Family and Medical Leave
Appointing Authority's Response

To: _____ Employee ID: _____

Employee Name

From: _____ Date: _____

Appointing Authority

I have reviewed your application for Family Leave. The request has been denied for the reason(s) indicated below (attach additional page(s) if necessary):

- ☐ You did not meet the eligibility requirement of employment with State government for at least 12 months.
- ☐ You did not meet the eligibility requirement of being present at work for at least 1,250 hours during the 12 months immediately before the beginning of family and medical leave. *(The 1,250 hours does not include holidays or time away from work on paid or unpaid leave.)*
- ☐ The individual with a serious health condition/serious injury or illness is not a qualifying family member
- ☐ The health condition for which family and medical leave was requested did not meet the criteria for a "serious health condition" or a "serious illness or injury" for military caregiver leave.
- ☐ Your family member did not meet the criteria for a covered service member or covered military member; or the covered service/military member does not meet the criteria for a qualifying family member.
- ☐ The issue for which you requested family leave does not meet the criteria of a qualifying exigency
- ☐ You did not provide certification/recertification as required.
- ☐ It has been more than 12 months since the birth of your child or your child was placed for adoption or foster care.
- ☐ Other terms or conditions (***SPECIFICS MUST BE PROVIDED):***

_____

_____

You have the right to request a review of this decision to:

Director, Human Resources
Georgia Department of Corrections
Gibson Hall – 2nd Floor, PO Box 1529
Forsyth, GA 31029
(478)992-5211

Your request, including a copy of the original request, all supporting documentation, and a copy of this letter must be filed with the person indicated above within three work days of your receipt of this decision.

Signature _____ Date _____

Appeal of Appointing Authority's Decision

I wish to request a review of this decision. Attached is my Family Leave Request Form and supporting medical certification or other documentation. I believe the decision to modify/deny my request is incorrect for the following reason(s) (attach additional pages if necessary):

_____

_____

_____

Employee Signature _____ Date _____

Employee Name (Printed) _____

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