Notice of Eligibility and Rights & Responsibilities
(Family and Medical Leave)
U.S. Department of Labor
Wage and Hour Division

U.S. Wage and Hour Division

RETURN TO EMPLOYEE - DO NOT SEND TO THE DEPARTMENT OF LABOR

OMB Control Number: 1235-0003
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In general, to be eligible an employee must have worked for an employer for at least 12 months, meet the hours of service requirement 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. Section II provides employees with information regarding their rights and responsibilities for taking FMLA leave, as required by 29 C.F.R. §§ 825.300(b), (c). Information about the FMLA may be found on the WHD website at http://www.dol.gov/whd/fmla.

Date: _____ From: _____
(Employer)

To: _____
(Employee)

On _____*(date)*, we learned that you need leave beginning on _____ *(date)* for one of the following reasons:

☐ The birth of a child, or placement of a child with you for adoption or foster care, and to bond with the newborn or newly-placed child

☐ Your own serious health condition

☐ Because you are needed to care for your family member due to his/her serious health condition: *(select family member)*
- ☐ spouse,
- ☐ child, or
- ☐ parent

☐ Because of a qualifying exigency arising out of the fact that your family member is on covered active duty or has been notified of an impending call or order to covered active duty status: *(select family member)*
- ☐ spouse,
- ☐ son or daughter, or
- ☐ parent

☐ Because you are the family member of a covered servicemember with a serious injury or illness: *(select your relationship to the covered servicemember)*
- ☐ spouse,
- ☐ son or daughter,
- ☐ parent, or
- ☐ next of kin

Employee Name: _____

SECTION I – NOTICE OF ELIGIBILITY

This Notice is to inform you that you:

☐ Are **eligible** for FMLA leave. *(See Section II below for information on 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 of service requirement.
  As of the first date of requested leave, you will have worked approximately:
  _____ hours of service towards this requirement.

- ☐ You are an airline flight crew employee and you have not met the special hours of service eligibility requirements for airline flight crew employees as of the first date of requested leave (*i.e.*, worked or been paid for at least 60% of your applicable monthly guarantee, and worked or been paid for at least 504 hours.)

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

If you have any questions, please do not hesitate to contact: _____ at
(Name of employer FMLA representative)

_____
(Contact information)

Employee Name: _____

SECTION II – ADDITIONAL INFORMATION NEEDED

As explained in Section I, you meet the eligibility requirements for taking FMLA leave and still have FMLA leave available in the applicable 12-month period. In order for us to determine whether your absence qualifies as FMLA leave, more information is needed. Once we obtain the information specified below, we will inform you, **within 5 business days**, whether your leave will be designated as FMLA leave and count towards the FMLA leave you have available. **If sufficient information is not provided in a timely manner, your leave may be denied.**

The following information must be returned to us by _____
(List the due date)

If you have any questions, please do not hesitate to contact: _____ at
(Name of employer representative)

_____
(Contact information)

(Select additional information needed as appropriate)

☐ We request that the leave be supported by a certification, as identified below. You have at least **15 calendar days** from receipt of this notice to provide the requested certification, absent unusual circumstances.

(Select as appropriate)

- ☐ Certification of Health Care Provider for the employee or the employee's family member
- ☐ Certification for Qualifying Exigency
- ☐ Certification for Serious Illness or Injury (*Military Caregiver Leave*)

A certification form that sets forth the information necessary to support your request:

- ☐ **is**
- ☐ **is not** enclosed.

☐ We request that you provide reasonable documentation or a statement to establish the relationship between you and your family member. (Family relationship includes *in loco parentis* situations, *i.e.*, situations when an individual assumed the obligations of a parent to the employee when the employee was a child, and when the employee has assumed the obligations of a parent for a child. Such documentation also may include documents regarding foster care or adoption-related activities, as appropriate.) You may choose to provide a statement of relationship or provide written documentation, such as a child's birth certificate or a court document. Official documents submitted for this purpose will be returned to you after examination.

☐ Other information needed as identified below *(e.g. documentation for military family leave*):

Explain: _____
_____

☐ No additional information requested.

Employee Name: _____

SECTION III – NOTICE OF RIGHTS AND RESPONSIBILITIES

Part A: FMLA Leave Entitlement

You have a right under the FMLA to take unpaid, job-protected FMLA leave in a 12-month period for certain family and medical reasons, including up to **12 weeks** of unpaid leave in a 12-month period for the birth of a child or placement of a child for adoption or foster care, for leave related to your own or a family member's serious health condition, or for certain qualifying exigencies related to the deployment of a military member to covered active duty. You also have a right under the FMLA to take up to **26 weeks** of unpaid, job-protected FMLA leave in a single 12-month period to care for a covered servicemember with a serious injury or illness (*Military Caregiver Leave*).

