

Date: [Date]

To: [Employee Name]

Employee ID: [ID Number]

Subject: Designation Notice (Family and Medical Leave Act)

Dear [Employee Name],

We have reviewed your request for leave under the FMLA and any supporting documentation that you have provided. We are writing to inform you that your leave request is:

Approved. All leave taken for this reason will be designated as FMLA leave. Your FMLA leave begins on [Date] and is expected to continue until [Date].

Not Approved. Your leave request is not approved because:

- The FMLA does not apply to your leave request.
- You have exhausted your FMLA leave entitlement in the current applicable 12-month period.

Additional Information Needed. We need additional information to determine whether your leave request can be approved:

- The certification you provided is incomplete or insufficient. You must provide the following information by [Date]: [Detail information needed].
- We are requiring a second or third medical opinion.

Your Responsibilities:

While on leave, you are required to [Company Policy regarding premium payments/reporting status]. You must notify [Name/Department] as soon as possible if your dates of leave change.

Return to Work:

You will be required to present a fitness-for-duty certificate to be restored to employment. If such certification is not received, your return to work may be delayed.

If you have any questions regarding this notice, please contact [Name/Department] at [Phone/Email].

Sincerely,

[Signature]

[Name of Sender]

[Title]