FAMILY AND MEDICAL LEAVE DESIGNATION NOTICE

SECTION I – FOR COMPLETION BY HARRIS COUNTY

Leave covered under the Family and Medical Leave Act (FMLA) must be designated as FMLA-protected and the employer must inform the employee of the amount of leave that will be counted against the employee's FMLA leave entitlement. In order to determine whether leave is covered under the FMLA, the employer may request that the leave be supported by a certification. If the certification is incomplete or insufficient, the employer must state in writing what additional information is necessary to make the certification complete and sufficient. While use of this form is optional, a fully completed Form 457 provides employees with the information required by 29 C.F.R. §§ 825.300(d), 825.301, and 825.305(c), which must be provided within five business days of the employer having enough information to determine whether the leave is for an FMLA-qualifying reason.

Date:_____*(mm/dd/yyyy)*

From:_____*(Employer)* To:_____*(Employee)*

On_____*(mm/dd/yyyy)*, we learned that you need leave *(beginning on)*_____ *(mm/dd/yyyy)* for one of the following reasons: *(Select as appropriate)*

☐ The birth of a child, or placement of a child with you for adoption or foster care, and to bond with the newborn or newly-placed child

☐ Your own serious health condition

☐ You are needed to care for your family member due to a serious health condition. Your family member is your:

☐ Spouse ☐ Parent ☐ Child under age 18 ☐ Child 18 years or older and incapable of self-care because of a mental or physical disability

☐ A qualifying exigency arising out of the fact that your family member is on covered active duty or has been notified of an impending call or order to covered active duty status. Your family member on covered active duty is your:

☐ Spouse ☐ Parent ☐ Child of any age

☐ You are needed to care for your family member who is a covered servicemember with a serious injury or illness. You are the servicemember's:

☐ Spouse ☐ Parent ☐ Child ☐ Next of kin

SECTION II – FOR COMPLETION BY HARRIS COUNTY - FMLA DENIAL/APPROVAL

We received your most recent information on _____ and decided to:

☐ **DESIGNATE**

Your request for FMLA leave is approved with a beginning date of _____*(mm/dd/yyyy)* and an end date of _____*(mm/dd/yyyy)*. All leave taken will be designated as FMLA leave and will count against the amount of FMLA leave you have available to use in the applicable 12-month period.

The FMLA requires that you notify us as soon as practicable if the dates of scheduled leave change, are extended, or were initially unknown. Based on the information you have provided to date, we are providing the following information about the amount of time that will be counted against the total amount of FMLA leave you have available to use in the applicable 12-month period (*Select as appropriate*):

☐ Provided there is no change from your anticipated FMLA leave schedule, the following number of hours, days, or weeks will be counted against your leave entitlement of _____ hours / _____ days / _____ weeks.

☐ Because the leave you will need will be unscheduled, it is not possible to provide the hours, days, or weeks that will be counted against your FMLA entitlement at this time. You have the right to request this information once in a 30-day period (if leave was taken in the 30-day period).

SECTION II – FOR COMPLETION BY HARRIS COUNTY - FMLA DENIAL/APPROVAL (CONTINUED)

Your FMLA request is approved for (*Select as appropriate*):

☐ **Continuous Leave:** Your leave will be designated as Continuous, with a beginning date of _____ *(mm/dd/yyyy)* and an end date of _____*(mm/dd/yyyy)* for the period of incapacity.

☐ **Intermittent Leave:** Periods of intermittent episodic incapacity due to flare-ups and or planned medical treatment(s) or appointments on the following basis:

- Frequency:_____times per: ☐ day / ☐ week / ☐ month
- Duration: Flare-ups lasting _____ hours / _____ days per episode
- Treatment:_____

☐ **Reduced Schedule:** Your reduced schedule is set from _____*(mm/dd/yyyy)* to _____*(mm/dd/yyyy)* for _____ hours per day, up to _____ hours per week.

Please be advised *(check all that apply):*

☐ We are requiring you to substitute or use applicable paid leave during your FMLA leave before taking unpaid FMLA leave. Any leave (paid or unpaid) taken for this reason will count against your FMLA entitlement. As a reminder, you may not take sick leave (I time) if the leave is for a family member's serious medical condition, but you may use available family sick leave (B time).

☐ You will be required to present a fitness-for-duty certificate to be restored to employment. If such certification is not timely received, your return to work may be delayed until certification is provided. If this box is checked, the department must attach a job description or list of essential functions for you to attach to your certification. The fitness-for-duty certification must address your ability to perform these functions.

☐ **DELAY - ADDITIONAL INFORMATION NEEDED**

Incomplete or Insufficient Certification

The certification you have provided is incomplete and/or insufficient to determine whether the FMLA applies to your leave request. *(Select as applicable)*

☐ The certification provided is incomplete and we are unable to determine whether the FMLA applies to your leave request. *"Incomplete" means one or more of the applicable entries on the certification have not been completed.*

☐ The certification provided is insufficient to determine whether the FMLA applies to your leave request. *"Insufficient" means the information provided is vague, unclear, ambiguous or non-responsive.*

Specify the information needed to make the certification complete and/or sufficient: _____

_____

You must provide the requested information no later than *(provide at least 7 calendar days* _____ *(mm/dd/yyyy),* unless it is not practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied.

Second and Third Opinions

☐ We request that you obtain a (☐second / ☐third opinion) medical certification at our expense, and we will provide further details at a later time. *Note: The employee or the employee's family member may be requested to authorize the health care provider to release information pertaining only to the serious health condition at issue.*

☐ **DENY**

☐ The FMLA does not apply to your leave request.

☐ Your FMLA leave request is not approved.

☐ You have exhausted your FMLA entitlement in the applicable 12-month period. Your FMLA leave request is not approved because:

_____

_____ _____

Employee Signature Date

_____ _____

Human Resources Representative Date