(INSERT DEPARTMENT LETTERHEAD)

(DATE)

CONFIDENTIAL – (SENT VIA EMAIL or HAND-DELIVERED) – Choose one

(EMPLOYEE FULL NAME)
(UIN)
(EMPLOYEE CLASSIFICATION)
(COLLEGE/UNIT)

Approval FMLA Leave – (*REASON FOR LEAVE* – Self or Family Member) – Choose one

Dear **(EMPLOYEE NAME)**:

Attached is a copy of the Family and Medical Leave (FMLA) Form submitted on your behalf. The **(DEPARTMENT NAME)** has verified that you are eligible for FMLA leave. Your FMLA leave begins/began **(DAY MONTH, YEAR)**. The time taken for this leave shall count toward your Family and Medical Leave Act entitlement of twelve-weeks of leave (*or twenty-six weeks of leave for care of an ill/injured covered service member* ***only***) per twelve (12) month period. Please be aware that any workers' compensation, parental leave, reasonable accommodations leave, and/or disability leave will also count against your 12-week FMLA entitlement. You are eligible for FMLA leave as follows:

Type of Leave:

- ☐ Block of time. List dates: _____
- ☐ Intermittent. Describe the specific circumstances that apply: _____
- ☐ Reduced schedule. List schedule: _____
- ☐ Unpaid leave will be used if leave balances are depleted.

Availability of Leave:

As of **(DATE)**, you have **(NUMBER) hours of FMLA** leave available.

Reason for Leave:

- ☐ Birth or adoption of a child
- ☐ Due to the employee's parent, child, or spouse's serious health condition Relationship:_____
- ☐ Placement of a foster child
- ☐ Due to employee's serious health condition
- ☐ Care of an ill/injured covered service member
- ☐ Qualifying military-related exigency

Other:

Parental leave	☐ has or	☐ has not	been approved for this leave.
A return-to-work slip	☐ will or	☐ will not	be required.
This leave	☐ will or	☐ will not	be charged against any VESSA entitlement.

When you request to use FMLA, you are to notify management by following departmental process, indicating absence or time off is due to an FMLA event (**indicating the event #1, #2**, **#3**, **etc**.), including if you would like to use sick, vacation, floating holiday, or unpaid time. If any portion of your leave is unpaid and you are presently

covered by payroll deduction in any of the University insurance options and wish to continue such coverage while on unpaid FMLA leave, please check with the U of I Payroll and Benefits Services Center at (217) 265-6363. The University will continue paying its portion of basic health and dental insurance coverage while you are on FMLA leave without pay; however, you must continue to pay your portion of the premium and for any optional coverage, or coverage will cease.

Please contact the **(DEPARTMENT)** Human Resources department at **(PHONE NUMBER)** with questions and for further information regarding your eligibility for Family and Medical Leave.

Sincerely,

(FULL NAME)
(CLASSIFICATION)

Enclosures: *FMLA Application*
Employee Resource List

c: **(EMPLOYEE'S SUPERVISOR)** – **Letter Only (No Medical Information)**
Department Medical File