NOTICE OF LEAVE DESIGNATION: FAMILY AND MEDICAL LEAVE ACT

FORM 704B

Employee Name _____ Emp. ID _____

Date _____

This notice is to inform you that your request for FMLA leave is:

☐ Not Approved for the following reason: _____

☐ Approved. All leave taken for this reason will be designated as FMLA leave. Given the information you have provided, we anticipate that the amount of leave needed will be: _____

If the above space is blank, it means we are unable to discern how much leave is needed. You have the right to request a report of hours designated as FMLA every 30 days if desired.

Please Note the Following Rights and Responsibilities:

1. Eligible employees are entitled to a total of 12 weeks of FMLA leave in a 12 month period (26 weeks for Military Caregiver Leave). The 12 month period is calculated on a rolling 12 month basis measured backward from the date of any FMLA leave usage.

2. Employees on FMLA are entitled to continue medical benefits, subject to the same costs and requirements as other employees not on leave. You must continue to pay your share of the premiums, and payment must be coordinated with the Risk Management Department. Under certain circumstances, if you do not return to employment following FMLA leave, you may be required to reimburse Fort Bend County for the County's share of any costs paid on your behalf during your FMLA leave.

3. You are entitled to reinstatement to the same or equivalent position at the same pay, benefits, and terms and conditions of employment if your leave does not extend beyond the FMLA entitlement and you comply with your responsibilities of leave.

4. You are required to contact your supervisor on the first workday of each week or other prearranged schedule to inform them of your status and intent to return to work.

5. You are required to use any accrued paid leave, including sick, vacation, compensatory and deferred time while you are on leave. If all paid leave is exhausted, the remaining leave will be without pay.

6. While on unpaid leave, you will not accrue any benefits such as vacation or sick leave, nor will you receive longevity payments.

7. You must provide re-certification of the need for leave if an extension to your original request is needed or the circumstances of your leave change significantly.

8. If the leave is due to your own serious illness or injury, you will be required to furnish certification from your medical provider that you are able to perform the essential functions of your position before returning to work. A job description was provided to you with the medical certification form.

Questions regarding FMLA can be directed to Human Resources at 281-341-8624

☐ **Employees on Worker's Compensation Leave: This notice is to inform you that leave taken due to your workers comp qualifying injury or illness will also be designated as FMLA leave. This designation will in no way affect your workers compensation benefits.**

_____ _____

Signature of Department Head or Elected Offical **Date**