Designation Notice
under the Family and Medical Leave Act

U.S. Department of Labor
Wage and Hour Division

WAGE AND HOUR DIVISION

DO NOT SEND TO THE DEPARTMENT OF LABOR.
PROVIDE TO EMPLOYEE.

OMB Control Number: 1235-0003
Expires: 6/30/2026

Leave covered under the Family and Medical Leave Act (FMLA) must be designated as FMLA-protected and the employer must inform the employee of the amount of leave that will be counted against the employee's FMLA leave entitlement. In order to determine whether leave is covered under the FMLA, the employer may request that the leave be supported by a certification. If the certification is incomplete or insufficient, the employer must state in writing what additional information is necessary to make the certification complete and sufficient. While use of this form is optional, a fully completed Form WH-382 provides employees with the information required by 29 C.F.R. §§ 825.300(d), 825.301, and 825.305(c), which must be provided within five business days of the employer having enough information to determine whether the leave is for an FMLA-qualifying reason. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

SECTION I - EMPLOYER

The employer is responsible in **all** circumstances for designating leave as FMLA-qualifying and giving notice to the employee. Once an eligible employee communicates a need to take leave for an FMLA-qualifying reason, an employer may not delay designating such leave as FMLA leave, and neither the employee nor the employer may decline FMLA protection for that leave.

Date: _____ *(mm/dd/yyyy)*

From: _____ *(Employer)* To: _____ *(Employee)*

On _____ *(mm/dd/yyyy)* we received your most recent information to support your need for leave due to: *(Select as appropriate)*

- ☐ The birth of a child, or placement of a child with you for adoption or foster care, and to bond with the newborn or newly-placed child
- ☐ Your own serious health condition
- ☐ The serious health condition of your spouse, child, or parent
- ☐ A qualifying exigency arising out of the fact that your spouse, child, or parent is on covered active duty or has been notified of an impending call or order to covered active duty with the Armed Forces
- ☐ A serious injury or illness of a covered servicemember where you are the servicemember's spouse, child, parent, or next of kin *(Military Caregiver Leave)*

We have reviewed information related to your need for leave under the FMLA along with any supporting documentation provided and decided that your FMLA leave request is: *(Select as appropriate)*

☐ **Approved.** All leave taken for this reason will be designated as FMLA leave. Go to Section III for more information.

☐ **Not Approved**: *(Select as appropriate)*
- ☐ The FMLA does not apply to your leave request.
- ☐ As of the date the leave is to start, you do not have any FMLA leave available to use.
- ☐ Other _____

☐ **Additional information** is needed to determine if your leave request qualifies as FMLA leave. *(Go to Section II for the specific information needed. If your FMLA leave request is approved and no additional information is needed, go to Section III.)*

SECTION II – ADDITIONAL INFORMATION NEEDED

We need additional information to determine whether your leave request qualifies under the FMLA. Once we obtain the additional information requested, we will inform you **within 5 business days** if your leave will or will not be designated as FMLA leave and count towards the amount of FMLA leave you have available. **Failure to provide the additional information as requested may result in a denial of your FMLA leave request**.

If you have any questions, please contact: _____ at _____
(Name of employer FMLA representative) *(Contact information)*

Incomplete or Insufficient Certification

The certification you have provided is incomplete and/or insufficient to determine whether the FMLA applies to your leave request. *(Select as applicable)*

☐ The certification provided is incomplete and we are unable to determine whether the FMLA applies to your leave request. *"Incomplete" means one or more of the applicable entries on the certification have not been completed.*

Employee Name: _____

☐ The certification provided is insufficient to determine whether the FMLA applies to your leave request. *"Insufficient" means the information provided is vague, unclear, ambiguous or non-responsive.*

Specify the information needed to make the certification complete and/or sufficient: _____

_____

You must provide the requested information no later than *(provide at least 7 calendar days)* _____ *(mm/dd/yyyy),* unless it is not practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied.

