Eligibility Notice
(Family and Medical Leave Act)

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division

U.S. Wage and Hour Division

OMB Control Number: 1215-0181

DRAFT FOR COMMENT—NOT APPROVED FOR USE

Expires: XX/XX/XXX

Instructions and use: Employers must provide employees with notice of their eligibility for FMLA protection. In general, to be eligible an employee must have worked for an employer for at least 12 months, have worked at least 1,250 hours 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 by employers is optional, a fully completed Form WH-381 provides an easy method of providing employees with the written information required by 29 C.F.R. § 825.300(b), which must be provided within five business days of the employee notifying the employer of the need for FMLA leave. An employee who is eligible for FMLA leave may need to provide additional information in order for the employer to determine whether the FMLA applies to the leave. (See Part B). A separate notice informs employees whether their specific leave request is determined to be FMLA-protected. Employers must retain a copy of this disclosure in their records for three years in accordance with 29 U.S.C. § 2616; 29 C.F.R. § 825.500.

[Part A]

TO: _____
Employee

FROM: _____
Employer Representative

DATE: _____

On _____, you informed us that you needed leave for:

_____ The birth of a child, or placement of a child with you for adoption or foster care;

_____ Your own serious health condition; or

_____ You are needed to care for your ____ spouse; _____child; _____ parent due to his/her serious health condition.

You notified us that you need leave beginning on _____ for this reason.

You further notified us that you need:

_____ A single period of leave and your expected return to work date is _____; or

_____ Leave intermittently or on a reduced leave schedule. If your need for leave is due to planned medical treatment, you have indicated that you will need the following leave: _____. If your leave is for flare-ups, the expected frequency (times per week, month, or year) and duration (hours or days per occurrence) is _____.

This Notice is to inform you that you:

_____ Are eligible for FMLA leave (See Part B below for Rights and Responsibilities)

_____ Are **not** eligible for FMLA leave, because:

_____ You have not met the FMLA's 12-month length of service requirement. As of today's date, you have worked ___ months towards this requirement.

_____ You have not met the FMLA's 1,250 hours worked requirement. As of today's date, you have worked _____ hours in the past 12-month period.

_____ You do not work and/or report to a site with 50 or more employees within 75-miles.

_____ You have exhausted your 12-week FMLA leave entitlement in the current 12-month period. Assuming the other eligibility requirements are met, you will once again be eligible for FMLA leave on _____.

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

[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 the current 12-month period. **However, in order for us to determine whether your absence qualifies as FMLA leave, you must return the following information to us by _____.** (Employers must allow at least 15 calendar days from receipt of this notice. An exception to the timely submission requirement applies when it is not practicable under the particular circumstances for the employee to do so despite the diligent, good faith efforts .) If sufficient information is not provided in a timely manner, the FMLA protections attached to your leave may be denied.

____ Sufficient medical certification to establish that you or your family member has a serious health condition. A medical certification form that sets forth the information necessary from your health care provider to support your request ____**is**/____ **is not** enclosed.

____ Sufficient documentation to establish that the family member is a parent, spouse, or child

____ Other information needed: _____.

____ No additional information requested

CONTINUED ON NEXT PAGE

If your leave does qualify as FMLA leave you will have the following **responsibilities** while on FMLA leave (only checked blanks apply):

____ Contact _____ at _____ 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. You have a minimum 30-day (or, indicate longer period, if applicable) 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, 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 will be required to use your available paid _____ **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 12 weeks of FMLA protection.

____ You will be required to present a fitness-for-duty certificate to be restored to employment. If such certification is not timely received, your return to work may be delayed until 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 these functions.

____ Due to your status within the company, you are considered a "key employee" under the FMLA. As 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. 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.

____ 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).

If the circumstances of your leave change, and you are able to return to work earlier than the date indicated on the reverse side of this form, 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 unpaid leave in a 12-month period.
- 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 12 week 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; 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.
- If we have not informed you above that you must use accrued paid leave while taking your unpaid FMLA leave entitlement, you have the right to have ____ **sick**, ____**vacation**, and/or ___ **other leave** run concurrently with your unpaid leave entitlement, provided you meet any applicable requirements of the leave policy. Any applicable conditions related to the substitution of paid leave are set forth below. If you do not meet the requirements for taking paid leave, you remain entitled to take unpaid FMLA leave.

_____

_____

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_____

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_____

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 12-week leave entitlement. If you have any questions, please do not hesitate to contact

_____ at _____.

PUBLIC BURDEN STATEMENT

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 AV, NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.**