Designation 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 inform employees in writing of whether a Family and Medical Leave Act (FMLA) leave will be designated as counting against the 12-week entitlement and the number of hours, days, or weeks to be counted as FMLA leave. In addition, when an employee provides a medical certification that 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 by employers is optional, a fully completed Form WH-382 provides an easy method of providing employees with the written information required by 29 C.F.R. §§ 825.300(c), -.301, and -.305(c), which must be provided within five business days of the employer receiving sufficient information to determine the leave is covered by the FMLA. 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.

To: _____

Date: _____

We have reviewed your request for leave under the Family and Medical Leave Act (FMLA) and any supporting documentation that you have provided.

We received your most recent documents on _____, and decided:

Approved:

_____ To designate your leave as "FMLA leave;" consequently,

► We will charge _____ against your FMLA entitlement, provided there is no deviation from your
Number of hours, days, or weeks
anticipated leave schedule. The FMLA generally provides that an employee may take up to 12 weeks of unpaid job protected leave within a 12-month period. We will notify you of any changes to the time charged.

Or

► We will notify you at least once in every 30-day period during which you take FMLA leave of how much leave you have used. The FMLA provides that you must notify us promptly of a need for FMLA leave and that you must adhere to our internal notification requirements that would not otherwise violate the FMLA.

Or

► Within the past thirty days you have used _____ of your FMLA entitlement.
Number of hours, days, or weeks

Or

► _____ This leave will count against your FMLA entitlement.

And (check if applicable):

_____ We are requiring you to substitute or use paid leave during you FMLA leave.

_____ You have requested to use paid leave during your FMLA leave. The leave will count against your leave entitlement unless we have notified you to the contrary.

Additional information needed to determine that the FMLA definition of a "serious health condition" is met:

_____ The medical certification you have provided is not complete and sufficient to make a designation of whether, or not, the FMLA applies to your leave request. You must provide the following information no later than _____,
Provide at least seven calendar days
unless it is not practicable under the particular circumstances despite your diligent good faith efforts, or we may deny your FMLA leave.

_____
Specify information needed to make the certification complete and sufficient

_____

_____ We are exercising our right to have you obtain a second or third opinion medical certification at our expense, and we will provide further details at a later time.

Not approved:

_____ Not to designate your leave as FMLA leave; consequently, the FMLA does not apply to the absences for which you have requested leave.

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.**