Second and Third Opinions

☐ We request that you obtain a (☐ second / ☐ third opinion) medical certification at our expense, and we will provide further details at a later time. *Note: The employee or the employee's family member may be requested to authorize the health care provider to release information pertaining only to the serious health condition at issue.*

SECTION III – FMLA LEAVE APPROVED

As explained in Section I, your FMLA leave request is approved. All leave taken for this reason will be designated as FMLA leave and will count against the amount of FMLA leave you have available to use in the applicable 12-month period. The FMLA requires that you notify us as soon as practicable if the dates of scheduled leave change, 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 the total **amount of FMLA leave** you have available to use in the applicable 12-month period: *(Select as appropriate)*

☐ Provided there is no change from your **anticipated FMLA 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 all that apply)*

☐ **Some or all of your FMLA leave will not be paid.** Any unpaid FMLA leave taken will be designated as FMLA leave and counted against the amount of FMLA leave you have available to use in the applicable 12-month period.

☐ **Based on your request, some or all of your available paid leave** *(e.g., sick, vacation, PTO)* **will be used during your FMLA leave.** Any paid leave taken for this reason will also be designated as FMLA leave and counted against the amount of FMLA leave you have available to use in the applicable 12-month period.

☐ **We are requiring you to use some or all of your available paid leave** *(e.g., sick, vacation, PTO)* **during your FMLA leave.** Any paid leave taken for this reason will also be designated as FMLA leave and counted against the amount of FMLA leave you have available to use in the applicable 12-month period.

☐ **Other:** _____
(e.g., Short- or long-term disability, workers' compensation, state medical leave law, etc.) Any time taken for this reason will also be designated as FMLA leave and counted against the amount of FMLA leave you have available to use in the applicable 12-month period.

Return-to-work requirements. To be restored to work after taking FMLA leave, you (☐ will be / ☐ will not be) required to provide a certification from your health care provider (fitness-for-duty certification) that you are able to resume work. This request for a fitness-for-duty certification is *only* with regard to the particular serious health condition that caused your need for FMLA leave. **If such certification is not timely received, your return to work may be delayed until the 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 the essential job functions.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

It is mandatory for employers to inform employees in writing whether leave requested under the FMLA has been determined to be covered under the FMLA. 29 U.S.C. § 2617; 29 C.F.R. § 825.300(d), (e). It is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 10 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THE DEPARTMENT OF LABOR. EMPLOYEE INFORMATION.

Notice of Eligibility & Rights and Responsibilities under the Family and Medical Leave Act

U.S. Department of Labor
Wage and Hour Division

WAGE AND HOUR DIVISION

DO NOT SEND TO THE DEPARTMENT OF LABOR.
PROVIDE TO EMPLOYEE.

OMB Control Number: 1235-0003
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In general, to be eligible to take leave under the Family and Medical Leave Act (FMLA), an employee must have worked for an employer for at least 12 months, meet the hours of service requirement in the 12 months preceding the leave, and work at a site with at least 50 employees within 75 miles. While use of this form is optional, a fully completed Form WH-381 provides employees with the information required by 29 C.F.R. §§ 825.300(b), (c) which must be provided within five business days of the employee notifying the employer of the need for FMLA leave. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

Date: _____ *(mm/dd/yyyy)*

From: _____ *(Employer)* To: _____ *(Employee)*

On _____ *(mm/dd/yyyy)*, we learned that you need leave *(beginning on)* _____ *(mm/dd/yyyy)* for one of the following reasons: *(Select as appropriate)*

☐ The birth of a child, or placement of a child with you for adoption or foster care, and to bond with the newborn or newly-placed child

☐ Your own serious health condition

☐ You are needed to care for your family member due to a serious health condition. Your family member is your:

☐ Spouse ☐ Parent ☐ Child under age 18 ☐ Child 18 years or older and incapable of self-care because of a mental or physical disability

☐ A qualifying exigency arising out of the fact that your family member is on covered active duty or has been notified of an impending call or order to covered active duty status. Your family member on covered active duty is your:

