Designation Notice
(Family and Medical Leave Act)
U.S. Department of Labor
Wage and Hour Division

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

OMB Control Number: 1235-0003
Expires: x/xx/20xx

Leave covered under the Family and Medical Leave Act (FMLA) must be designated as FMLA-protected and the employer must inform the employee of the amount of leave that will be counted against the employee's FMLA leave entitlement. In order to determine whether leave is covered under the FMLA, the employer may request that the leave be supported by a certification. If the certification 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), 825.301, and 825.305(c).

SECTION I - EMPLOYER

Date: _____ From: _____
(Employer)

To: _____
(Employee)

On _____ *(date)* we received your most recent information to support your need for leave due to:

- ☐ 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
- ☐ The serious health condition of your spouse, child, or parent
- ☐ A qualifying exigency arising out of the fact that your spouse, son, daughter or parent is on covered active duty or has been notified of an impending call or order to covered active duty with the Armed Forces
- ☐ A serious injury or illness of a covered servicemember where you are the servicemember's spouse, child, parent, or next of kin *(Military Caregiver Leave)*

We have reviewed information related to your need for leave under the FMLA along with any supporting documentation provided and decided: ***(Select as appropriate)***

☐ Your FMLA leave request is **Approved.** All leave taken for this reason will be designated as FMLA leave.
See Section III below for information.

☐ Your FMLA Leave request is **Not Approved**: ***(Select as appropriate)***
- ☐ The FMLA does not apply to your leave request.
- ☐ As of the date the leave is to start, you do not have any FMLA leave available to use.
- ☐ Other _____

☐ **Additional information** is needed to determine if your leave request qualifies as FMLA leave. ***See Section II below for specific information needed.***

Employee Name: _____

SECTION II – ADDITIONAL INFORMATION NEEDED

We are requesting additional information to determine whether your leave request qualifies under the FMLA. Once we obtain the additional information requested, we will inform you **within 5 business days** if your leave will or will not be designated as FMLA leave and count towards the amount of FMLA leave you have available. **Failure to provide the additional information as requested may result in a denial of your FMLA leave request**.

If you have any questions, please contact:

_____ at _____.
(Name of employer FMLA representative) *(Contact information)*

Incomplete or Insufficient Certification

The certification you have provided is incomplete and / or insufficient to determine whether the FMLA applies to your leave request.

☐ The certification provided is incomplete and we are unable to determine whether the FMLA applies to your leave request. *"Incomplete" means one or more of the applicable entries on the certification have not been completed.*

☐ The certification provided is insufficient to determine whether the FMLA applies to your leave request. *"Insufficient" means the information provided is vague, unclear, ambiguous or non-responsive.*

Specify information needed to make the certification complete and / or sufficient:

_____

_____

_____

You must provide the requested information no later than _____ *(List date due, provide at least seven calendar days)*, unless it is not practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied.

Second and Third Opinions

☐ We request that you obtain a second or third opinion medical certification at our expense, and we will provide further details at a later time. *Note: The employee or the employee's family member may be requested to authorize his or her health care provider to release information pertaining only to the serious health condition at issue.*

Employee Name: _____

SECTION III – FMLA LEAVE APPROVED

As explained in Section I, your FMLA leave request is approved. All leave taken for this reason will be designated as FMLA leave and will count against the amount of FMLA leave you have available to use in the applicable 12-month period. The FMLA requires that you notify us as soon as practicable if the dates of scheduled leave change, 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 the total **amount of FMLA leave** you have available to use in the applicable 12-month period:

(Select as appropriate)

☐ Provided there is no deviation from your **anticipated FMLA leave schedule**, the following number of hours, days or weeks will be counted against your leave entitlement:

_____

_____

☐ 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. You have the right to request this information once in a 30-day period (if leave was taken in the 30-day period).

Please be advised: ***(check if applicable)***

☐ (1) **You will not be paid during your FMLA leave.**
Any unpaid FMLA leave taken will count against the amount of FMLA leave you have available to use.

☐ (2) **Based on your request, you are substituting or using paid leave during your FMLA leave.**
(E.g., sick leave, vacation pay, PTO)
Any paid leave taken for this reason will count against the amount of FMLA leave you have available to use.

☐ (3) **We are requiring you to substitute or use paid leave during your FMLA leave.**
(E.g., sick leave, vacation pay, PTO)
Any paid leave taken for this reason, will count against the amount of FMLA leave you have available to use.

☐ (4) **Your FMLA leave will be used at the same time with other types of paid leaves or benefits.**
(E.g. short or long-term disability, workers' compensation, state medical leave law)
Any paid leave or benefit taken for this reason will count against the amount of FMLA leave you have available to use.

Employee Name: _____

☐ (5) **Return-to-work requirements.**

To be restored to work after taking FMLA leave, you will be required to provide a certification from your health care provider (fitness-for-duty certification) that you are able to resume work. This request for a fitness-for-duty certification is *only* with regard to the particular serious health condition that caused your need for FMLA leave. **If such certification is not timely received, your return to work may be delayed until the certification is provided.**

A list of the essential functions of your position:

- ☐ **is attached.** If attached, the fitness-for-duty certification must address your ability to perform these functions.
- ☐ **is not attached.**

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

It is mandatory for employers to inform employees in writing whether leave requested under the FMLA has been determined to be covered under the FMLA. 29 U.S.C. § 2617; 29 C.F.R. § 825.300(d), (e). 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.

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