Date: [Insert Date]

To: [Medical Assistant Name]
Employee ID: [Insert ID]
Position: Medical Assistant

Subject: Notice of Eligibility and Rights & Responsibilities

Dear [Employee Name],

This letter is in response to your request for a leave of absence starting on [Start Date] for the following reason: [Insert Reason, e.g., personal illness, family care, or pregnancy].

1. Eligibility Status
Based on your employment history and hours worked, you are:
[ ] **Eligible** for leave under the Family and Medical Leave Act (FMLA).
[ ] **Not eligible** for leave under FMLA because: [Insert Reason].

2. Rights and Responsibilities
If your leave is approved, you have the following rights while on leave:

- Your health insurance benefits will be maintained under the same conditions as if you continued to work.
- You have the right to be restored to the same or an equivalent position (Medical Assistant or similar grade) upon your return.
- Your use of FMLA leave will not result in the loss of any employment benefit that accrued prior to the start of your leave.

3. Required Documentation
To complete your request, please provide the following by [Insert Due Date]:

- Medical Certification from a healthcare provider.
- Estimated duration of the leave.

4. Substitution of Paid Leave
You [will/will not] be required to use your available sick or vacation time concurrently with this leave. Once your paid time off is exhausted, the remainder of the leave will be unpaid.

Please contact the Human Resources Department at [Phone Number] or [Email Address] if you have any questions regarding this notice.

Sincerely,

[Signature]
[Name of HR Representative]

[Title]
[Organization Name]