HERKIMER COUNTY

Employer Response to Employee
Request for Family or Medical Leave
(Family and Medical Leave Act of 1993)

DATE: _____

TO: _____
(Employee's Name)

FROM: _____
(Name of appointing authority)

SUBJECT: Request for Family/Medical Leave

On _____, you notified us of your need to take family/medical leave due to:
(date)

____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 your ____spouse, ___child, ___ parent, for which you are needed to provide care;

____caring for a family member who is injured while on active military duty (up to 26 weeks of leave);

____the urgent needs related to a family member's current active military duty or a call to active military duty.

You notified us that you need this leave beginning on _____ and that you expect leave to continue until on or about _____. (date)
(date)

Except as explained below, you have a right under the FMLA for up to twelve (12) weeks of unpaid leave in a 12-month period for the reasons listed above. Also, your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work and 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 leave. 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; or (2) 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.

This is to inform you that: (check appropriate lines; explain where necessary)

1. You are _____ (eligible) ____ (not eligible) for leave under the FMLA.

2. The requested leave _____ (will) _____ (will not) be counted against your annual FMLA entitlement.

3. You will be required to use your available ____sick, ____vacation, and/or ____other leave during your

   FMLA absence. This means that you will receive your paid leave and the leave will also be considered protected FMLA leave and counted against your FMLA leave entitlement.

4. You _____ (will) _____ (will not) be required to furnish medical certification of a serious health condition. If required, you must furnish certification by _____ (insert date—must be at least 15 days after employee is notified of this requirement) or we may delay the commencement of your leave until the certification is submitted.

Return completed original form to employee. Place one photocopy in employee's departmental personnel file and attach one photocopy to Report of Personnel Change form forwarded to Personnel Department noting commencement of leave.