KANSAS STATE UNIVERSITY
FAMILY AND MEDICAL LEAVE ACT

NOTICE OF DESIGNATION OF FMLA LEAVE

__________________________________	____________________________
Name	Department
__________________________________	____________________________
Employee ID Number	Date

This serves to notify you that the University has designated your medical leave as qualifying for Family and Medical Leave Act (FMLA) coverage as a serious medical condition under the provisions noted below.

Leave Approved From:________________________________Through:_____________________
__________ FMLA Personal Illness/Injury
__________ FMLA Family Illness/Injury
__________ FMLA Childbirth/Adoption/Placement

Leave Used/to be Used:
__________ Hours Sick Leave
__________ Hours Annual Leave
__________ Hours Leave without pay

If you do not feel that this leave should qualify as “serious” for FMLA coverage, please provide either a letter or an FMLA "Certification of Health Care Provider” to more fully describe the nature or your medical condition.

Please feel free to discuss any questions regarding FMLA with your division/department head or Human Resource Services (785) 532-6277.

____	_________________________________
Signature	Date