FMLA NOTICE AND DESIGNATION FORM
(Completed by Employer)

TO:	
FROM:	
DATE:	DATES OF LEAVE: _____ to _____

Eligibility Section

1. Eligible for Family and Medical Leave Act (FMLA) Leave?* ___ Yes ____ No
2. Employee has FMLA leave available? ___ Yes ____ No

*An eligible employee is one who (1) has been employed for at least 12 months; (2) has worked at least 1,250 hours of service in the past 12 consecutive months; and (3) is employed at a worksite where 50 or more employees are employed within 75 miles of that worksite.

If the response to Questions 1 or 2 is "No," the remainder of this form need not be completed. Provide only this page of the FMLA Notice and Designation Form to the employee.

Designation of Leave **

Check appropriate blank.

3. Leave of absence is:
   (a) ____ not designated as FMLA leave.
   (b) ____ designated as FMLA leave.***
   (c) ____ preliminarily designated as FMLA leave.***

**FMLA leave is available (1) for the birth of the employee's child, and to care for the newborn child; (2) for placement with the employee of a child for adoption or foster care; (3) to care for the employee's spouse, child or parent with a serious health condition; and (4) for the employee's own serious health condition.

***FMLA leave shall not exceed 12 workweeks in a rolling 12-month period measured backward from the date of leave. Only that portion of the leave that does not exceed the 12-week period may be designated or preliminarily designated as FMLA leave.

If leave is not designated or preliminarily designated as FMLA leave, provide only this page of the FMLA Notice and Designation Form to the employee. Otherwise, continue to second page.

Employer completes items 5 and 6.

4. You have a right under FMLA for up to 12 workweeks of unpaid leave in a 12-month period. Your leave of absence will be counted against your FMLA entitlement.

5. Is medical certification of the serious health condition required? ____ Yes ____ No

   If required, you must furnish certification before the leave begins, or if that is not possible, within 15 days of our request for the certification. If you fail to do so, we may: (a) delay the commencement of your leave; or (b) withdraw any designation of FMLA leave, in which case your leave of absence would be unauthorized, subjecting you to discipline up to and including termination.

6. In accordance with the Company's paid leave policies, you may choose or the Company will require you to use accrued paid leave during some or all of the leave as follows:

   _____.

7. Since FMLA requires the maintenance of your health benefits during leave, you need to continue paying your normal premium during the leave to avoid a lapse in coverage. Your payments are due at the same time they normally would be made by payroll deduction. If your payment is more than 30 days late, your group health insurance may be canceled, provided you receive 15 days written notice that coverage will lapse.

8. If the Company pays your portion of a premium payment for group health coverage or other benefits (e.g. life insurance, disability payments) during the leave, the Company reserves the right to recoup these expenses.

9. You may be required to reimburse us for our share of group health insurance premiums if you do not return to work following FMLA leave for a reason other than (a) a serious health condition which would entitle you to FMLA leave; or (b) other circumstances beyond your control.

10. You will be required to present a fitness-for-duty certificate before we restore you to employment if you took leave for your own serious health condition (this does not apply to intermittent leave).

11. Upon returning from FMLA leave, you will normally be restored to your original job, or to an equivalent job with equivalent pay, benefits, and other employment terms and conditions.

For employers who plan to assert the "key employee" exception, complete the following:

12. You are a "key employee" under the FMLA definition. _____ Yes _____ No

    If you are 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 the company.

    At this time, we _____ have or _____ have not determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic injury to us.

CERTIFICATION OF HEALTH CARE PROVIDER FORM

(Family and Medical Leave Act of 1993)

1. Employee's Name: _____

2. Patient's Name (if different from employee): _____

3. The attached sheet describes what is meant by a "serious health condition" under the Family and Medical Leave Act. Does the patient's condition[1] qualify under any of the categories described? If so, please check the applicable category.

   (1)__ (2)__ (3)__ (4)__ (5)__ (6)__ or none of the above _____

4. Describe the medical facts which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories:

   _____

5.(a) State the approximate date the condition commenced, and the probable duration of the condition, and the probable duration of the patient's present incapacity[2]:

   _____

   _____

   (b) Will it be necessary for the employee to intermittently work or to work a reduced schedule as a result of the condition (including for treatment described in 6 below)?

   _____

   If yes, give the probable duration: _____

   (c) If the condition is a chronic condition (condition #4) or pregnancy, state whether the patient is presently incapacitated[2] and the likely duration and frequency of episodes of incapacity[2]:

   _____

   _____

   _____

6.(a) If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments. _____

   _____

   _____

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[1] Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking FMLA leave.

[2] "Incapacity," for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom.

If the patient will be absent from work or other daily activities because of treatment on an intermittent or part-time basis, also provide an estimate of the probable number and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any. _____

(b) If any of these treatments will be provided by another provider of health services (e.g., physical therapist), please state the nature of the treatments. _____

(c) If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment): _____

7.(a) If medical leave is required for the employee's absence from work because of the employee's own condition (including absences due to pregnancy or a chronic condition), is the employee unable to perform work of any kind? _____

(b) If able to perform some work, is the employee unable to perform any one or more of the essential functions of the employee's job (the employee or the employer should supply you with information about the essential job functions)? _____

If yes, please list the essential functions the employee is unable to perform: _____

(c) If neither (a) nor (b) applies, is it necessary for the employee to be absent from work for treatment? _____

8.(a) If leave is required to care for a family member of the employee with a serious health condition, does the patient require assistance for basic medical or personal needs or safety, or for transportation? _____

(b) If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery? _____

(c) If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need: _____

_____

_____

_____ _____

(Signature of Health Care Provider) *(Type of Practice)*

_____ _____

(Address) *(Telephone Number)*

_____

(Date)

To be completed by the employee needing family leave to care for a family member:

State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule.

_____ _____

(Employee Signature) *(Date)*

Note: It is the employee's responsibility to ensure that the healthcare provider fully completes this form.