

**City of Clarksville
Family and Medical Leave (FML) Notification**

Employee Name and Mailing Address	Date
Name	
Mailing Address	Employee Social Security Number
City, State and Zip code	

On _____, you were will be placed on:
Month/Day/Year

Family and Medical Leave (FML) for:

- Birth of your child, or the placement of a child with you for adoption or foster care;
- A serious health condition affecting your ability to perform the essential functions of your job; or
- Active Duty Leave for immediate family (spouse, children, or parent) called to active duty in Armed Forces; or
- A serious health condition affecting your spouse, child, or parent, for whom you need to provide care.
- Caregiver Leave for your spouse, child, parent, or nearest blood relative for whom you need to provide care.

This leave began/will begin on _____ and you expect the leave to continue until _____
month/day/year month/day/year

Should leave be taken for medical conditions and sick time is not available, you will be able to use other time balances as appropriate.

Except as explained below, you are eligible under the FMLA for up to 12 workweeks of paid/unpaid leave in a 12-month period for the reasons listed above. Also, your health benefits must be maintained during any period of unpaid FML leave under the same conditions as 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 FML. If you do not return to work following FML for a reason other than (1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FML; or (2) other circumstances beyond your control, you may be required to reimburse the City for the city paid portion of health insurance premiums paid on your behalf during your FML.

This is to inform you that:

1. You are are not eligible for leave under the FMLA.
2. The requested leave will will not be counted against your 12-month period for FML entitlement.
3. You will be required to furnish a Leave Application and (a) a dated health care provider's statement from the attending health care provider that contains the medical facts associated with the injury/illness and the expected duration of the injury/illness; or (b) proof of event. Medical facts identify the cause or nature of the illness or injury (i.e., viral illness, internal bleeding, back pain, upper respiratory infection). You must furnish these documents within 15 calendar days of the date this notification was provided to you in person or mailed. Commencement of your leave may be delayed until the documents are received. Failure to furnish medical certification could result in disciplinary action or administrative separation from employment. If the statement is for the care of a family member, it must also include the type and duration of assistance required from the employee and projected date of recovery. If the employee is released to return to work, the health care provider's statement should list any restrictions or limitations and should indicate whether the limitations are temporary or permanent. If no restrictions are listed, the health care provider's statement shall be considered an unconditional release.

4. Certification or proof of event may cover the entire 12 workweeks in a single application. If the circumstances of your leave change and you are able to return to work earlier than the date indicated previously in this notification, you will will not be required to notify us at least two workdays prior to the date you intend to report for work.
5. The following accrued time categories shall be used for your designated FML:
 - Vacation
 - Sick Leave (If applicable)

NOTE: If any Compensatory Time is utilized upon exhaustion of sick and vacation time, it will not count as FML.
6. If you normally pay a portion of the premiums for your health insurance, these payments will still be required during the period of FML without pay. You will have 30 calendar days from the date you were placed in leave without pay to make eligible changes to your insurance coverage. If your spouse is a City employee, you and your covered dependent(s) may be eligible to be placed on your spouse's insurance coverage. You must contact the Human Resources Benefits Representative to make any eligible insurance changes. You will receive notification from the Human Resources Benefit Representative, regarding total monthly premiums due. Upon your return to work from FML, your full coverage will be reinstated to the level held at the time leave without pay began.
7. You will will not be required to present a health care provider's statement releasing you to full duty prior to returning to work. If such statement is required but not received, your return to work will be delayed until this statement is provided.
8. If a serious health condition requires leave that extends beyond your original health care provider's statement (to a maximum of 12 workweeks), you WILL be required to furnish another statement. The additional health care provider's statement must be furnished no later than 15 calendar days following the expiration of the initial request.

HUMAN RESOURCES REPRESENTATIVE:

Name (Please Print)

Phone Number

Signature

Date

Date Mailed: _____

If signed in person:

Employee Signature

Date

Copy: Unit/Department Medical File