

**Notice of Eligibility and Rights &
Responsibilities: (Family and Medical Leave Act)**

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 employees with the 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. Part B provides employees with information regarding their rights and responsibilities for taking FMLA leave, as required by 29 C.F.R. § 825.300(b), (c).

Part A — NOTICE OF ELIGIBILITY

TO: _____
Employee

FROM: _____
Employer Representative

DATE: _____

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

- ☐ The birth of a child, or placement of a child with you for adoption or foster care;
- ☐ Your own serious health condition;
- ☐ Because you are needed to care for your ____ spouse; ____ child; ____ parent due to his/her serious health condition.
- ☐ Because of a qualifying exigency (“emergency”) arising out of the fact that your ____ spouse; ____ son or daughter; ____ parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves.
- ☐ Because you are the ____ spouse; ____ son or daughter; ____ parent; ____ next of kin of a covered service member with a serious injury or illness.

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 (only one reason need be checked, although you may not be eligible for other reasons):
 - ☐ 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 ____ months towards this requirement.
 - ☐ You have not met the FMLA's 1,250-hours-worked requirement.
 - ☐ You do not work and/or report to a site with 50 or more employees within 75-miles.

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

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 applicable 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.** (If a certification is requested, employers must allow at least 15 calendar days from receipt of this notice; additional time may be required in some circumstances.) If sufficient information is not provided in a timely manner, your leave may be denied.

- ☐ Sufficient certification to support your request for FMLA leave. A certification form that sets forth the information necessary to support your request **is/** **is not** enclosed.
- ☐ Sufficient documentation to establish the required relationship between you and your family member.
- ☐ Other information needed: _____

- ☐ No additional information requested

THE GENETIC INFORMATION NON-DISCRIMINATION ACT OF 2008 (“GINA”) PROHIBITS EMPLOYERS AND OTHER ENTITIES COVERED BY GINA TITLE II FROM REQUESTING OR REQUIRING GENETIC INFORMATION OF AN INDIVIDUAL OR A FAMILY MEMBER OF THE INDIVIDUAL, EXCEPT AS SPECIFICALLY ALLOWED BY THIS LAW. TO COMPLY WITH THIS LAW, WE ARE ASKING THAT YOU NOT PROVIDE ANY GENETIC INFORMATION WHEN RESPONDING TO THIS REQUEST FOR MEDICAL INFORMATION. ‘GENETIC INFORMATION’ AS DEFINED BY GINA, INCLUDES AN INDIVIDUAL’S FAMILY MEDICAL HISTORY, THE RESULTS OF AN INDIVIDUAL’S OR FAMILY MEMBER’S GENETIC TEST, THE FACT THAT AN INDIVIDUAL OR INDIVIDUAL’S FAMILY MEMBER SOUGHT OR RECEIVED GENETIC SERVICES, AND GENETIC INFORMATION OR A FETUS CARRIED BY AN INDIVIDUAL OR INDIVIDUAL’S FAMILY MEMBERS OR AN EMBRYO LAWFULLY HELD BY AN INDIVIDUAL OR FAMILY MEMBER RECEIVING ASSISTIVE REPRODUCTIVE SERVICES.

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 FMLA leave entitlement.
- ☐ Due to your status within the company, you are considered a "key employee" as defined in 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 (2) 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 calculated as:
 - ☐ the calendar year (January — December).
 - ☐ a fixed leave year based on _____.
 - ☐ 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.
- You have a right under the FMLA for up to 26 weeks of unpaid leave in a single 12-month period to care for a covered service member with a serious injury or illness. This single 12-month period commenced on _____.
- 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 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; 2) the continuation, recurrence, or onset of a covered service member's serious injury or illness which would entitle you to FMLA leave; or 3) 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. Applicable conditions related to the substitution of paid leave are referenced or set forth below. If you do not meet the requirements for taking paid leave, you remain entitled to take unpaid FMLA leave.

☐ For a copy of conditions applicable to sick/vacation/other leave usage please refer to _____available at:_____.

☐ Applicable conditions for use of paid leave:

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 FMLA leave entitlement. If you have any questions, please do not hesitate to contact:

_____ at _____.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, 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 20 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; RETURN IT TO THE EMPLOYER.**