

Date: [Date]

To: [Employee Name]

From: [Employer Name/HR Department]

Subject: Designation Notice (Family and Medical Leave Act)

Dear [Employee Name],

We have reviewed your request for leave under the Family and Medical Leave Act (FMLA) and any supporting documentation provided, including the medical certification from your physician.

Determination:

Your FMLA leave request is **APPROVED**. All leave taken for this reason will be designated as FMLA leave and will count against your applicable FMLA leave entitlement.

Leave Details:

- **Continuous Leave:** Your leave is approved for the period of [Start Date] to [End Date]. You are expected to return to work on [Return Date].
- **Intermittent Leave:** Based on the medical certification, you are approved for intermittent leave. This leave may be taken periodically as medically necessary. You are required to follow standard call-in procedures for each absence and specify that the absence is for FMLA purposes.

Responsibilities and Requirements:

- **Paid Leave:** You [will/will not] be required to use your accrued paid time off (vacation, sick, or personal leave) concurrently with your FMLA leave.
- **Benefit Premiums:** To maintain your health insurance benefits during unpaid leave, you must continue to pay your portion of the premium costs. Please contact [Department/Name] to arrange payment.
- **Fitness-for-Duty:** Before returning to work, you [will/will not] be required to present a fitness-for-duty certification from your physician specifically addressing your ability to perform the essential functions of your job.

If you have any questions regarding your FMLA rights or this designation, please contact [Name of HR Representative] at [Phone Number/Email].

Sincerely,

[Name]

[Title]

[Company Name]