[Company Name]
[Department]
[Address]
[City, State, Zip Code]

[Date]

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

Subject: Notice of Eligibility and Rights & Responsibilities (Family Medical Leave)

Dear [Employee Name],

On [Date], we were informed of your need for leave to care for your [Family Member Relation: e.g., parent/spouse/child], [Family Member Name], due to their serious health condition. This letter is to inform you of your eligibility for leave under the [Applicable Law, e.g., Family and Medical Leave Act (FMLA)].

1. Eligibility Status:

As of [Date], your eligibility status is as follows:

- [ ] You **are eligible** for leave under the [Applicable Law].
- [ ] You **are NOT eligible** for leave under the [Applicable Law] because:
    - [ ] You have not met the [Number] months of employment requirement.
    - [ ] You have not met the [Number] hours of service requirement during the previous 12-month period.
    - [ ] Other: [Reason]

2. Required Documentation:

To determine if your leave qualifies as protected leave, you must provide a **Medical Certification** completed by the healthcare provider of your family member. This documentation must be returned to [Department/Name] by [Deadline Date]. Failure to provide this documentation may result in the delay or denial of your leave protection.

3. Rights and Responsibilities:

If your leave is approved, you will have the following rights and responsibilities:

- You have a right to up to [Number] weeks of unpaid leave in a 12-month period.
- Your health benefits will be maintained during the leave under the same conditions as if you continued to work.

- You must use your accrued [Paid Time Off/Sick Leave/Vacation] concurrently with this leave.
- You will be reinstated to the same or an equivalent job position upon return from leave.

Please contact [Name/HR Department] at [Phone Number/Email] if you have any questions regarding this notice.

Sincerely,

[Name]
[Title]
[Company Name]