|  |
| --- |
| DOTLOGOMISSOURI DEPARTMENT OF TRANSPORTATION NOTICE OF ELIGIBILITY AND RIGHTS AND RESPONSIBILITIES FAMILY AND MEDICAL LEAVE ACT (FMLA) LEAVE |

|  |  |
| --- | --- |
| Employee’s Name: |  |
| Home Address: |  |
| Home Phone Number: |  |
| Job Title: |  |
| District/Division/Office: |  |

|  |  |
| --- | --- |
| Date: |  |
| Dear |  |

|  |  |  |  |
| --- | --- | --- | --- |
| We have received your notice of need for FMLA leave. You have requested leave under the FMLA for: | | | |
|  | the birth of your child | | |
|  | the placement (adoption or foster care) of a child with you | | |
|  | your serious health condition |  | |
|  | the care of your spouse/child/parent with a serious health condition | |  |
|  | the qualifying exigency arising out of the fact that your spouse/child/parent is a member of the Armed Forces on covered active duty or call to covered active duty status | | |
|  | the care of an injured/ill servicemember for whom you are the spouse/child/parent/next of kin | | |

|  |  |  |
| --- | --- | --- |
| This notice is to inform you that you: | | |
|  | are eligible for FMLA leave (see rights and responsibilities described below and on following page) | |
|  | are **not** eligible for FMLA leave, because | |
|  |  | you have not met the FMLA’s 12-month length of service requirement |
|  |  | you have not met the FMLA’s 1,250-hours-worked requirement |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| If you meet the eligibility requirements for taking FMLA leave, we may need additional information. **In order to determine whether your absence qualifies as FMLA leave, you must return the following** | | | | |
| **i****nformation to us as soon as possible, but no later than** | | |  | (15 days from the date of |
| this notice). If sufficient information or an explanation of why you have been unable to obtain the information is not provided by this deadline, absences will be considered unauthorized and appropriate disciplinary action, up to and including termination, may be taken. | | | | |
|  | sufficient certification to support your request for FMLA leave **(the certification form is enclosed)** | | | |
|  | sufficient documentation to establish the required relationship between you and your family member | | | |
|  | other information needed: |  | | |
|  | no additional information requested | | | |

|  |  |  |
| --- | --- | --- |
| Employee Name: |  |  |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| You have anticipated the following dates of leave: | | | | | | | | | |
| expected start date: | |  | | | expected date of return to work: | | | |  |
| You have also indicated you would like to use the following type(s) of leave to cover this absence, in accordance with the department’s leave usage policies, and in this order: | | | | | | | | | |
|  | Parental leave | | use all | use | |  | hours | Apply 1st 2nd 3rd 4th | |
|  | Paid sick leave | | use all | use | |  | hours | Apply 1st 2nd 3rd 4th | |
|  | Paid annual leave | | use all | use | |  | hours | Apply 1st 2nd 3rd 4th | |
|  | Compensatory time | | use all | use | |  | hours | Apply 1st 2nd 3rd 4th | |
|  | Unpaid FMLA leave | | use all | use | |  | hours | Apply 1st 2nd 3rd 4th | |

If it is determined that the period of absence is for an FMLA qualifying event, please be aware:

1. If you are requesting leave for your own serious health condition, to care for your family member with a serious health condition, or to care for an injured/ill servicemember, you must first exhaust your accrued paid sick leave before taking unpaid FMLA leave (unless the servicemember being cared for does not fall under the department’s sick leave policy definition of immediate family and sick leave cannot be used).
2. You have the right, but will not be required to, use other accrued paid leave before taking unpaid FMLA leave.
3. All unpaid leave taken for the reason listed on this form is being/will be designated by the department as FMLA leave and will count toward your FMLA leave entitlement.
4. While you are on unpaid FMLA leave, the department will continue to provide its share of premiums for health insurance coverage; however, you are responsible for manually making your share of premium payments during this time. State sponsored life insurance and disability insurance coverage provided to you at no cost is not included in the department's share of health insurance coverage provided to employees on unpaid FMLA leave. You have the option of continuing coveragefor health, life, or disability insurance by making manual payments during your approved FMLA leave. If you have any questions regarding your benefits or the amount of premium payments due while on unpaid FMLA leave, please contact your benefits representative,

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Telephone Number: |  |

If premium payments are not made on or before the due date, coverage may lapse.

1. You may be required to furnish periodic reports of your status and intent to return to work.
2. Prior to returning to work from leave for your own serious health condition, you will be required to provide a certification from your health care provider indicating whether you are able to return to full duty or with restrictions. You will not be allowed to return to work until we receive a completed certification from your treating physician.
3. You will be restored to the same or an equivalent job upon return from FMLA leave.
4. Failure to return to work at the end of your approved leave period may be treated as a resignation unless an extension has been agreed upon and approved in writing by the department.
5. If you fail to return to work after taking FMLA leave, you may be required to reimburse health insurance premiums paid by the department on your behalf while you were on unpaid FMLA leave.

|  |  |  |
| --- | --- | --- |
| Please refer to Personnel Policy 3512, “Family and Medical Leave,” for further information about FMLA | | |
| leave. If you have any questions, please contact me at telephone number: |  | . |

Sincerely,

|  |  |  |
| --- | --- | --- |
|  | Date: |  |
| HR Signature |  | |

Both the employee and the local human resources representative should retain a copy of this form.