

U.S. Department of Labor  
Employment Standards  
Administration  
Wage and Hour Division

**Designation Notice  
(Family and Medical Leave Act)**

**Leave covered under the Family and Medical Leave Act (FMLA) must be designated as FMLA-protected and the employer must inform the employee of the amount of leave that will be counted against the employee's FMLA leave entitlement. In order to determine whether leave is covered under the FMLA, the employer may request that the leave be supported by a 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 by employers is optional, a fully completed Form WH-382 provides an easy method of providing employees with the written information required by 29 C.F.R. §§ 825.300(c), 825.301, and 825.305(c).**

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To: \_\_\_\_\_

Date: \_\_\_\_\_

We have reviewed your request for leave under the FMLA and any supporting documentation that you have provided.

We received your most recent information on \_\_\_\_\_ and decided:

\_\_\_\_\_ **Your FMLA leave request is approved. All leave taken for this reason will be designated as FMLA leave.**

**The FMLA requires that you notify us as soon as practicable if dates of scheduled leave change or 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 your leave entitlement:**

\_\_\_\_\_ Provided there is no deviation from your anticipated 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 FMLA entitlement at this time. You have the right to request this information once in a 30-day period (if leave was taken in the 30-day period).

**Please be advised (check if applicable):**

\_\_\_\_\_ You have requested to use paid leave during your FMLA leave. Any paid leave taken for this reason will count against your FMLA leave entitlement.

\_\_\_\_\_ We are requiring you to substitute or use paid leave during your FMLA leave.

\_\_\_\_\_ You will be required to present a fitness-for-duty certificate to be restored to employment. If such certification is not timely received, your return to work may be delayed until certification is provided. A list of the essential functions of your position **is is not** attached. If attached, the fitness-for-duty certification must address your ability to perform these functions.

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**\_\_\_\_\_ Additional information is needed to determine if your FMLA leave request can be approved:**

\_\_\_\_\_ The certification you have provided is not complete and sufficient to determine whether the FMLA applies to your leave request. You must provide the following information no later than \_\_\_\_\_, unless it is not \_\_\_\_\_ (Provide at least seven calendar days) practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied.

\_\_\_\_\_  
\_\_\_\_\_  
(Specify information needed to make the certification complete and sufficient)

\_\_\_\_\_ We are exercising our right to have you obtain a second or third opinion medical certification at our expense, and we will provide further details at a later time.

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\_\_\_\_\_ Your FMLA Leave request is Not Approved.

\_\_\_\_\_ The FMLA does not apply to your leave request.

\_\_\_\_\_ You have exhausted your FMLA leave entitlement in the applicable 12-month period.

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**. DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.**