Georgia Department of Corrections
Family and Medical Leave Act
Designation Notice

To: ____
Name, Job Title, Employee ID

From: ____
Name, Job Title, Facility

Date: ____

We have reviewed your request for leave under the FMLA and any supporting documentation you have provided. We received your most recent information on and have determined:

☐ **Your FMLA request is approved. All leave taken for this purpose, beginning on , will be designated as FMLA leave.**

The FMLA requires that you notify us as soon as practicable if dates of your scheduled leave change or are extended, or were initially unknown. Based on the information you have provided to-date we are providing the following information regarding the amount of time that will be counted against your leave.

- ☐ Provided there is no deviation from your anticipated leave schedule, the following amount of time will be counted against your 12-week leave entitlement: . You are expected to report to work on .
- ☐ Because the leave you will need will be unscheduled, it is not possible to provide the amount of time that will be charged against your 12-week FMLA entitlement at this time. You have the right to request this information once every 30 days.

Please be advised:

- ☐ You have requested to use paid leave during your FMLA leave. Any paid leave taken during this time will count against your FMLA entitlement.
- ☐ You will be required to present a fitness-for-duty certificate to be restored to employment. If such certification is not timely received, your return to work may be delayed until the certification is provided.

☐ **Additional information is needed to determine if your absence will be designated as FMLA leave.**

- ☐ The certification you have provided is not complete and sufficient to determine whether the FMLA applies to your leave request. You must provide the following information no later than :

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- ☐ We are exercising our right to have you obtain a second or third opinion at our expense, and will provide further details at a later time.

☐ **Your FMLA request is not approved.**

- ☐ The FMLA does not apply to your leave request.
- ☐ You have exhausted your FMLA leave entitlement for the applicable 12-week period.

If you have further questions or concerns, please contact at .

______________________________ ______________________________
Appointing Authority Signature Date

Retention Schedule: Upon completion, this form shall be retained permanently in the official and local medical file of the employee.

Employee Name: ____

Employee ID: ____

Continuation of Benefits
While on Family Leave without Pay, health insurance and most flexible benefits may be continued by paying the monthly premiums in a timely manner. You will receive correspondence from GaBreeze regarding payment of your Flexible Benefits premiums while you are on leave without pay (LWOP).

To ensure that your Health Insurance coverage continues, you must provide a Request to Continue Health Benefits During Leave of Absence Without Pay form and, if applicable, a Disability Certification form completed by the medical provider. These forms along with a **money order** made payable to the Georgia Department of Corrections in the amount of $0.00 must be returned to your local Human Resources Office by the 15th of the month prior to coverage. Forms are enclosed. You will not receive a billing statement.

Please ensure that your employee identification number is on your health insurance payment. If you fail to pay your Flexible Benefits or Health Benefits premiums while on leave without pay, you may not be covered during this absence.

Retirement
Should you submit paperwork for retirement while on an approved leave of absence or at any time in the future, you must continue your health insurance coverage until that period of time in order to maintain insurance coverage at the employee rate upon retirement. If you fail to continue your health insurance coverage at any point prior to retirement, you will not be allowed to resume coverage upon retirement. Also, should you choose to file for disability retirement, you must do so while still an employee of the state.

If you participate in the Deferred Compensation Program you will not be able to continue making deferrals during this period of leave without pay. Upon return, that deduction will begin again unless you submit the required form to stop or modify your deferral. If you have any other payroll-deducted benefits, please contact the provider directly.

If you desire to continue your benefits, it is your responsibility to complete the steps described above. If you have any questions concerning these terms, contact your local Human Resources Office.

____ ____
Appointing Authority Signature Date

Retention Schedule: Upon completion, this form shall be retained permanently in the official and local medical file of the employee.