U.S. Department of Labor
Wage and Hour Division

Fact Sheet # 28D: Employer Notification Requirements under the Family and Medical Leave Act

Effective communication is a key component of a successful Family and Medical Leave Act (FMLA) program. Covered employers must provide employees with certain critical notices about the FMLA. An employer generally will be covered under the FMLA if it is a private employer with 50 or more employees, a public agency, or a public or private elementary or secondary school.

All covered employers must display a general notice about the FMLA (an FMLA poster). Additionally, covered employers who have employees who are eligible for FMLA leave must:

- Provide employees with general notice about the FMLA;
- Notify employees concerning their eligibility status and rights and responsibilities under the FMLA; and
- Notify employees whether specific leave is designated as FMLA leave and the amount of time that will count against their FMLA leave entitlement.

This fact sheet provides general guidance concerning each of these employer notification requirements.

GENERAL NOTICE REQUIREMENTS

To meet the general notice requirements of the FMLA, covered employers must display a poster in plain view for all workers and applicants to see, notifying them of the FMLA provisions and providing information concerning how to file a complaint with the Wage and Hour Division. A covered employer must display this poster even if it has no eligible employees. An employer who willfully violates this posting requirement may be subject to a civil money penalty. For current penalty amounts, see www.dol.gov/whd/fmla/applicable_laws.htm. Employers may post the Wage and Hour Division's FMLA Poster, which is available at no cost from the WHD website at *www.dol.gov/whd/fmla*, to satisfy this requirement, or may use another format so long as the information provided includes, at a minimum, all the information contained in the FMLA Poster.
In addition to displaying a poster, a covered employer who has any eligible employees also must provide a general notice containing the same information that is in the poster in its employee handbook (or other written material about leave and benefits). If no handbook or written leave materials exist, the employer must distribute this general notice to new employees upon hire. Employers may meet this general notice requirement by either duplicating the general notice language found on the FMLA Poster or by using another format so long as the information provided includes, at a minimum, all the information contained in the FMLA Poster.

The poster may be posted electronically and the general notice may be distributed electronically provided all other requirements are met.

ELIGIBILITY AND RIGHTS AND RESPONSIBILITIES NOTICE REQUIREMENTS

Employee eligibility is determined, and notice of eligibility status must be provided, the first time the employee takes leave for an FMLA-qualifying reason in the employer's designated 12-month leave year.

The eligibility notice may be either oral or in writing and **must**:

- Be provided within **five business days** of the initial request for leave or when the employer acquires knowledge that an employee leave may be for an FMLA-qualifying reason;
- Inform the employee of his or her eligibility status; and
- If the employee is determined to be *not* eligible for FMLA leave, state at least one reason why.

The eligibility notice is not required for FMLA absences for the same qualifying reason during the same leave year or for FMLA absences for a different qualifying reason where the employee's eligibility status has not changed. If the employee requests leave for a different qualifying reason in the same leave year and the employee's eligibility status has changed, the employer must notify the employee of the change in eligibility status within five business days.

Each time employers are required to provide the eligibility notice, they must also provide employees with a rights and responsibilities notice, notifying employees of their obligations concerning the use of FMLA leave and the consequences of failing to meet those obligations.

The rights and responsibilities notice must be **in writing** and **must include**, as applicable:

- Notice that the leave may be counted as FMLA leave;
- The employer's designated 12-month period for counting FMLA leave entitlement;
- Any requirement for the employee to furnish a certification and the consequences for failing to do so;
- Information regarding the employee's right or the employer's requirement for substitution of paid leave and conditions relating to any substitution, and the employee's right to take unpaid FMLA leave if the conditions for paid leave are not met;
- Instructions for making arrangements for any premium payments for maintenance of health benefits that the employee must make during leave (and potential employee liability if the employee fails to return to work after FMLA leave);
- Notice of designation as "key" employee and what that could mean; and
- The employee's right to job restoration and maintenance of benefits.

The rights and responsibilities notice may be distributed electronically provided all other requirements are met. Employers may use Form WH-381, which is available at no cost from the WHD website at *www.dol.gov/whd/fmla*, to provide notice of eligibility and rights and responsibilities.