(Select as appropriate)

☐ The 12-month period for FMLA leave (other than *Military Caregiver Leave*) is calculated as:

- ☐ The calendar year (January 1st - December 31st)
- ☐ A fixed leave year based on _____
  (e.g., a fiscal year beginning on July 1 and ending on June 30)
- ☐ 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. *(Each time an employee takes FMLA leave, the remaining leave is the balance of the 12 weeks not used during the 12 months immediately before the FMLA leave is to start.)*

☐ The single 12-month period for *Military Caregiver Leave* started on _____

☐ ***You are considered a key employee*** as defined under the FMLA due to your status within the company. Your FMLA leave cannot be denied for this reason; however, 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 determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic harm to us. Additional information will be provided separately concerning your status as key employee and restoration:

- ☐ Yes
- ☐ No

Part B: "Substitution" of Paid Leave (Concurrent Leave Usage)

You have a right under the FMLA to request to use accrued paid leave to run concurrently with some or all of the unpaid FMLA leave period, provided you meet any applicable requirements of our leave policy for paid leave to run concurrently. Concurrent leave use means the absence will count against both the designated paid leave and unpaid FMLA leave at the same time. If you do not meet the requirements for taking paid leave, you remain entitled to take available unpaid FMLA leave in the applicable 12-month period.

Even if you do not request it, the FMLA allows us to require you to use your available sick, vacation, or other paid leave during your FMLA absence.

Employee Name: _____

(Select as appropriate)

☐ **Your FMLA leave will be unpaid.**
Any unpaid FMLA leave taken will be designated as FMLA leave and counted against the amount of FMLA leave you have available to use in the applicable 12-month period.

☐ **You have requested to use your available paid leave during your FMLA leave.** *(e.g., sick, vacation, PTO)*
Any paid leave taken for this reason will also be designated as FMLA leave and counted against the amount of FMLA leave you have available to use in the applicable 12-month period.

☐ **We are requiring you to use your available paid leave during your FMLA leave.** *(e.g., sick, vacation, PTO)*
Any paid leave taken for this reason will also be designated as FMLA leave and counted against the amount of FMLA leave you have available to use in the applicable 12-month period.

☐ **Your FMLA leave will be used at the same time as:**
(Select as appropriate)
- ☐ Short-term disability
- ☐ Long-term disability
- ☐ Workers' compensation
- ☐ State-required family medical leave

Any paid leave taken for this reason will also be designated as FMLA leave and counted against the amount of FMLA leave you have available to use in the applicable 12-month period.

The applicable conditions for use of paid leave include: _____
_____

For more information about conditions applicable to sick/vacation/other paid leave usage please refer to
_____ available at:
_____

Part C: Maintain Health Benefits

Your health benefits must be maintained during any period of unpaid FMLA leave under the same conditions as if you continued to work. You must continue to make any normal contributions to the cost of the health insurance premiums.

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 FMLA 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.

Employee Name: _____

You may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave if you do not return to work following **unpaid** FMLA leave for a reason other than:

- the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; or
- the continuation, recurrence, or onset of a covered servicemember' s serious injury or illness which would entitle you to FMLA leave; or
- other circumstances beyond your control.

Part D: Maintain Other Employee Benefits

Your employee benefits, such as pensions or life insurance, must be maintained during any period of FMLA leave under the same conditions as if you continued to work.

Contact _____ at _____

to make arrangements to continue your employee benefits while you are on FMLA leave.

Part E: Return-to-Work Requirements

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. An equivalent position is one that is virtually identical to your former position in terms of pay, benefits, and working conditions. At the end of your FMLA leave, all benefits must also be resumed in the same manner and at the same level provided when the leave began. You do not have return-to-work rights under the FMLA if your need for leave extends beyond the amount of FMLA leave you have available to use.

Part F: Other Requirements While on Leave

☐ 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 expected, you will be required to notify us at least two workdays prior to the date you intend to report for work.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

It is mandatory for employers to provide employees with notice of their eligibility for FMLA protection and their rights and responsibilities. 29 U.S.C. § 2617; 29 C.F.R. § 825.300(b), (c). 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 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 Avenue, N.W., Washington, D.C. 20210.

EMPLOYEE INFORMATION - DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.