Date: [Date]

To: [Employee Name]

Employee ID: [Employee ID Number]

Subject: Eligibility Determination for Continuous Family Medical Leave

Dear [Employee Name],

We received your request for a continuous leave of absence for family medical reasons starting on [Start Date] and ending on or about [Expected End Date].

Based on the information provided and our records, we have determined that:

[ ] You ARE eligible for leave.
This leave will be counted against your annual entitlement under the Family and Medical Leave Act (FMLA) and/or applicable state leave laws.

[ ] You ARE NOT eligible for leave because:
[ ] You have not met the 12-month employment requirement.
[ ] You have not met the hours-of-service requirement in the previous 12 months.
[ ] You have exhausted your leave entitlement for the current 12-month period.
[ ] Other: [Reason]

Required Documentation:

To finalize your request, you must provide a completed Medical Certification form. This documentation must be returned to the Human Resources department by [Due Date]. Failure to provide sufficient documentation may result in the denial of your leave protection.

Employee Responsibilities:

- You must notify your supervisor of any changes to your expected return-to-work date.
- You are responsible for making arrangements to pay your portion of health insurance premiums while on unpaid leave.
- Before returning to work, you may be required to provide a fitness-for-duty certification.

If you have any questions regarding this determination or your leave rights, please contact [HR Contact Name] at [Phone Number/Email].

Sincerely,

[Name]
[Title]
[Company Name]