City of Manchester

Family and Medical Leave Policy

November 2013

Guidance regarding this policy will be provided by the Human Resources Department, One City Hall Plaza, Manchester, NH. Tel: 624-6543.

The City reserves the right to make changes to this policy in order to comply with changes in the Family and Medical Leave Act of 1992 (the FMLA), and/or court decisions which may affect the language of this policy. This policy has been updated to comply with new FMLA regulations that became effective in 2009 and 2010. The changes to the City FMLA Policy incorporate revisions to the FMLA, including leave due to a qualifying military exigency and leave to care for a "covered military service member" (including veterans) with a serious injury or illness.

Policy Statement

It is the policy of the City of Manchester to grant up to 12 weeks of leave during a 12-month period to eligible employees for the birth, adoption, or placement into foster care of a child, for the serious health condition of specified family members, the employee's own serious health condition or for a qualifying military exigency. The City grants up to 26 weeks of leave during a 12-month period when leave is taken by a spouse, son, daughter, parent or next of kin to care for a seriously ill or injured "covered service member" (see "Military-Related FMLA Leave"). FMLA leave will be paid, unpaid, or a combination of both, depending on the circumstances as specified in the City of Manchester Family and Medical Leave Policy (see "Substitution of Accrued Paid Leave"). The Family and Medical Leave Policy will be administered by the City's FMLA Administrator.

Eligibility

An employee is eligible for FMLA leave if he/she has been employed by the City for at least 12 months, and has worked at least 1,250 hours (does not include any paid or unpaid time off) in the 12-month period immediately preceding the request for leave. The twelve months do not need to be consecutive and may be based on separate periods of employment as specified in FMLA regulations. Once the FMLA Administrator has made a determination as to whether an employee is eligible for FMLA leave, the FMLA Administrator will advise the employee of the determination, his/her rights and obligations under the FMLA, as well as the consequences of failing to meet such obligations. (see "Notice to the Employee Regarding Eligibility for FMLA Leave").

Leave Entitlement

An eligible employee is entitled to up to 12 weeks of unpaid leave (26 weeks for military caregiver leave) within a 12-month period for any of the following reasons:

A. The birth of a child of the employee and to care for the newborn child;

B. The placement with the employee of a child for adoption or foster care;

C. To provide care for the employee's spouse, child, parent or other blood relative or ward (residing in the same household) with a serious health condition;

D. To take medical leave when the employee is unable to perform any of the essential functions of the position due to a serious health condition;

E. A qualifying military-related exigency arising out of the fact that the employee's spouse, son, daughter, or parent is on active duty or has been notified of an impending call or order to active duty in support of a contingency operation (see Military-Related FMLA Leave);

F. To provide care for a covered service member with a serious injury or illness if the employee is the spouse, son, daughter, parent or next of kin of the covered service member (see "Military-Related FMLA Leave").

The 12-Month Period

The 12-month period is measured forward from the date an employee's first FMLA leave begins. The next 12-month period begins the first day FMLA leave is taken after completion of any previous 12-month period.

In the case of leave taken to care for a covered service member with a serious injury or illness, an employee who does not take all 26 workweeks of leave to care for the covered service member during the single 12-month period, will forfeit any remaining military caregiver leave.

Substitution of Accrued Paid Leave

As allowed under the FMLA, the City requires the substitution of accrued paid leave for unpaid FMLA leave time, as follows:

- Accrued sick (and/or sick leave bank credits, if awarded), vacation, and personal leave (if applicable), in that order, will be substituted for unpaid FMLA leave when leave is taken for the employee's own serious health condition. Employees eligible for sick leave have the option of using such sick leave, upon approval of his/her department or office head, for absence due to the serious health condition of a spouse, child or other blood relative or ward residing in the same household when FMLA leave is approved, or may use other accrued paid leave such as Vacation or Personal leave*.

  * Note: The City will allow the substitution of paid sick leave for the mother during the period of maternity disability, typically up to 6 weeks, unless the mother's health care provider certifies that additional leave is required due to medical necessity, and will allow 2 weeks of paid sick leave to be substituted for unpaid FMLA leave for the father to provide care for the spouse (residing in the same household), unless the mother's health care provider certifies that additional leave is required due to medical necessity.

- Accrued vacation, then personal leave (if applicable), in that order, will be substituted for the unpaid FMLA leave in the case of parental care for and bonding with a newborn child, the adoption of a child, the placement of a foster child, to provide care for a parent, spouse or child who does not reside in the employee's household, or for a qualifying military exigency.