☐ Spouse ☐ Parent ☐ Child of any age

☐ You are needed to care for your family member who is a covered servicemember with a serious injury or illness. You are the servicemember's:

☐ Spouse ☐ Parent ☐ Child ☐ Next of kin

Spouse means a husband or wife as defined or recognized in the state where the individual was married, including in a common law marriage or same-sex marriage. The terms "child" and "parent" include *in loco parentis* relationships in which a person assumes the obligations of a parent to a child. An employee may take FMLA leave to care for an individual who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave to care for a child for whom the employee has assumed the obligations of a parent. No legal or biological relationship is necessary.

SECTION I – NOTICE OF ELIGIBILITY

This Notice is to inform you that you are:

☐ **Eligible** for FMLA leave. *(See Section II for any Additional Information Needed and Section III for information on your Rights and Responsibilities.)*

☐ **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 requested leave, you will have worked approximately: _____ towards this requirement.
(months)

☐ You have not met the FMLA's 1,250 hours of service requirement. As of the first date of requested leave, you will have worked approximately: _____towards this requirement.
(hours of service)

Employee Name: _____

☐ You are an airline flight crew employee and you have not met the special hours of service eligibility requirements for airline flight crew employees as of the first date of requested leave (i.e., worked or been paid for at least 60% of your applicable monthly guarantee, and worked or been paid for at least 504 duty hours.)

☐ You do not work at and/or report to a site with 50 or more employees within 75-miles as of the date of your request.

If you have any questions, please contact: _____ *(Name of employer representative)*

at _____ *(Contact information).*

SECTION II – ADDITIONAL INFORMATION NEEDED

As explained in Section I, you meet the eligibility requirements for taking FMLA leave. Please review the information below to determine if additional information is needed in order for us to determine whether your absence qualifies as FMLA leave. Once we obtain any additional information specified below we will inform you, **within 5 business days**, whether your leave will be designated as FMLA leave and count towards the FMLA leave you have available. **If complete and sufficient information is not provided in a timely manner, your leave may be denied.**

(Select as appropriate)

☐ No additional information requested. If no additional information requested, go to Section III.

☐ We request that the leave be supported by a certification, as identified below.

☐ Health Care Provider for the Employee
☐ Health Care Provider for the Employee's Family Member
☐ Qualifying Exigency
☐ Serious Illness or Injury *(Military Caregiver Leave)*

Selected certification form is ☐ attached / ☐ not attached.

If requested, medical certification must be returned by _____ *(mm/dd/yyyy) (Must allow at least 15 calendar days from the date the employer requested the employee to provide certification, unless it is not feasible despite the employee's diligent, good faith efforts.)*

☐ We request that you provide reasonable documentation or a statement to establish the relationship between you and your family member, including *in loco parentis* relationships (as explained on page one). The information requested must be returned to us by _____ *(mm/dd/yyyy).* You may choose to provide a simple statement of the relationship or provide documentation such as a child's birth certificate, a court document, or documents regarding foster care or adoption-related activities. Official documents submitted for this purpose will be returned to you after examination.

☐ Other information needed *(e.g. documentation for military family leave*): _____.

The information requested must be returned to us by _____ *(mm/dd/yyyy).*

If you have any questions, please contact: _____ *(Name of employer representative)*

at _____ *(Contact information).*

SECTION III – NOTICE OF RIGHTS AND RESPONSIBILITIES

Part A: FMLA Leave Entitlement

You have a right under the FMLA to take unpaid, job-protected FMLA leave in a 12-month period for certain family and medical reasons, including up to **12 weeks** of unpaid leave in a 12-month period for the birth of a child or placement of a child for adoption or foster care, for leave related to your own or a family member's serious health condition, or for certain qualifying exigencies related to the deployment of a military member to covered active duty. You also have a right

under the FMLA to take up to **26 weeks** of unpaid, job-protected FMLA leave in a single 12-month period to care for a covered servicemember with a serious injury or illness (*Military Caregiver Leave*).

