# Family and Medical Leave Act (FMLA) Paperwork Packet

Red text denotes a field that needs to be changed by the user.

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## Attachment #1: Sample FMLA Request Forms

### Sample Form #1 – One Block of Time

This memo is to notify you of my need for leave under the Family and Medical Leave Act. I require a leave of absence from [Start Date] to [End Date] because:

I am temporarily unable to work because of my own serious health condition.

I will be caring for a family member (spouse, child, or parent) with a serious health condition.

I have attached a completed certification from a health care provider documenting my need for leave.

It is my understanding that I am eligible for up to 12 weeks of leave per year under the Family Medical leave Act and that I will be reinstated to my job after my leave. [Note: If covered by your company’s health insurance include this sentence: “it is also my understanding that (Company Name) will continue my health insurance during my leave.]

The Family and Medical Leave Act specifies that employers must provide specific written notice to an employee of rights and responsibilities regarding leave within five (5) business days if feasible of when that employee gives notice of the need for leave (29 C.F.R. 825.301). I look forward to receiving this information from you.

Please let me know immediately and in writing if you require anything further from me. I appreciate your assistance with this matter.

I acknowledge that completion of this Employee Request for FMLA form does not imply that the leave will be approved. I understand that the approval for FMLA is subject to meeting eligibility qualifications as set forth by the U.S. Department of Labor.

### Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Name (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Supervisor Signature of acknowledgement: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Name (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Sample Form #2 – Intermittent Leave

Red text denotes a field that needs to be changed by the user.

This memo is to notify you of my need for intermittent leave under the Family and Medical Leave Act. I require intermittent leave from [Start Date] to [End Date] because:

Temporary absences due to my own serious health condition.

Temporary absences due to caring for a family member (spouse, child, or parent) with a serious health condition.

I have attached a completed certification from a health care provider documenting my need for leave.

It is my understanding that I am eligible for up to 12 weeks of leave per year under the Family Medical leave Act and that I will be reinstated to my job after my leave. It is also my understanding that when a health care provider certifies a need for intermittent FMLA leave for a period exceeding 30 days, an employer may not require additional certifications during that period unless a request is made to extend the leave, circumstances change significantly, or the employer receives information that casts doubt on the need for leave. (See 29 C.F.R. 825.308(b)(2)).

The Family and Medical Leave Act specifies that employers must provide specific written notice to an employee of rights and responsibilities regarding leave within five (5) business days if feasible of when that employee gives notice of the need for leave (29 C.F.R. 825.301). I look forward to receiving this information from you.

Please let me know immediately and in writing if you require anything further from me. I appreciate your assistance with this matter.

I acknowledge that completion of this Employee Request for FMLA form does not imply that the leave will be approved. I understand that the approval for FMLA is subject to meeting eligibility qualifications as set forth by the U.S. Department of Labor.

### Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Name (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Supervisor Signature of acknowledgement: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Name (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Sample Form #3 – Reduced Schedule

Red text denotes a field that needs to be changed by the user.

This memo is to notify you of my need for a reduced schedule under the Family and Medical Leave Act. It is medically necessary to change my schedule because of:

My own serious health condition.

Caring for a family member (spouse, child, or parent) with a serious health condition.

I have attached a completed certification from a health care provider documenting my need for a reduced schedule.

It is my understanding that I am eligible for up to 12 weeks of leave per year under the Family Medical leave Act and that I will be reinstated to my job after my leave. [Note: If covered by your company’s health insurance include this sentence: “it is also my understanding that (Company Name) will continue my health insurance during my leave.]

The Family and Medical Leave Act specifies that employers must provide specific written notice to an employee of rights and responsibilities regarding leave within five (5) business days if feasible of when that employee gives notice of the need for leave (29 C.F.R. 825.301). I look forward to receiving this information from you.

Please let me know immediately and in writing if you require anything further from me. I appreciate your assistance with this matter.

I acknowledge that completion of this Employee Request for FMLA form does not imply that the request will be approved. I understand that the approval for FMLA is subject to meeting eligibility qualifications as set forth by the U.S. Department of Labor.

### Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Name (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Supervisor Signature of acknowledgement: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Name (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Attachment #2: Family Medical Leave Act (FMLA) Addendum Safe Harbor Genetic Information Nondiscrimination Act (GINA) FMLA Certification Disclosure

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law.

To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information.

‘Genetic information,’ as defined by GINA, includes an individual’s family medical history, the results of an individual’s or family member’s genetic tests, the fact that an individual or an individual’s family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual’s family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Please complete and return this form to your Human Resources Representative or Direct Manager with the completed “Certification of Health Care Provider” Form.

### Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Name (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Health Care Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Name (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Attachment #3: Benefits Continuation Letter

Red text denotes a field that needs to be changed by the user.

[Date]

[Employee Name]  
[Street Address]  
[City, State ZIP]

### Re: Benefits Continuation

Dear [Employee Name]:

As previously discussed, the company has approved your request for a Family and Medical Leave Act (FMLA) leave of absence. The purpose of this letter is to explain to you the process of continuing your company sponsored benefit plans while on FMLA leave.

It is important to note that continuing your benefits during this time is optional. You are not required to elect to continue benefits during your medical leave. Should you wish to discontinue any of your benefits plans, please notify us immediately so we may make the proper adjustments with the insurance carrier(s).

Should you wish to continue your benefits during this time, you will be required to remit payment for your portion of the benefits premiums. As long as you continue to send in payment for the employee’s portion of your benefit plans, the company will continue to pay its portion of the benefit plans as well.

Below we have detailed the employee’s portion of your current insurance plans:

|  |  |  |
| --- | --- | --- |
|  | Pay Period Cost | Monthly Cost |
| Medical Insurance | $ | $ |
| Dental Insurance | $ | $ |
| Vision Insurance | $ | $ |
| Life Insurance | $ | $ |
| Other: [list] | $ | $ |
| **Total** | $ | $ |

You will be required to make payments on a monthly basis to continue your current insurance benefits. Insurance payments are due on the first of the month for that month’s coverage. Your first payment will be due on [Date (generally the first day of the leave)] and will be prorated to cover the following pay periods: [List pay period dates]. Therefore, if you would like to continue all of your current insurance plans, the amount of the first payment will be [Enter amount].

The monthly amount will be [Enter amount] thereafter, and will be due on the first day of each month. Should you return to work in the middle of a month, we will prorate your final month of premiums at that time.

Your benefits payments should be mailed to:

[Name]  
[Street Address]  
[City, State ZIP]

In accordance with FMLA guidelines and our company policy, if your payment is more than thirty (30) days late the company will cancel your company sponsored insurance plans. The company will send you a written notice of cancellation at least 15 days prior to the cancellation to ensure you are aware that your insurance coverage is in jeopardy.

In accordance with federal law, you may be eligible to continue your benefit plans under the Consolidated Omnibus Budget Reconciliation Act (COBRA). For example, should you inform the company of your intent not to return from work, you will be eligible to continue your benefits under COBRA, and the company will mail you a separate notice regarding your COBRA rights and responsibilities. However, should you fail to make payment to the company within the timelines delineated above to continue your health insurance plan while on leave, you may forfeit your right to COBRA eligibility under the federal law. So please work closely with us so we may assist you with respect to managing your benefit plans during your leave.

Should the company cancel your coverage due to lack of payment, you will have the right to restore your insurance coverage without condition once you return to work. While it is not our intention to do so, should the company opt to cover any of the employee portion of your insurance premiums while you are on leave, the company retains the right to deduct such premiums from your paycheck once you return to work.

It is important to us that you understand your rights and responsibilities regarding benefits continuation during your medical leave. If you have any questions or concerns, please contact [Enter Name], whose contact information is listed below.

Sincerely,

[Signature]

[Name and Position Title]

[Contact Information]

## Attachment #4: 15-Day Non-Payment Letter

Red text denotes a field that needs to be changed by the user.

[Date]

[Employee Name]  
[Street Address]  
[City, State ZIP]

### Re: Benefits Continuation

Dear [Employee Name]:

As previously discussed, the company has approved your request for a medical leave of absence. The purpose of this letter is to notify you that your benefit premium payment is late. The due date of your first benefit premium payment was [Date]. Your benefits may be in jeopardy if you do not remit payment in a timely manner.