- Up to 26 weeks of leave may be taken during a single 12-month period by a spouse, son, daughter, parent or next of kin, to care for a covered service member who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status or is otherwise on the temporary disability retired list, for a serious injury or illness. Note that up to 12 weeks of accrued sick leave, vacation or personal leave, if awarded, will be substituted for unpaid FMLA

leave when leave is taken for this purpose. Accrued vacation and personal leave will be substituted for the remaining 14 weeks prior to going on unpaid leave.

- In no case can use of leave be credited as **FMLA** leave after leave has ended and employee has returned to work.

Retention of Health Benefits

While an employee is on FMLA leave, the City will continue to provide health care coverage (medical and/or dental) to the employee who has such coverage, so long as the employee continues to pay his/her portion of the monthly health care premium(s). An employee who is on unpaid FMLA leave status must forward payment for his/her portion of the monthly health care premium(s) by the 15th of the month for which the premium is due.

The City's obligation to maintain health insurance coverage ceases if an employee's share of the premium is more than 30 days late.

Maintaining Benefits Other Than Health Care

While an employee is on paid FMLA leave, all benefits to which the employee would normally be entitled will continue.

When an employee is on unpaid FMLA leave for more than 10 calendar days in a month, he/she will not accrue benefits, for example, vacation, sick leave, personal leave, etc.

FMLA leave time is considered continued service for purposes of pension vesting and seniority.

Right to Reinstatement

Upon return from FMLA leave an employee is entitled to be reinstated to his/her previous job or to a position with equivalent pay, benefits and substantially equivalent duties.

An employee on FMLA leave has no greater or lesser right to reinstatement or to other benefits and conditions of employment than if the employee had been continuously employed during the FMLA leave period, except if the FMLA leave is on a non-paid status, then such unpaid time shall not count towards seniority and benefit calculations as determined by existing policies. Therefore, an employee whose position is eliminated or who is laid off while he/she is on FMLA leave is not entitled to be reinstated upon completion of the FMLA leave.

Designation of FMLA leave

It is the City's responsibility and right to designate leave as FMLA leave. FMLA leave may be designated upon request by the employee, or when the City has sufficient information concerning the leave status of an employee to presume that the employee has a qualifying serious health condition as defined under the FMLA. The City's FMLA Administrator will request and obtain sufficient information from the employee to determine whether the leave qualifies as FMLA leave, to include a medical certification from the employee's or family member's health care provider. In addition, the FMLA Administrator or a physician authorized by the City may contact the health care provider for purposes of clarification and authentication of the medical certification (whether

initial certification or recertification) after the City has given the employee an opportunity to cure any deficiencies with the certification as set forth in the FMLA regulations. Once the FMLA Administrator has determined that leave qualifies as FMLA leave, the employee will be notified that the leave is approved for FMLA leave and will be counted towards the employee's FMLA leave entitlement (see "Notice to the Employee Regarding the Designation of FMLA Leave").

Notice and Medical Certification

When requesting FMLA leave employees will be required to provide:

1. Sufficient information to determine if the requested leave may qualify for FMLA leave protection and the anticipated timing and duration of the leave. Sufficient information may include the inability to perform job functions, a family member's inability to perform daily activities or other need for care by the employee, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees must also inform the City if the requested leave is for a reason for which FMLA leave was previously approved and taken (see "Request for FMLA Leave" form).

   If the need for the leave is foreseeable, this information must be provided 30 days in advance of the anticipated beginning date of the leave. If the need for leave is not foreseeable, this information must be provided as soon as is practicable and in compliance with the City's normal call-in procedures, absent unusual circumstances.

2. Medical certification supporting the need for leave due to a serious condition affecting the employee or an employee's immediate family member must be provided within 15 calendar days of the City's request to provide the certification (additional time may be permitted in some circumstances). If the employee fails to do so, the City may delay the commencement of FMLA leave, withdraw any designation of FMLA leave or deny the leave, in which case the leave of absence would be treated in accordance with our standard leave of absence and attendance policies. Second or third medical opinions and periodic re-certifications may also be required

3. Periodic reports (at least every 30 days) during the leave to the Department Head regarding the status of the employee's leave and intent to return to work.

4. Medical certification of fitness for duty before returning to work, if the leave was due to the employee's serious health condition. The City will require this certification to address whether the employee can perform the essential functions of his/her position.

   Again, failure to comply with the foregoing requirements may result in delay or denial of FMLA leave.