The 12-month period for FMLA leave is calculated as: *(Select as appropriate)*

- ☐ The calendar year (January 1st - December 31st)
- ☐ A fixed leave year based on _____
  (e.g., a fiscal year beginning on July 1 and ending on June 30)
- ☐ The 12-month period measured forward from the date of your first FMLA leave usage.
- ☐ A "rolling" 12-month period measured backward from the date of any FMLA leave usage. *(Each time an employee takes FMLA leave, the remaining leave is the balance of the 12 weeks not used during the 12 months immediately before the FMLA leave is to start.)*

If applicable, the single 12-month period for *Military Caregiver Leave* started on _____ *(mm/dd/yyyy)*.

You (☐ are / ☐ are not) considered a key employee as defined under the FMLA. Your FMLA leave cannot be denied for this reason; however, we may not restore you to employment following FMLA leave if such restoration will cause substantial and grievous economic injury to us.

We (☐ have / ☐ have not) determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic harm to us. Additional information will be provided separately concerning your status as key employee and restoration.

Part B: Substitution of Paid Leave – When Paid Leave is Used at the Same Time as FMLA Leave

You have a right under the FMLA to request that your accrued paid leave be substituted for your FMLA leave. This means that you can request that your accrued paid leave run concurrently with some or all of your unpaid FMLA leave, provided you meet any applicable requirements of our leave policy. Concurrent leave use means the absence will count against both the designated paid leave and unpaid FMLA leave at the same time. If you do not meet the requirements for taking paid leave, you remain entitled to take available unpaid FMLA leave in the applicable 12-month period. Even if you do not request it, the FMLA allows us to require you to use your available sick, vacation, or other paid leave during your FMLA absence.

(Check all that apply)

- ☐ **Some or all of your FMLA leave will not be paid.** Any unpaid FMLA leave taken will be designated as FMLA leave and counted against the amount of FMLA leave you have available to use in the applicable 12-month period.
- ☐ **You have requested to use some or all of your available paid leave** *(e.g., sick, vacation, PTO)* during your FMLA leave. Any paid leave taken for this reason will also be designated as FMLA leave and counted against the amount of FMLA leave you have available to use in the applicable 12-month period.
- ☐ **We are requiring you to use some or all of your available paid leave** *(e.g., sick, vacation, PTO)* during your FMLA leave. Any paid leave taken for this reason will also be designated as FMLA leave and counted against the amount of FMLA leave you have available to use in the applicable 12-month period.
- ☐ **Other:** *(e.g., short- or long-term disability, workers' compensation, state medical leave law, etc.)*_____
  Any time taken for this reason will also be designated as FMLA leave and counted against the amount of FMLA leave you have available to use in the applicable 12-month period.

The applicable conditions for use of paid leave include: _____.

For more information about conditions applicable to sick/vacation/other paid leave usage please refer to _____

_____ available at: _____.

Employee Name: _____

Part C: Maintain Health Benefits

Your health benefits must be maintained during any period of FMLA leave under the same conditions as if you continued to work. During any paid portion of FMLA leave, your share of any premiums will be paid by the method normally used during any paid leave. During any unpaid portion of FMLA leave, you must continue to make any normal contributions to the cost of the health insurance premiums. To make arrangements to continue to make your share of the premium payments on your health insurance while you are on any unpaid FMLA leave, contact _____ at _____.

You have a minimum grace period of (☐ 30-days or ☐ _____ *indicate longer period, if applicable)* 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, or, at our option, we may pay your share of the premiums during FMLA leave, and recover these payments from you upon your return to work.

You may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave if you do not return to work following **unpaid** FMLA leave for a reason other than: the continuation, recurrence, or onset of your or your family member's serious health condition which would entitle you to FMLA leave; or the continuation, recurrence, or onset of a covered servicemember' s serious injury or illness which would entitle you to FMLA leave; or other circumstances beyond your control.

