Ohio Department of Medicaid

DESIGNATION NOTICE FAMILY MEDICAL LEAVE ACT

Employee Name:	Date: / /		
Address:	City	State	Zip

We have reviewed your request for leave under the FMLA and any supporting documentation that you have provided. We received your most recent information on Date / / and decided:

The FMLA leave request is approved. All leave taken for this reason between begin date (/ /) and end date (/ /) will be designated as FMLA leave.

FMLA number is Designated FMLA number.
Self; spouse; child; son or daughter; parent; next of kin

The FMLA requires that you notify us as soon as practicable if dates of scheduled leave change or 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 your leave entitlement.

Provided there is no deviation from your anticipated leave schedule, the following number of hours, days, or weeks will be counted against your leave entitlement**: (approved dates/time off or restrictions)**

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. We are requesting you provide treatment updates once every 30 days after you have an absence.

Please be advised:

We are requiring you to use accrued leave during FMLA absences.

You will be required to present a fitness-for-duty certificate to be restored to employment no later than two working days prior to your return to work date. If such certification is not timely received, your return to work may be delayed until such 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 duties.

Additional information is needed to determine if your FMLA leave request can be approved:

The certification you have provided is not complete and sufficient to determine whether the FMLA applies to your leave request. You must provide the following information no later than (allow seven days) date / / , unless it is not practicable under the particular circumstance despite your diligent good faith efforts, or your leave may be denied.
Note: *(add any information that is missing or unclear on the application)*

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.

Your FMLA leave request is not approved.
You have not met the FMLA's 1,250 hours work requirement.
You have not met the FMLA's 12 month length of service requirement.
You have exhausted your FMLA leave entitlement in the applicable 12 month period.

If you have questions, please contact (name) at (phone number)( ) .