Serious Health Condition

An employee is entitled to take FMLA leave if he/she suffers from a serious health condition that prevents him/her from performing the essential functions of his/her job, or if he/she is needed to provide care for a family member with a serious health condition. A serious health condition is defined as an illness, injury, impairment, or physical or mental condition that involves:

- any period of incapacity or treatment connected with inpatient care--for example, an overnight stay in a hospital, hospice, or residential medical care facility; or

- any period of incapacity requiring absence of more than 3 calendar days from work, school, or other regular daily activities, and which also involves: (1) two visits to a health care provider, which must occur within 30 days of the beginning of the period of incapacity *unless* extenuating circumstances exist preventing a follow-up visit from occurring as planned by the health care provider; or (2) one visit to a health care provider *and* a regimen of continuing treatment, such as prescription medication. In both cases, the first (or only) in-person treatment must occur within seven (7) days of the first day of incapacity; or

- prenatal care, complications with pregnancy, giving birth, recovery from birth; or

- continuing treatment by (or under the supervision of) a health care provider for a chronic or long-term health condition that is incurable or so serious that, if left un-treated, would likely result in a period of incapacity of more than 3 calendar days. For chronic conditions requiring periodic visits for treatment, such visits must take place at least twice a year.

- an injury or illness incurred by a service member (including a member of the National Guard or Reserves) in the line of duty on active duty in the Armed forces that may render the member medically unfit to perform the duties of the member's office, grade, rank, or rating.

  Note: Questions about what illnesses are covered under this policy should be directed to the Human Resources Department.

Medical Certification

The City requires an employee to submit medical certification from a health care provider showing that the employee or family member has a serious health condition that qualifies for FMLA leave. Such medical certification must be provided to the Human Resources Department within 15 days from the date the employee receives the certification form, unless it is not practicable due to circumstances beyond the employee's control and despite the good faith efforts of the employee to obtain the certification.

The medical certification must be complete and sufficient. A certification is considered incomplete if one or more of the applicable entries have not been completed. A certification is considered insufficient if the information provided is vague, ambiguous, or non-responsive. The need for leave must be documented by the employee's or family member's treating healthcare provider through our medical certification process (see definition of "serious health condition").

The FMLA Administrator may request a second opinion with a provider of the City's choice, at the City's expense. If the initial and subsequent opinions conflict, the City has the option to require the employee to obtain certification from a third health care provider, again at the City's expense. The third opinion is final and binding. The third health care provider must be approved jointly by the FMLA Administrator and the employee.

Recertification

The City requires recertification every 30 days while the employee is on leave, unless the medical certification indicates that the minimum duration of the condition is more than 30 days. Recertification may be requested earlier when:

- The employee requests an extension of the leave; or

- Circumstances described by the original certification have changed significantly (e.g., the duration of the illness, the nature of the illness); or

- The City receives information that casts doubt upon the continuing validity of the certification. In all cases, the City requires recertification every 6 months while the employee is on leave.

Confidentiality of Medical Records

Records and documents relating to medical certifications, recertification or medical histories of employees or employees' family members shall be maintained at the Human Resources Department, in files/records separate from the employee's personnel file, and treated as confidential medical records, except that

1. Supervisors and managers may be informed regarding necessary restrictions on the work or duties of an employee and necessary accommodations;

2. First aid and safety personnel may be informed (when appropriate) if the employee's physical or medical condition might require emergency treatment; and

3. Government officials investigating compliance with FMLA (or other pertinent laws) shall be provided relevant information upon request.

Fitness-for-Duty Certification

When an employee who has been on FMLA medical leave (due to his/her serious health condition) is ready to return to work, the City will require a fitness-for-duty certification, signed by the employee's health care provider, prior to the start of work, stating that the employee is able to return to work.

If the employee decides not to return to work at the end of his/her FMLA medical leave because he/she has not recovered from his/her serious health condition, the FMLA Administrator may verify that the employee is unable to return to work by requesting another medical certification.

Other Employment and Overtime

Because the purpose of FMLA is to allow an employee to help balance work and family life by taking reasonable leave to meet personal and family obligations and to tend to vital needs at home, the acceptance or continuance of other employment during a consecutive FMLA Leave period is inconsistent with the purpose of FMLA. For this reason, the acceptance or continuation of other employment, including overtime and outside details, during any consecutive FMLA Leave period is prohibited. If an employee on FMLA leave violates this provision, the employee will be subject to disciplinary action.

Employees taking intermittent leave or a reduced-leave schedule may continue other employment during the FMLA leave periods; however, employees must give priority to the efficient operations of the City and their department, as opposed to those of the second employer, when scheduling the FMLA leave.

Health Care Provider

A person who qualifies as a "health care provider" is responsible for issuing certification of an employee or family member's illness. See "Definitions" for a more detailed definition of "Health Care Provider."