Employers must be responsive to answer questions from employees concerning their FMLA leave.

DESIGNATION NOTICE REQUIREMENTS

The employer is responsible in all circumstances for designating leave as FMLA-qualifying and giving notice of the designation to the employee. This notice **must**:

- Be provided in writing **within five business days** of having enough information to determine whether the leave is FMLA-qualifying;
- Be provided for each FMLA-qualifying reason per applicable 12-month period (additional notice is required for any changes in the designation information);
- Include the employer's designation determination, and any substitution of paid leave and/or fitness for duty requirements; and
- Provide the amount of leave that is designated and counted against the employee's FMLA entitlement, if known. If the amount of leave is not known at the time of the designation, the employer must provide this information to the employee upon request, but no more often than once in a 30-day period and only if leave was taken in that period.

If the requested leave is not FMLA-qualifying, the notice may be a simple written statement that the leave does not qualify and will not be designated as FMLA leave.

If an employer is unable to determine whether a leave request should be designated as FMLA-protected because a submitted certification is incomplete or insufficient, the employer is required to state in writing what additional information is needed. The employer may use the designation notice to inform the employee that the certification is incomplete or insufficient and identify what information is needed to make the certification complete and sufficient.

Employers may use Form WH-382, which is available at no cost from the WHD website at *www.dol.gov/whd/fmla*, to provide this designation notice.

ALL NOTICES

Employers also may be required to provide notices in languages other than English where a significant portion of the employer's workforce is not literate in English.

Employers are also required to comply with all applicable requirements under Federal or State law for notices provided to sensory-impaired individuals.

CONSEQUENCES OF FAILURE TO PROVIDE NOTICE

Failure to follow the notice requirements may constitute an interference with, restraint, or denial of the exercise of an employee's FMLA rights. *See* Fact Sheet #77B: Protections for Individual under the FMLA. An employer may be liable for compensation and benefits lost by reason of the violation, for other actual monetary losses sustained as a direct result of the violation, and for appropriate equitable or other relief, including employment, reinstatement promotion, or any other relief tailored to the harm suffered.

For additional information, visit the Wage and Hour Division Website, *http://www.wagehour.dol.gov* and/or call our toll-free helpline, 1-866-4-USWAGE (1-866-487-9243) available 8 a.m. to 5 p.m. in your time zone.

This publication is for general information and is not to be considered in the same light as official statements of position contained in the regulations.

U.S. Department of Labor
Frances Perkins Building
200 Constitution Avenue, NW
Washington, DC 20210

1-866-4-USWAGE
TTY: 1-866-487-9243
Contact Us

Certification of Health Care Provider for Employee's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT

OMB Control Number: 1235-0003
Expires: 8/31/2021

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: _____

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions: _____

_____

Check if job description is attached:

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: _____
First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b). Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____)_____ Fax:(_____)_____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

   Mark below as applicable:
   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
   ___No ___Yes. If so, dates of admission:

   _____

   Date(s) you treated the patient for condition:

   _____

   Will the patient need to have treatment visits at least twice per year due to the condition? ___No ___ Yes.

   Was medication, other than over-the-counter medication, prescribed? ___No ___Yes.

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
   ____No ____Yes. If so, state the nature of such treatments and expected duration of treatment:

   _____

2. Is the medical condition pregnancy? ___No ___Yes. If so, expected delivery date: _____

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

   Is the employee unable to perform any of his/her job functions due to the condition: ____ No ____ Yes.

   If so, identify the job functions the employee is unable to perform:

   _____

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

   _____

   _____

   _____

   _____

   _____

   _____

   _____

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___No ___Yes.

   If so, estimate the beginning and ending dates for the period of incapacity: _____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ___No ___Yes.

   If so, are the treatments or the reduced number of hours of work medically necessary? ___No ___Yes.

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   _____

   Estimate the part-time or reduced work schedule the employee needs, if any:

   _____ hour(s) per day; _____ days per week from _____ through _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ____No ____Yes.

   Is it medically necessary for the employee to be absent from work during the flare-ups? ____ No ____Yes. If so, explain:

   _____

   _____

   Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency : _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or ___ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

Signature of Health Care Provider **Date**

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**