Employee Name: _____

Designation Notice

DO NOT SEND TO THE DEPARTMENT OF LABOR.
PROVIDE TO EMPLOYEE.

Leave covered under the Connecticut Family and Medical Leave Act (CTFMLA) must be designated as CTFMLA-protected and the employer must inform the employee of the amount of leave that will be counted against the employee's CTFMLA leave entitlement. In order to determine whether leave is covered under the CTFMLA, the employer may request that the leave be supported by a medical certification. If the certification is incomplete or insufficient, the employer must state in writing what additional information is necessary to make the certification complete and sufficient. While use of this form is optional, a fully completed Designation Notice provides employees with the information required by law, which must be provided within five business days of the employer having enough information to determine whether the leave is for an CTFMLA-qualifying reason. Information about the CTFMLA may be found https://portal.ct.gov/DOLUI/newfmlaguidance.

SECTION I – EMPLOYER

The employer is responsible in **all** circumstances for designating leave as CTFMLA-qualifying and giving notice to the employee. Once an eligible employee communicates a need to take leave for an CTFMLA-qualifying reason, an employer may not delay designating such leave as CTFMLA leave, and neither the employee nor the employer may decline CTFMLA protection for that leave.

Date: _____ *(mm/dd/yyyy)*
From: _____ *(Employer)* To: _____ *(Employee)*
On _____ *(mm/dd/yyyy)* we received your most recent information to support your need for leave due to: *(Select as appropriate)*

☐ 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
☐ The serious health condition of your family member
☐ To serve as an organ or bone marrow donor
☐ A qualifying exigency arising out of the fact that your spouse, child, or parent is on covered active duty or has been notified of an impending call or order to covered active duty with the Armed Forces
☐ A serious injury or illness of a covered servicemember where you are the servicemember's spouse, child, parent, or next of kin *(Military Caregiver Leave)*

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

☐ **Approved.** All leave taken for this reason will be designated as CTFMLA leave. Go to Section III for more information.

☐ **Not Approved**: *(Select as appropriate)*
☐ The CTFMLA does not apply to your leave request.
☐ As of the date the leave is to start, you do not have any CTFMLA leave available to use.
☐ Other _____

Explain with details the reason for denial:

_____

_____

_____

☐ **Additional information** is needed to determine if your leave request qualifies as CTFMLA leave. *(Go to Section II for the specific information needed. If your CTFMLA leave request is approved and no additional information is needed, go to Section III.)*

Employee Name: _____

SECTION II – ADDITIONAL INFORMATION NEEDED

We need additional information to determine whether your leave request qualifies under the CTFMLA. 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 CTFMLA leave and count towards the amount of CTFMLA leave you have available. **Failure to provide the additional information as requested may result in a denial of your CTFMLA leave request**.

If you have any questions, please contact: _____ at _____
(Name of employer FMLA representative) *(Contact information)*

Incomplete or Insufficient Certification

The certification you have provided is incomplete and/or insufficient to determine whether the CTFMLA applies to your leave request. *(Select as applicable)*

☐ The certification provided is incomplete and we are unable to determine whether the CTFMLA applies to your leave request. *"Incomplete" means one or more of the applicable entries on the certification have not been completed.*

☐ The certification provided is insufficient to determine whether the CTFMLA 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 complete and/or sufficient: _____

_____

_____

You must provide the requested information no later than *(provide at least 7 calendar days)* _____ *(mm/dd/yyyy),* unless it is not practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied. If you require additional time to respond, please contact the person above or your leave may be denied.

Second and Third Opinions

☐ We request that you obtain a (☐ second / ☐ third opinion) 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.*

SECTION III – CTFMLA LEAVE APPROVED

As explained in Section I, your CTFMLA leave request is approved. All leave taken for this reason will be designated as CTFMLA leave and will count against the amount of CTFMLA leave you have available to use in the applicable 12-month period. The CTFMLA 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 CTFMLA leave you have available to use in the applicable 12-month period: *(Select as appropriate)*

☐ Provided there is no change from your **anticipated CTFMLA 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 **unscheduled**, it is not possible to provide the hours, days, or weeks that will be counted against your CTFMLA entitlement at this time. You have the right to request this information once in a 30-day period in conjunction with an absence.

Please be advised: *(check all that apply)*

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

☐ **Based on your request, some or all of your available paid leave** *(e.g., sick, vacation, PTO)* **will be used during your CTFMLA leave.** Any paid leave taken for this reason will also be designated as CTFMLA leave and counted against the amount of CTFMLA leave you have available to use in the applicable 12-month period.

Employee Name: _____

☐ **We are requiring you to use some or all of your available paid leave, subject to your right to retain up to 2 weeks of accrued paid leave** *(e.g., sick, vacation, PTO)* **during your CTFMLA leave.** Any paid leave taken for this reason will also be designated as CTFMLA leave and counted against the amount of CTFMLA leave you have available to use in the applicable 12-month period.

☐ **Other:** _____ *(e.g., Short- or long-term disability, workers' compensation, CT Paid Leave, etc.)* Any time taken for this reason will also be designated as CTFMLA leave and counted against the amount of CTFMLA leave you have available to use in the applicable 12-month period.

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

A job description of your position (☐ is / ☐ is not) attached. If attached, it must be provided to your health care provider so that he/she can consider whether you are able to perform the essential functions of your job in making the fitness-for-duty determination.

DO NOT SEND THE COMPLETED FORM TO THE DEPARTMENT OF LABOR.
PROVIDE TO EMPLOYEE.
