[Date]

[Employee Name]
[Employee Address]
[City, State, Zip Code]

Subject: Confirmation of FMLA Eligibility for Maternity Leave

Dear [Employee Name],

We received your request for family and medical leave due to pregnancy and the upcoming birth of your child. We are writing to confirm your eligibility under the Family and Medical Leave Act (FMLA).

Eligibility Status:

You are eligible for leave under the FMLA. Based on our records, your requested leave period is expected to begin on [Estimated Start Date] and conclude on or about [Estimated End Date].

Leave Entitlement:

Under the FMLA, eligible employees are entitled to up to 12 weeks of unpaid, job-protected leave within a 12-month period. This leave will count against your annual FMLA entitlement.

Required Documentation:

To finalize your leave approval, please provide the "Certification of Health Care Provider" form by [Due Date]. This form must be completed by your medical professional.

Benefits and Job Restoration:

- Your health insurance coverage will be maintained during your leave under the same conditions as if you continued to work. You will remain responsible for your portion of the premiums.
- Upon return from FMLA leave, you will be restored to your original position or an equivalent position with equivalent pay, benefits, and other employment terms.

Paid Leave Integration:

While FMLA is unpaid, you may choose to use, or the company may require you to use, your accrued [Paid Time Off / Sick Leave / Short Term Disability] concurrently with your FMLA leave.

Please contact the Human Resources department at [Phone Number] or [Email Address] if you have any questions or if your expected leave dates change.

Sincerely,

[Signature]
[Name of HR Representative]
[Company Name]