Should you wish to continue your benefits at this time, you will be required to remit payment for your portion of the benefits premiums on or before [Date, at least 15 days from the date of this letter]. As long as you continue to send in payment for the employee’s portion of your benefit plans, the company will continue to pay its portion of the benefit plans as well.

Below we have detailed the employee’s portion of your current insurance plans:

|  |  |  |
| --- | --- | --- |
|  | Pay Period Cost | Monthly Cost |
| Medical Insurance | $ | $ |
| Dental Insurance | $ | $ |
| Vision Insurance | $ | $ |
| Life Insurance | $ | $ |
| Other: [list] | $ | $ |
| **Total** | $ | $ |

As previously stated, you are required to make payments on a monthly basis to continue your current insurance benefits. Insurance payments are due on the first of the month for that month’s coverage.

Your benefits payments should be mailed to:

[Name]  
[Street Address]  
[City, State ZIP]

In accordance with our company policy, if your payment is more than thirty (30) days late the company will cancel your company sponsored insurance plans. This is your official written notice informing you that you insurance coverage may be in jeopardy. We will cancel all benefit coverage on [Date, same as above at least 15 days from date of this letter] if we do not receive you payment in full.

Should the company cancel your coverage due to lack of payment, you will have the right to restore your insurance coverage without condition once you return to work. While it is not our intention to do so, should the company opt to cover any of the employee portion of your insurance premiums while you are on leave, the company retains the right to deduct such premiums from your paycheck once you return to work.

It is important to note that continuing your benefits during this time is optional. You are not required to elect to continue benefits during your medical leave. Should you wish to discontinue any of your benefits plans, please notify us immediately so we may make the proper adjustments with the insurance carrier(s).

In accordance with federal law, you may be eligible to continue your benefit plans under the Consolidated Omnibus Budget Reconciliation Act (COBRA). For example, should you inform the company of your intent not to return from work, you will be eligible to continue your benefits under COBRA, and the company will mail you a separate notice regarding your COBRA rights and responsibilities. However, should you fail to make payment to the company within the timelines delineated above to continue your health insurance plan while on leave, you may forfeit your right to COBRA eligibility under the federal law. So please work closely with us so we may assist you with respect to managing your benefit plans during your leave.

It is important to us that you understand your rights and responsibilities regarding benefits continuation during your medical leave. If you have any questions or concerns, please contact [Enter Name], whose contact information is listed below.

Sincerely,

[Signature]

[Name and Position Title]

[Contact Information]

## Attachment #5: Fitness for Duty Certification

Red text denotes a field that needs to be changed by the user.

## Fitness for Duty Certificate Information

This form is to be completed by a health care provider. An employee who has taken medical leave must present this Fitness for Duty Certification to their supervisor prior to returning to work. This form is for return to work purposes of medical leave of absence due to an illness or injury, whether work or non-work related. Because employees are valuable resources, health care providers should assist employees in returning to work as soon as possible.

## Health Care Professionals

Your patient has three return-to-work options. [A job description is attached for your reference.]

* Full Release. The patient has no work restrictions. They can return to their prior position because you, the health care provider certify, that they can perform the essential functions of their job.
* Modified Duty. The patient has some work restrictions. Work restrictions must be specifically notated on page two of this form. Each modified duty work restriction request will be reviewed carefully to determine if the employee can perform the essential functions of the job and return to work.
* Not Released. The patient is not released to work in any capacity due to physical or behavioral limitations.

