

UNIVERSITY OF HAWAII
DESIGNATION NOTICE TO EMPLOYEE

For Hawaii Family Leave Law (HFLL) and Family and Medical Leave Act (FMLA)

I. Date: _____
Employee First and Last Name: _____
Campus/School/Program: _____ BU: _____
Prepared by: _____ Phone #: _____
(Human Resources Unit or Designee (print and sign)
Period of leave: Start Date: _____ End Date: _____

II. Additional information is needed to determine if your HFLL and/or FMLA leave can be approved:

_____ The UH Form 46b "Notice of Eligibility and Rights & Responsibilities" dated _____ requesting the appropriate certification and/or documentation was not received. You must provide the certification and/or documentation no later than _____ (provide at least 7 calendar days), unless it is not practicable under the particular circumstances despite your diligent good faith efforts. If not, your leave may be denied.

_____ The certification you have provided is not complete and insufficient to determine whether the HFLL and/or FMLA apply to your leave request. You must provide the following information no later than _____ (provide at least 7 calendar days), unless it is not practicable under the particular circumstances despite your diligent good faith efforts. If not, 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 will provide further details at a later time.

III. We have reviewed your supporting document(s) for leave under the _____ Hawaii Family Leave Law (HFLL) and/or the _____ Family & Medical Leave Act (FMLA) on _____ and determined (check all that applies):

_____ Your HFLL leave request is approved. All leave taken for this reason will be designated as HFLL leave.

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

_____ Your HFLL leave will run concurrently with your FMLA leave.

_____ Your HFLL leave request is NOT approved or does not apply to your leave request.

_____ Your FMLA leave request is NOT approved or does not apply to your leave request.

_____ You have exhausted your HFLL leave entitlement in the applicable calendar year.

_____ You have exhausted your FMLA leave entitlement in the applicable calendar year.

IV. You are required to notify us as soon as practicable if the dates of the scheduled leave changes or are extended, or were initially unknown. Based on the information you have provided, we are providing the following information about the amount of time that will be counted against your leave entitlement. You have the option to substitute paid leave during your Family Leave entitlement. (Check all that applies)

_____ 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 need will be unscheduled, it is not possible to provide the hours, days, or weeks that will be counted against your HFLL and/or FMLA entitlement(s) at this time. You have the right to request this information once in a 30-day period (only if leave is taken).

_____ You will be required to submit a certificate from a health care provider stating that you are physically and/or mentally able to resume your duties to be restored to employment. If such certification is not timely received, your return to work may be delayed until certification is provided.

Comments: _____

Should you need further information, contact your HR unit or designee listed above.