

[Date]

To: [Employee Name]

Position: [Job Title]

Clinic Department: [Department Name]

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

Dear [Employee Name],

This letter is to inform you that we have received your request for a leave of absence for your own serious health condition or to care for a family member, beginning on [Start Date] and expected to end on or around [End Date].

Part A: Eligibility Notice

Based on our records, you are eligible for leave under the Family and Medical Leave Act (FMLA). You have met the requirements of at least 12 months of employment and at least 1,250 hours of service during the previous 12-month period.

Part B: Rights and Responsibilities

- **Certification:** You must provide a complete and sufficient Medical Certification form by [Due Date] to support your request.
- **Job Restoration:** Upon return from FMLA leave, you will be restored to your original position or an equivalent position with equivalent pay and benefits.
- **Benefits:** Your health insurance coverage will be maintained during your leave under the same conditions as if you had continued to work. You are responsible for paying your portion of the premiums during this period.
- **Substitution of Paid Leave:** You may be required to use your accrued PTO or sick leave concurrently with your FMLA leave.

Part C: Next Steps

Please find the attached Medical Certification Form. Please have your healthcare provider complete this form and return it to the Human Resources Department via secure fax or email by the deadline stated above.

Once we receive the completed certification, we will notify you within five business days whether your leave is officially designated as FMLA leave.

If you have any questions regarding your leave or benefits, please contact the HR Department at [Phone Number] or [Email Address].

Sincerely,

[Name]

[Title]

[Clinic Name]