[CURRENT DATE]

[EMPLOYEE NAME]
[EMPLOYEE ADDRESS]
[CITY, STATE, ZIP]

Dear [EMPLOYEE NAME]:

On [MM/DD/YYYY] you notified us of your need to take a leave of absence beginning on [MM/DD/YYYY] until [MM/DD/YYYY] due to:

- ☐ - The birth of a child, or the placement of a child with you for adoption or foster care.
- ☐ - A serious health condition that makes you unable to perform the essential functions of your job.
- ☐ - A serious health condition affecting your (spouse/child/parent), for which you are needed to provide care.
- ☐ - Other [OTHER, IF ANY].

At this time, you are not eligible for leave under federal or state leave laws. However, you have met eligibility requirements for an unpaid personal leave of absence.

Your request for a personal leave of absence from [MM/DD/YYYY] until [MM/DD/YYYY] has been approved.

You ☐ Will ☐ Will Not be required to use any accrued paid leave prior to taking unpaid leave. [COMPANY NAME] will continue to pay its portion of the cost of your benefits, including health, dental, life and disability insurance benefits, while you are on this leave of absence. You must continue to pay your portion of the benefits, which may be made by payroll deductions (when applicable) or by check or money order submitted to the HR department each pay period.

If you fail to pay your portion of the benefits for more than 30 days, you and your beneficiaries' coverage(s) will be terminated, and you will be offered COBRA to continue benefits, excluding life and disability insurance.

Benefits such as vacation, sick, personal days and holidays will not accrue while you are on a leave of absence.

While on leave, you ☐ Will ☐ Will Not be required to furnish us with periodic reports every [indicate interval of periodic reports, as appropriate for the particular leave situation] of your status and intent to return to work. If the circumstances of your leave change and you are able to return to work earlier than the date indicated, you ☐ Will ☐ Will Not be required to notify us at least three work days prior to the date you intend to report to work.

If you are unable to return by the end of your leave, you must request an extension of the leave, in writing, five days prior to the leave expiration date. If [COMPANY NAME] does not extend the leave, you must return to work on the originally scheduled return date or be considered to have voluntarily resigned from your position. Extensions of leave will only be considered on a case-by-case basis.

If you are on a leave of absence due to medical reasons, you must submit a physician's statement releasing you back to work on or prior to your date of return.

Upon the expiration of the leave, you may be returned to your former position, if available. If the position is not available, you may be offered another available position for which you are qualified. If no position is available when you are able to return to work, you will be terminated and may apply for the next available position.

Failure to return to work upon the expiration of the leave of absence or refusing an offer of reinstatement for which you are qualified will be considered a voluntary resignation of employment.

If you have any questions, please contact me at [PHONE NUMBER].

Sincerely,

_____ (HR Signature)

[HR REP NAME]
[HR REP TITLE]