

FAMILY MEDICAL LEAVE ACT CHECK LIST

Employee Name: _____

Reason for Leave: ___ Employee illness ___ Family illness ___ Birth/Adoption

Beginning date of Leave: _____

Ending date of Leave: _____

EMPLOYER INITIATED:

- _____ Eligibility determined
- _____ Letter to employee granting provisional approval with FMLA application and medical certification form included, allowing 15 calendar days for return of the documents
- _____ FMLA application and medical certification form NOT received within timeframe identified, FMLA Usage Report initiated, copy of completed Report to HR
- _____ Application and medical certification received and reviewed
- _____ Letter to employee if leave is not eligible for FMLA
- _____ Copy of FMLA ineligibility letter to HR Records
- _____ Complete department portion of FMLA, if leave is FMLA eligible
- _____ Copy of FMLA application form and letter to the employee indicating eligibility for the leave, as well as the department's expectations at the end of the leave (i.e.: Physician statement returning employee to work required)
- _____ Copy of eligibility letter to HR Records (letter only)
- _____ Create confidential medical file for employee
- _____ Initiate FMLA Usage Report
- _____ Letter to employee (2 weeks prior to end of Leave) warning of Leave expiration
- _____ Copy of completed FMLA Usage Report to HR Records

EMPLOYEE INITIATED:

- _____ FMLA application and medical certification received and reviewed
- _____ Eligibility determined
- _____ Letter to employee if leave is not eligible for FMLA
- _____ Copy of FMLA ineligibility letter to HR Records
- _____ Complete department portion of FMLA, if leave is FMLA eligible
- _____ Copy of FMLA application form and letter to employee indicating eligibility for the leave, as well as the department's expectations at the end of the leave (i.e.: Physician statement returning employee to work required)
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