## Gina Provision

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

## Submission

The Fitness for Duty Certification can be submitted to the following, or may be provided to the employee:

[List Employer’s Confidential Contact Information Here]

## Fitness for Duty Certification

|  |  |
| --- | --- |
| Employee/Patient Name (Last, First, & Middle) | Date of Exam |
|  |  |
| Employee’s Release for Duty Status | |
| Full, unrestricted duty effective \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_  Modified duty effective \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ and next evaluation date \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_  Not released for any type of duty. Next evaluation date will be \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ | |

### Physical and/or Behavioral Restrictions

Check and explain any that may apply.

|  |  |
| --- | --- |
| Lifting Restrictions | Explanation |
| Sedentary, 0 to 10 pounds |  |
| Light, 10 to 20 pounds |  |
| Moderate, 20 to 50 pounds |  |
| Heavy, 50 to 100 pounds |  |
| Other Physical Restrictions | |
| Pulling/Pushing/Carrying |  |
| Reaching/Working above Shoulder |  |
| Walking |  |
| Standing |  |
| Stooping |  |
| Kneeling |  |
| Repeated Bending |  |
| Climbing |  |
| Operating a Motor Vehicle |  |
| Finger Manipulation (typing) |  |
| Pain (frequency, degree, signs) |  |
| Behavioral Restrictions | |
| Understanding |  |
| Remembering |  |
| Sustained concentration |  |
| Follow-through on instructions |  |
| Decision making |  |
| Receiving supervision |  |
| Relating to co-workers |  |
| Other Restrictions, Considerations, or Notes | |
|  | |

I hereby certify that the facts in this document are true and correct.

### Health Care Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Name (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Attachment #6: Work Restrictions Response Letter & Employee Acknowledgment Form

Red text denotes a field that needs to be changed by the user.

[Date]

[Employee Name]  
[Street Address]  
[City, State ZIP]

### Re: Work Restrictions

Dear [Employee Name]:

We have modified your job duties to ensure compliance with your doctor’s orders. Your health and safety is of upmost importance to us. Therefore, we ask that you exercise caution when you return to work and that under no circumstances do you perform a job duty that requires you to perform a restricted motion as per your physician’s letter.

On the letter provided to us on [Date] from your treating physician, your treating physician, has listed the following work restrictions:

[List restrictions]

It is important that you do not attempt to perform any of these activities upon your return to work. If a job duty needs to be performed that involves one of these restricted activities, you are required to delegate the job duty to another employee. Until you are further along in your recovery and these restrictions are lifted, under no circumstances are you to disregard these restrictions while performing work for [Company Name].

Please be assured that your disability records will be maintained in accordance with applicable confidentiality requirements as delineated in the ADA.

Again, we are glad that you are back!

Sincerely,

[Signature]

[Name and Position Title]

[Contact Information]

## Team Member Acknowledgement of Work Restrictions

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Employee Name) understand that my treating physician has released me to return to work as of [Date] with the following restrictions:

[List restrictions]

I understand that under no circumstances am I permitted to perform job duties that requires me to violate the above listed restrictions. Should such job duties need to be performed, I will ask or delegate another team member to perform them. I understand that my inability to perform these motions at this time will not be taken into account when my performance is reviewed and I will not be retaliated against based on my current medical status or work restrictions. Should I have any concerns in this regard, I will immediately bring them to the attention of the Human Resources Department.

I understand the restrictions listed here and agree to follow them at all times during the course of my work at [Company Name] (until your doctor revises the restrictions).

### Employee Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Name (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Attachment #7: Links to Federal FMLA Forms

WH-380-E Certification of Health Care Provider for Employee’s Serious Health Condition

* <http://www.dol.gov/whd/forms/WH-380-E.pdf>

WH-380-F Certification of Health Care Provider for Family Member’s Serious Health Condition

* <http://www.dol.gov/whd/forms/WH-380-F.pdf>

WH-381 Notice of Eligibility and Rights & Responsibilities

* <http://www.dol.gov/whd/forms/WH-381.pdf>

WH-382 Designation Notice

* <http://www.dol.gov/whd/forms/WH-382.pdf>

WH-384 Certification of Qualifying Exigency for Military Family Leave

* <http://www.dol.gov/whd/forms/WH-384.pdf>

WH-385 Certification for Serious Injury or Illness of Covered Servicemember -- for Military Family Leave

* <http://www.dol.gov/whd/forms/WH-385.pdf>

WH-385-V Certification for Serious Injury or Illness of a Veteran for Military Caregiver Leave

* <http://www.dol.gov/whd/forms/wh385V.pdf>

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