

EMPLOYER RESPONSE TO EMPLOYEE REQUEST FOR MEDICAL LEAVE

Date _____

TO: _____
(Employee's Name)

FROM: _____
(Employer representative)

SUBJECT: Request for Medical Leave

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

- ☐ the birth or adoption of a child; or
☐ the serious health condition affecting ☐ you, ☐ your spouse, ☐ your child, ☐ your parent, for which you are needed to provide care.

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

Except as explained below, you have a right to twelve (12) weeks of unpaid leave in a 12-month period for the reasons listed above. Also, your health benefits will be maintained during any period of unpaid leave under the same conditions as if you continued to work. If you do not return to work following leave for a reason other than: (1) the continuation, recurrence, or onset of a serious health condition which would entitle you to 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 leave.

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

1. You are ☐ eligible ☐ not eligible for leave.
2. The requested leave ☐ will ☐ will not be counted against your annual leave entitlement.
3. 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 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 leave for unpaid leave. If paid leave will be used, the following conditions will apply:
 - 5(a). If you normally pay a portion of the premiums for your health insurance, these payments will continue during the period of leave. Arrangements for payment have been discussed with you and it is agreed that you will make premium payments as follows: (Set forth dates, e.g., the 10th of each month, or pay periods, etc. that specifically cover the agreement with the employee.)
 - 5(b). 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 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 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 ☐ will not be required to present a fitness-for-duty certificate prior to being restored to employment. If such certification is required but not received, your return to work may be delayed until certification is provided.
7. While on leave, you ☐ will ☐ will not be required to furnish us with periodic reports every _____ and intent to return to work). 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 ☐ will not be required to notify us at least two work days prior to the date you intend to report for work.
8. You ☐ will ☐ will not be required to furnish recertification relating to a serious health condition.

Employer's Signature

Date