Texas Department of Criminal Justice
Notification of Medical and Family Leave

Employee Name				Date
Last	First		MI	(mm/dd/yyyy)
Employee Mailing Address				**Month/Day of Birth**
Street or P.O. Box	City	State	Zip Code	(mm/dd)

Your leave began on _____ for the following reason:
mm/dd/yyyy

- ☐ The birth of a child, or the placement of a child with you for adoption or foster care;
- ☐ Your own serious health condition;
- ☐ Because you are needed to care for your ☐ spouse ☐ child or ☐ parent due to a serious health condition;
- ☐ Because of a qualifying exigency arising out of the fact that your ☐ spouse ☐ child or ☐ parent is on covered active duty or called to a covered active duty status in support of a contingency operation; or
- ☐ Because you are the ☐ spouse ☐ child ☐ parent or ☐ next of kin caring for a military member with a serious injury or illness.

This notice is to inform you that: (Check applicable boxes)

☐ **You are eligible for family medical leave (FML)**
You meet the eligibility requirements for taking FML and still have FML available in the applicable 12-month period. If sufficient information is not provided in a timely manner, your FML may be denied.

☐ **You are not eligible for FML, because:**
- ☐ You have not met the *Family Medical Leave Act* (FMLA)'s 12-month length of service requirement;
- ☐ You have not met the FMLA's 1,250 hours worked requirement;
- ☐ You have exhausted your FML entitlement in the current 12-month period; or
- ☐ Leave requested is not for an FMLA reason.

☐ **You are eligible for sick leave, not FMLA eligible**.

☐ **You are eligible for state parental leave following the date of birth of your child or placement of a child for adoption or foster care.** Proof of the event shall be required.

You must return the certification for your leave by: _____
mm/dd/yyyy

Your available leave balances are:

Vacation: _____ Sick: _____ Overtime: _____ Compensatory: _____ Holiday: _____

☐ **You shall be or have been placed in a leave without pay (LWOP) status effective:** _____
mm/dd/yyyy

The maximum number of LWOP calendar days an employee may take for any combination of LWOP-FML, LWOP-Medical, LWOP-State Parental, and LWOP-Other is 180 calendar days within a rolling 12-month period unless the employee is eligible for state parental leave or FML when the 180 calendar day limit is exhausted.

As of the date of this notification you had _____ calendar days of LWOP remaining. It is your responsibility to communicate with your human resources representative and to know when your available days of LWOP will exhaust.

General Provisions:

* It is your responsibility to obtain and submit required documentation to remain in an approved leave status. Your failure to submit proper documentation as required by policy may be cause for disciplinary action or separation from employment.
* You are required to notify your supervisor should your leave change, become extended, or was initially unknown.
* You shall be required to use your available accrued paid leave during your absence. Unless otherwise instructed by you, donated sick leave will be applied. For an FMLA absence, your paid leave and unpaid leave shall be counted against your FML entitlement.
* You shall be required to furnish a PERS 24, Leave Request, and the FML certification, if the leave is designated as FML.
* If the leave is state parental leave, you shall be required to furnish a PERS 24 and proof of event.
* If the leave is non-FMLA, you shall be required to furnish a PERS 24 and a dated health care provider's statement (HCPS) from the attending health care provider that contains the medical facts associated with the injury or illness and the expected duration of the illness or injury within 15 calendar days of the date this notification was provided to you in person or mailed. In addition:

  a. If the statement is for the care of a family member, it must also include the type and duration of assistance required from you.
  b. The HCPS shall support the duration of time requested, not to exceed six months.
  c. If a serious health condition requires leave that extends beyond your original HCPS, you shall be required to furnish another statement no later than 15 calendar days following the expiration of the previous request.

* If leave was taken for your own serious health condition, you shall be required to present an HCPS release to return to work. If such statement is required but not received, your return to work shall be delayed until this statement is provided. If any permanent restrictions or limitations are listed on the release to work, your return to work shall be governed by PD-14, "Americans with Disabilities Act and Employment of Persons with a Permanent or Long-Term Medical Condition."
* **If you normally pay a portion of the premiums for your health insurance, these payments shall still be required during any period of LWOP – FML, to include tobacco usage premiums. You shall have 30 calendar days from the date you were placed in LWOP to make eligible changes to your insurance or TexFlex coverage.** If your spouse is a state employee, you and your covered dependent(s) may be eligible to be placed on your spouse's insurance coverage. You must contact your human resources representative to make any eligible insurance or TexFlex changes. You shall receive notification from the Employees Retirement System of Texas (ERS) regarding total monthly premiums due. Upon your return to work from FML, your full coverage shall be reinstated to the level held at the time LWOP began. If you do not return to work following FML for a reason other than: (1) the continuation, recurrence or onset of a serious health condition which would entitle you to FML; or (2) other circumstances beyond your control, you may be required to reimburse TDCJ for the state paid portion of health insurance premiums paid on your behalf during your FML.

If your leave qualifies as FML, you will have the following rights while on FML:

* You have a right under the FMLA for up to 12 workweeks of unpaid leave in a 12-month period calculated as a "rolling" 12-month period measured backward from the date of any FML usage.
* You have a right under the FMLA for up to 26 workweeks of unpaid leave in a single 12-month period to care for a military member with a serious injury or illness. This single 12-month period commenced on: _____ mm/dd/yyyy
* Your health insurance benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work.
* You must be reinstated to the same or an equivalent job with the same pay, benefits and terms and conditions of employment on your return from FML. If your leave extends beyond the end of your FMLA entitlement, you do not have return rights under FMLA.

Once we obtain the information from you as specified above, we will inform you, within five workdays, whether your leave will be designated as FML entitlement. If you have questions, please contact the human resources representative below.

HUMAN RESOURCES REPRESENTATIVE:

Name: _____ (Please Print) Phone Number: _____

Signature: _____ Signature date (mm/dd/yyyy): _____

Date Mailed (mm/dd/yyyy): _____

If signed in person:

Employee Signature: _____ Signature Date (mm/dd/yyyy): _____

Note to Employee: With few exceptions, you are entitled upon request: (1) to be informed about the information the TDCJ collects about you; and (2) under Texas Government Code §§ 552.021 and 552.023, to receive and review the collected information. Under Texas Government Code § 559.004, you are also entitled to request, in accordance with TDCJ procedures, that incorrect information the TDCJ has collected about you be corrected.

Copy: Unit or Department Medical File