Date: [Date]

To: [Employee Name]

From: [Employer Name/HR Department]

Subject: Notice of Eligibility and Rights & Responsibilities (FMLA)

Dear [Employee Name],

On [Date], you informed us that you need a leave of absence for your own serious health condition. This letter is to inform you of your eligibility for leave under the Family and Medical Leave Act (FMLA).

1. Eligibility Status:

Based on the information provided, you are eligible for FMLA leave. This means you meet the service requirements of having worked for the company for at least 12 months and at least 1,250 hours during the previous 12-month period.

2. Documentation Required:

To determine if your absence qualifies as FMLA leave, you must submit a "Certification of Health Care Provider for Employee's Serious Health Condition" form. This form is attached to this letter. You must return this form to Human Resources by [Insert Date - typically 15 days from receipt].

3. Rights and Responsibilities:

- If your leave is approved, you have a right to up to 12 weeks of unpaid, job-protected leave in a 12-month period.
- Your health insurance benefits will be maintained during the leave under the same conditions as if you continued to work. You will remain responsible for your portion of the premiums.
- Upon returning from leave, you must be reinstated to the same or an equivalent job position.
- You may be required to use your accrued paid sick, vacation, or personal time concurrently with your FMLA leave.

4. Fitness-for-Duty Requirement:

Before returning to work, you will be required to provide a fitness-for-duty certification from your healthcare provider confirming that you are able to resume your essential job functions.

Please contact [Name of HR Contact] at [Phone Number/Email] if you have any questions regarding your leave or these requirements.

Sincerely,

[Signature]

[Name of Authorized Representative]
[Job Title]