

**SECTION I – REQUEST FOR LEAVE**

|                         |                                      |                         |  |
|-------------------------|--------------------------------------|-------------------------|--|
| Employee Name           | Employee ID (e.g. TAMS ID)           | Department              |  |
| HR Representative Name  | HR Representative Phone              | HR Representative Fax   |  |
| HR Representative Email | Date Supporting Information Received | Designation Notice Date |  |

**SECTION II – REASON FOR LEAVE**

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    Domestic Partner    Parent    Child    Sibling    Grandchild

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 is your:

Spouse    Domestic Partner    Parent    Child (Any Age)

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 is your:

Spouse    Domestic Partner    Parent    Child (Any Age)    Next of Kin

**SECTION III – DECISION**

We have reviewed information related to your need for leave under the FMLA along with any supporting documentation provided and decided that your FMLA leave request is: (Select as appropriate)

**Approved.** All leave taken for this reason will be designated as FMLA leave. (See Sections IV-VI)

**Not Approved:**

The FMLA does not apply to your leave request.

As of the date the leave is to start, you do not have any FMLA leave available.

Additional information is needed. (See Section VII)

Other: \_\_\_\_\_

SECTION IV – FMLA LEAVE APPROVED

As explained in Section III, your FMLA leave request is approved. All leave taken for this reason 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:

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:

\_\_\_\_\_  
\_\_\_\_\_

Because the leave you will need will be intermittent, 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 V – LEAVE TIME

Please be advised: (check all that apply)

**Sick Leave.** You are required to use all available sick time before taking unpaid FMLA leave. All paid and unpaid leave taken will be designated as FMLA and counted against the amount of FMLA leave you have available to use.

**Other Leave Time.** Based on your request, some or all of your available leave time (personal, vacation, and/or compensatory) will be used during your FMLA leave. Any paid leave taken for this reason will also be designated as FMLA leave and counted against your FMLA leave entitlement.

**Unpaid Leave.** Some or all of your FMLA leave will not be paid. Any unpaid FMLA leave taken will be designated as FMLA leave and counted against the amount of FMLA leave you have available to use in the applicable 12-month period.

**Other:** \_\_\_\_\_  
(Short- or long-term disability (except workers' compensation). Disability leave will be counted against your available FMLA leave but you will not be required to use your sick leave before going on unpaid FMLA leave)

**NOTE: read the Notice of Eligibility and Rights and Responsibilities carefully for additional information regarding leave time and maintaining health benefits.**

SECTION VI – FITNESS FOR DUTY (RETURN TO WORK)

To return to work after taking FMLA, you are required to provide a certification from your health care provider (fitness-for-duty certification) that you are able to resume work. This request for fitness-for-duty certification is only with regard to the particular serious health condition that caused your need for FMLA leave. **If such a certification is not timely received, your return to work may be delayed until the certification is provided.**

A list of essential job functions for your position is attached. The fitness-for-duty certification must address your ability to perform these functions.

SECTION VII – ADDITIONAL INFORMATION NEEDED

We need additional information to determine whether your leave request qualifies under the FMLA. Once we obtain the additional information requested, we will inform you within **5 business days** if your leave will or will not be designated as FMLA leave and count towards the amount of FMLA leave you have available. **Failure to provide the additional information as requested may result in a denial of your FMLA leave request.**

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.

Specify the information needed to make the certification complete or attach a copy of the certificate with areas noted that need to be addressed:

\_\_\_\_\_

You must provide the requested information no later than \_\_\_\_\_ (7 calendar days), unless it is not practicable under the circumstances, despite your diligent good faith efforts, or your leave may be denied.

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 sufficient or attach a copy of the certificate with areas noted that need to be addressed:

\_\_\_\_\_

You must provide the requested information no later than \_\_\_\_\_ (7 calendar days), unless it is not practicable under the circumstances, despite your diligent good faith efforts, or your leave may be denied.

We request that you obtain a  second or  third 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. **Legal / OER Approval Required**

SECTION VII – MORE INFORMATION

All questions can be directed to your HR Representative listed in Section I of this form. The State of Maine's Primary Family and Medical Leave Policy and Family and Medical Leave Policy for Employees Taking Leave for a Grandchild with a Serious Health Condition are available on <https://www.maine.gov/bhr/state-hr-professionals/rules-policies/policy-practices-manual>.

**Review Section V of the Notice of Eligibility and Rights and Responsibilities carefully for additional information regarding leave time and maintaining health benefits.**