



**DOUGLAS COUNTY, NEBRASKA
NOTICE OF ELIGIBILITY AND RIGHTS & RESPONSIBILITIES
FAMILY AND MEDICAL LEAVE ACT**

[Part A – NOTICE OF ELIGIBILITY]

TO: _____

FROM: _____

DATE: _____

On _____, you informed us that you needed leave beginning on _____ for:

- The birth of a child or placement of a child with your for adoption or foster care;
- Your own serious health condition
- Because you are needed to care for your spouse son or daughter parent due to a serious health condition;
- Because of a qualifying exigency arising out of the fact that your spouse son or daughter parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves.
- Because you are the spouse son or daughter parent next of kin of a covered service member with a serious injury or illness.

This Notice is to inform you that you:

- Are eligible for FMLA leave (See Part B below for Rights and Responsibilities)
- Are not eligible for FMLA leave, because (only one reason need be checked, although you may not be eligible for other reasons:
 - You have not met the FMLA’s 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately _____ months towards this requirement.
 - You have not met the FMLA’s 1,250-hours-worked requirement.

If you have any questions, contact _____ or view the FMLA poster located in _____.

[Part B – RIGHTS AND RESPONSIBILITIES FOR TAKING FMLA LEAVE]

As explained in Part A, you meet the eligibility requirements for taking FMLA leave and still have FMLA leave available in the applicable 12-month period. **However, in order for us to determine whether your absence qualifies as FMLA leave, you must return the following information to us by _____.** (If a certification is requested, employers must allow at least 15 calendar days from receipt of the notice; additional time may be required in some circumstances). If sufficient information is not provided in a timely manner, your leave may be denied.

Please Provide:

- Sufficient certification to support your request for FMLA leave. A certification form that sets forth the information necessary to support your request is enclosed is not enclosed.
- Sufficient documentation to establish the required relationship between you and your family member.
- Other information needed: _____

No additional information requested.

If your leave does qualify for FMLA leave you will have the following responsibilities while on FMLA leave (only checked boxes apply):

- Contact the HR Benefits Office at 444-6533 to make arrangements to continue to make your share of the premium payments on your health insurance to maintain health benefits while you are on leave. You have a minimum 30-day (or, indicate longer period, if applicable) grace period in which to make premium payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse, or at our option, we may pay your share of the premium during FMLA leave, and recover these payments from you upon your return to work.
- You will be required to use your available paid **sick leave** if applicable during your FMLA absence. This means that you will receive your paid leave and the leave will also be considered protected FMLA leave and counted against your FMLA leave entitlement. At your option, you can use accrued vacation, comp time, or floating holiday once sick leave is exhausted.
- Due to your status within the County, you are considered a “key employee” as defined in the FMLA. As a “key employee,” restoration to employment may be denied following FMLA leave on the grounds that such restoration will cause substantial and grievous economic injury to us. We have have not determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic harm to us.
- While on leave, you will be required to furnish us with periodic reports of your status and intent to return to work every _____ . (Indicate interval of periodic reports, as appropriate for the particular leave situation).

If the circumstances of your leave change and you are able to return to work earlier than the date indicated on the next page, you will be required to notify us at least two workdays prior to the date you intend to report to work.

If your leave does qualify as FMLA leave, you will have the following rights while on FMLA leave:

You have a right under the FMLA for up to 12 weeks of unpaid leave in a 12-month period calculated as the 12-month period measured forward from the date of your first FMLA leave usage.

You have a right under the FMLA for up to 26 weeks of unpaid leave in a single 12-month period to care for a covered service member with a serious injury or illness. This single 12-month period commenced on _____.

Your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work. 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 FMLA-protected leave. (If your leave extends beyond the end of your FMLA entitlement, you do not have return rights under FMLA).

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, 2) the continuation, recurrence, or onset of a covered service member’s serious injury or illness which would entitle you to FMLA leave, or 3) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave.

Once we obtain the information from you as specified above, we will inform you within 5 business days, whether your leave will be designated as FMLA leave and count towards your FMLA entitlement. If you have any questions, please do not hesitate to contact:

_____ at _____.