Part D: Other Employee Benefits

Upon your return from FMLA leave, your other employee benefits, such as pensions or life insurance, must be resumed in the same manner and at the same levels as provided when your FMLA leave began. To make arrangements to continue your employee benefits while you are on FMLA leave, contact _____ at _____.

Part E: Return-to-Work Requirements

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. An equivalent position is one that is virtually identical to your former position in terms of pay, benefits, and working conditions. At the end of your FMLA leave, all benefits must also be resumed in the same manner and at the same level provided when the leave began. You do not have return-to-work rights under the FMLA if you need leave beyond the amount of FMLA leave you have available to use.

Part F: Other Requirements While on FMLA Leave

While on leave you (☐ will be / ☐ will not 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 FMLA leave situation).

If the circumstances of your leave change and you are able to return to work earlier than expected, you will be required to notify us at least two workdays prior to the date you intend to report for work.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

It is mandatory for employers to provide employees with notice of their eligibility for FMLA protection and their rights and responsibilities. 29 U.S.C. § 2617; 29 C.F.R. § 825.300(b), (c). It is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 10 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THE DEPARTMENT OF LABOR. EMPLOYEE INFORMATION.

FAMILY & MEDICAL LEAVE ACT (FMLA)

Employer Response to Employee
Request for Family or Medical Leave

DATE:

TO: _____
(Employee's name)

FROM: _____
(Name of appropriate employer representative)

SUBJECT: Request for FMLA Leave

On _____, you notified us of your need to take FMLA 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.

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

Except as explained below, you have a right under the FMLA for up to twelve (12) weeks of unpaid leave in a twelve (12) month period for the reasons listed above. Your health benefits will be maintained during the FMLA leave under the same conditions as if you continued to work, and you will be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your timely return from FMLA 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 health insurance premiums paid on your behalf during the FMLA leave.

This is to inform you that: (check appropriate boxes; explain where indicated)

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

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

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

4. We will require that you substitute accrued paid leave for unpaid FMLA leave. If paid leave will be used the following conditions will apply: (Explain)

5. (a) Since you normally pay a portion of the premiums for your health insurance, these payments will continue during the period of FMLA leave. Arrangements for payment have been discussed with you and it is agreed that you will make premium payments as follows:

   (b) You have a minimum thirty (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 fifteen (15) days before the date that your health coverage will lapse, or, at our option, we may pay your share of the premiums during FMLA leave, and recover these payments from you upon your return to work. We _____ will _____ will not pay your share of health insurance premiums while you are on leave.

   (c) We _____ will ____ will not do the same with other benefits (e.g., life insurance, disability insurance, etc.) while you are on FMLA leave. If we do pay your premiums for other benefits, when you return from leave you _____ will _____ will not be expected to reimburse us for the payments made on your behalf.

6. You will be required to present a fitness-for-duty certificate prior to being restored to employment. Your return to work may be delayed until the certification is provided.

7. (a) You _____ are _____ are not a "key employee" as described in paragraph 825.218 of the FMLA regulations. If you are a "key employee", restoration to employment may be denied following FMLA leave on the grounds that such restoration will cause substantial and grievous economic injury to us.

   (b) We _____ have _____ have not determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic harm to us. (Explain (a) and/or (b) below. See paragraph 825.218 of the FMLA regulations.)

8. While on leave, you will be required to furnish us with periodic reports every 30 days of your status and intent to return to work unless the health care provider certifies that the condition will last longer than 30 days, in which case you must provide status reports immediately after the period your health care provider has specified is over. If the circumstances of your leave change and you are able to return to work earlier than the date indicated on this form, you will be required to notify us at least two work days prior to the date you intend to report for work.

I _____ voluntarily and freely give my consent for the Corporation's health care provider to contact my health care provider to provide clarification and authenticity for any medical documentation.

Dated: _____ _____
(Employee Signature)

Dated: _____ _____
(Corporation Representative Signature)