POLK STATE COLLEGE
FAMILY AND MEDICAL LEAVE ACT
NOTICE TO EMPLOYEE REQUESTING LEAVE

Dear PSC Employee: _____

Our Human Resources Office has received your request for Family and Medical Leave Act (FMLA) leave dated ___, for __ days (up to 60), beginning ___.

It has been ___ Approved _____ Disapproved

1. Your FMLA leave will be counted against the annual entitlement of 12 weeks (60 days).

2. You MUST substitute accrued paid leave for FMLA leave when it is available and equivalent.

3. You MUST pay your health insurance premium for any FMLA leave which is a leave of absence without pay, if the absence is in excess of sixty days (60) days. You must also continue to make any co-payments/dependent's health premiums that you now make.

4. PSC requires a certification from your health care provider/physician stating that you are able to return to your job duties, BEFORE RETURNING TO WORK.

5. You have the right to be restored to the same or an equivalent job upon return from leave.

6. YOU MUST keep your supervisor REGULARLY informed of your leave status and when you expect to return to work.

7. Contact your supervisor or Human Resources if you have questions.

Attachment

Christine DiOrazio _____
Human Resources Generalist

_____
Date

Employee Notified_____ Payroll Notified_____