Sample Memorandum

Agency Designation of Family or Medical Leave

TO: _____
(Employee's name)

FROM: _____
(Name of appropriate agency representative)

SUBJECT: Designation of Family/Medical Leave

We have designated your absence which began on (date) as Family and Medical Leave (FMLA) (check boxes where appropriate).

☐ The birth of a child, or the placement of a child for adoption or foster care; or

☐ A serious personal health condition; or

☐ A serious health condition affecting your spouse, child, parent, for which you are needed to provide care.

Leave under the FMLA may be designated for up to 12 weeks of paid/unpaid leave each calendar year for the reasons listed above. Your health benefits must be maintained during any period of unpaid FMLA leave under the same conditions as would apply if you continued to work and you must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from leave. If you do not return to work following FMLA leave for a reason other than: (1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; or (2) other circumstances beyond your control, you will be required to reimburse the State for the share of health insurance premiums paid on your behalf during your FMLA leave.

This is to inform you that: (check boxes where appropriate)

1. ☐ The designated leave will be counted against your annual FMLA entitlement. As of (date) you have used ___ weeks of your 12-week annual entitlement for calendar year _____.

2. ☐ You may choose to substitute accrued paid leave for unpaid FMLA leave. Please contact (name) at (phone number) to discuss use of credits.

3. ☐ (a) If you normally pay a portion of the premiums for your health insurance, these payments must be made during the period of FMLA leave. If you remain on the payroll, your premium deductions will automatically continue.

If you are on leave without pay, information on continuing premium payments will be sent to you by the Employee Benefits Division, NYS Department of Civil Service, after we have notified the Division of your FMLA leave.

If you make direct premium payments while on unpaid FMLA leave, you have a 30-day grace period in which to make payment. If payment has not been made timely, your group health insurance will be canceled.

The State will not pay your share of the premiums for your health insurance while you are on leave.

☐ (b) The State will continue to pay the full share premium cost for your dental and vision coverages while you are on FMLA leave.

☐ (c) If you wish to continue paying the premium for your life and/or accident and sickness coverage while on unpaid FMLA leave, contact your Health Benefits Administrator for information.

4. ☐ (a) You will be required to present a fitness-for-duty certificate prior to being restored to employment. If such certificate is not received, your return to work may be delayed until such certification is provided.

☐ (b) You will *not* be required to present a fitness-for-duty certificate prior to being restored to employment.

5. ☐ (a) You will be required to furnish us with periodic reports of your status and intent to return to work every 30 days while on FMLA leave.

☐ (b) You will *not* be required to furnish us with periodic reports of your status and intent to return to work every 30 days while on FMLA leave.

6. ☐ (a) Since your absence is due to a serious health condition, you will be required to furnish medical recertification every 30 days confirming continuation of the condition.

☐ (b) You will *not* be required to furnish medical recertification every 30 days relating to the serious health condition.