certification of a serious health condition for self or other applicable individual

\_\_\_\_\_ Documentation supporting the birth of your child or placement of child for adoption or foster care

3. Upon returning to work on (date), you will return to your same position/job or to an equivalent position/job.

4. Insurance Premiums

If you participate in the State Insurance Program, you may cancel your insurances within 31 days after commencement of the leave of absence. If your insurance is canceled, you may re-enroll within 31 days after returning from the leave.

You have the right to continue paying the same premium rate for state health and state life insurance as if you were actively working.

If the leave of absence will involve the use of accrued leave, applicable premiums are payroll deducted. If only a portion of accrued leave is to be used during the leave of absence:

- a. contact the Payroll Office and request assistance in calculating the number of hours of accrued leave that must be used each pay period in order to ensure premiums and other miscellaneous deductions are deducted from your biweekly pay;
- b. notify me, prior to the leave commencing, of the type of accrued leave and number of accrued leave hours you will use each pay period during the leave of absence; and
- c. the number of hours of leave you accrue during this period will be proportionate to the hours paid during each pay period.

If the leave of absence is to be without pay, contact Human Resources prior to beginning your leave of absence or, if a medical emergency prevented that, contact Human Resources during the first week of the absence to ensure that employer contributions are paid for your health insurance. In addition, you must also contact Human Resources to discuss payment arrangements for your portion of the premium. If payment is not made according to instructions provided to you by Human Resources, your health insurance may be canceled.

5. If the leave of absence is due to your serious health condition, you will be required to present a release from your physician authorizing you to return to employment. If such certification is not received, your return to work may be delayed until the certification is provided.

6. If the circumstances of your leave change and you are able to return to work earlier than the date indicated above, you will \_\_\_ will not \_\_\_ be required to notify us at least two workdays prior to the date you intend to report for work.

I understand that I must comply with all of the above statements, as relating to my leave of absence. I understand that this leave of absence, whether with or without pay, counts towards my entitlement under the Family and Medical Leave Act.

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Signature of Employee

Date

NOTE TO SUPERVISOR: PROVIDE THE EMPLOYEE WITH TWO COPIES OF THIS DOCUMENT AND REQUEST THAT THE EMPLOYEE SIGN BOTH COPIES. THE SUPERVISOR AND THE EMPLOYEE SHOULD EACH RETAIN A COPY WITH ORIGINAL SIGNATURES.

NOTE: Contents extracted from U. S. Department of Labor - Form WH-381 December 1994.