

SAMPLE DENIAL LETTER

Date:

Dear _____,

Your request of _____ for use of family leave has been received and reviewed. However, your request has been denied due to the following:

- _____ 1. Did not meet eligibility requirements of employment (employed a minimum of 12 months by the appointing authority and for 1,250 hours over the previous 12 months).
- _____ 2. Did not meet definition of “qualifying family member” (employee’s spouse, child, parent or spouse’s parent).
- _____ 3. Did not meet criteria for “serious health condition” determination.
- _____ 4. Did not provide certification/recertification or did not meet requirements of same.
- _____ 5. Birth of child or placement for adoption/foster care exceeded 12 months.
- _____ 6. Other terms or conditions (specifics must be provided).

You have the right to appeal this decision within three (3) work days of receipt to the Executive Director, 1501-A Kalamazoo Drive, P.O. Box 1320, Griffin, GA 30224, phone number (770) 229-3069 by using one of the following options:

- 1. Hand deliver;
- 2. Fax to 770-229-3223;
- 3. Express mail; or
- 4. Other expedited methods.

You must provide all supporting documentation at the time of appeal. Failure to appeal within three (3) work days shall result in forfeiture of any further right of appeal.

Sincerely,

Signature of Clinical Director of MH/AD Services or Director of Developmental Disabilities

cc: Executive Director
Personnel Manager

APPEAL TO MCINTOSH TRAIL CSB EXECUTIVE DIRECTOR

I wish to appeal this decision. Enclosed is my Family Leave Request Form and supporting documentation.

Signature of Employee

Date