Intermittent and Reduced Schedule Leave

An employee has the right to take FMLA medical leave on a reduced schedule or intermittent leave basis for the employee's serious health condition or to care for a family member with a serious health condition, if the intermittent or reduced leave is "medically necessary" and such medical leave can be best accommodated through an intermittent or reduced leave schedule as certified by a health care provider.

- A reduced leave schedule consists of a reduction in either the normal hours per day or hours per week that an employee works.

- Intermittent leave is leave taken at varying times of the week or day. It may be taken in blocks as small as one hour.

To qualify, the employee or family member must have a serious health condition and the intermittent leave or reduced leave schedule must be certified as medically necessary by a health care provider. Employees who take intermittent leave for planned medical treatment have an obligation to make a "reasonable effort" to schedule treatment so as not to unduly disrupt their department's operations.

A mother or father who takes FMLA family leave to care for his/her newborn or adopted child or recently placed foster care child, who does not have a serious health condition, may take leave intermittently or on a reduced leave schedule with the agreement of the Department Head.

If an employee is taking intermittent leave, the City may temporarily transfer the employee to an available alternative position for which the employee is qualified and which better accommodates recurring periods of leave. The alternative position must have equivalent pay and benefits but need not have equivalent duties. Benefits such as vacation and sick leave accrual will be reduced proportionately based on the number of hours worked.

Leave for Purposes Not Covered Under FMLA

If an employee requests and is granted authorized leave for a purpose that does not qualify as FMLA leave (e.g., leave to care for a parent-in-law, or a blood relative other than a Spouse, Child or Parent who does not live in the same household), that leave time will not be charged against the 12-week FMLA entitlement. Thus, an employee who takes two weeks of authorized vacation leave to care for a parent-in-law will still have 12 weeks of FMLA leave remaining when he/she returns from the vacation leave.

Employee's Notice of No Intent to Return to Work

If an employee unequivocally advises his/her Department Head that he/she does not intend to return to work, or fails to return to work (without having been granted additional leave), without good reason, at the conclusion of the FMLA medical leave, the employment relationship is deemed terminated, and the employee's entitlement to reinstatement, continued leave, and health benefits (subject to COBRA) ceases. Also, the City is entitled to recover its cost of the health care premium (while on unpaid leave) directly from the employee.

"Good reason" in this case would be because of the continuation, recurrence, or onset of the employee's or family member's serious health condition, or circumstances beyond the employee's control.

Spouses Employed By the City

A husband and wife who are eligible for FMLA leave and are both employed by the City of Manchester are permitted to take no more than a combined total of 12 weeks of FMLA leave for the birth or adoption of a child, the placement of a foster care child, or the care of a family member with a serious health condition.

Each will, however, be entitled to the difference between the amount he or she has taken individually and 12 weeks, for his/her personal qualifying serious health condition within the same 12-month period.

Worker's Compensation Absences

An employee on a leave of absence when approved for Worker's Compensation due to a work related injury/illness will not have that time charged against his/her 12-week FMLA entitlement. If an employee is denied Worker's Compensation, and has an injury or illness that constitutes a "serious health condition" as defined under the FMLA, the leave of absence from work will be designated as FMLA leave.

Fraudulently Taking FMLA Leave

An employee who fraudulently obtains FMLA leave is not protected by the FMLA's job restoration or maintenance of health benefits provisions and may be subject to disciplinary action up to and including discharge.

Military-Related FMLA Leave

FMLA leave may also be available to eligible employees in connection with certain service-related medical and non-medical needs of family members. There are two forms of such leave. The first is Military Caregiver Leave, and the second is Qualifying Exigency Leave. Each of these leaves is detailed below.

Military Caregiver Leave

Military Caregiver Leave is designed to allow eligible employees to care for certain family members who have sustained serious injuries or illnesses in the line of duty while on active duty. The military

family member must be a "covered service member," which means: (1) a current member of the regular Armed Forces, National Guard or Reserves, (2) who is undergoing medical treatment, recuperation, or therapy; is otherwise in outpatient status, or is otherwise on the temporary disability retired list, (3) for a serious injury or illness that may render the service member medically unfit to perform the duties of the member's office, grade, rank, or rating. Military Caregiver leave is also available to care for veterans of the regular Armed Forces or the National Guard or Reserves (see definition of "Covered Service Member").

Military Caregiver Leave applies on a per-injury/per-illness basis for each service member. Consequently, an eligible employee may take separate periods of caregiver leave for each and every covered service member, and/or for each and every serious injury or illness of the same covered service member. A total of no more than 26 workweeks of Military Caregiver Leave, however, may be taken within any "single 12-month period."

Within the "single 12-month period" described above, an eligible employee may take a combined total of 26 weeks of FMLA leave including up to 12 weeks of leave for any other FMLA-qualifying reason (i.e. birth or adoption of a child, serious health condition of the employee or close family member, or a qualifying exigency). For example, during the "single 12-month period, " an eligible employee may take up to 16 weeks of FMLA leave to care for a covered service member when combined with up to 10 weeks of FMLA leave to care for a newborn child.

An employee seeking Military Caregiver Leave is required to provide a Certification for Leave to Care for a Covered Service Member Form completed by an authorized health care provider, an Invitational Travel Orders (ITOs) or Invitational Travel Authorization (ITAs). Confirmation of the family relationship to the seriously injured or ill covered service member will be required when an employee supports his or her request for FMLA leave with a copy of an ITO or ITA.

Qualifying Exigency Leave

Eligible employees may take unpaid "Qualifying Exigency Leave" to tend to certain "exigencies" arising out of active duty or a call or order to active duty of a "covered military member". Up to 12 weeks of Qualifying Exigency Leave is available in any 12-month period, as measured by the same method that governs measurement of other forms of FMLA leave within the FMLA policy. Although Qualifying Exigency leave may be combined with leave for other FMLA-qualifying reasons, under no circumstances may the combined total exceed 12 weeks in any 12-month period (with the exception of Military Caregiver Leave as set forth above).

Under recent amendments to the FMLA, an eligible employee who is the spouse, son, daughter, or parent of a covered military member, may take qualifying exigency leave to attend to any qualifying exigency while the covered military member is on active duty, or has been notified of an impending call or order to active duty, in support of a contingency operation as either of the following:

- A member of a regular component of the Armed Forces, duty during the deployment of the member with the Armed Forces to a foreign country.

- A member of a reserve component of the Armed Forces, duty during the deployment of the member with the Armed Forces to a foreign country under a call or order to active duty.

The Department of Labor has defined a ***qualifying exigency*** by referring to a number of broad categories in which employees can use FMLA leave, including the following:

- *Short-notice deployment:* to address any issue that arises out of short notice (with seven days or less) of an impending call or order to active duty

- *Military events and related activities*: to attend any official military ceremony, program, or event related to active duty or a call to active duty status or to attend certain family support or assistance programs and informational briefings.

- *Childcare and School activities*: To arrange for alternative childcare; to provide childcare on a urgent, immediate need basis; to enroll in or transfer to a new school or daycare facility; or to attend meeting with staff at a school or daycare facility.

- *Financial and legal arrangements*: to make or update various financial or legal arrangements; or to act as the covered military member's representative before a federal, state, or local agency in connection with service benefits

- *Counseling*: to attend counseling (by someone other than a health care provider) for the employee, the covered military member, or for a child or dependent when necessary as a result of duty under a call or order to active duty.

- *Temporary rest and recuperation*: to spend time with a covered military member who is on short-term, temporary rest and recuperation leave during the period of deployment. Eligible employees may take up to five days of leave for each instance of rest and recuperation.

- *Post-Deployment activities*: to attend arrival ceremonies, reintegration briefings and events, and any other official ceremony or program sponsored by the military for a period of up to 90 days following termination of the covered military member's active duty status. This also encompasses leave to address issues that arise from the death of a covered military member while on active duty status.

- *Mutually agreed leave*: Other events that arise from the close family member's duty under a call or order to active duty, providing that the City and the employee agree that such leave shall qualify as an exigency and agree to both the timing and duration of such leave.

An employee seeking Qualifying Exigency Leave is required to provide a copy of the covered military member's active duty orders or other documentation issued by the military which indicates that the covered military member is on active duty or call to active duty status in support of a contingency operation, and the dates of the covered military member's active duty service, a statement setting forth the nature and details of the specific exigency, the amount of leave needed and the employee's relationship with the military member, within 15 days.

Qualifying Military Caregiver and Exigency Leaves will be governed by, and handled in accordance with the FMLA and applicable regulations and nothing within this policy should be construed to be inconsistent with those regulations.

Recordkeeping

The City will keep a record of an employee's FMLA-related leaves for at least 3 years.

Note: More specific information regarding the records which will be maintained is contained under "Records Maintenance."

FMLA Administrative Process

Employees shall notify their Department Head (or designee) regarding the need for FMLA leave. The Department Head (or designee) will notify the Human Resources Department as soon as possible regarding the employee's request.

- **City of Manchester FMLA Request Form** should be completed by the employee requesting FMLA leave.
  (see Attachment 1)

- **Certification for Employee's Serious Health Condition Form** should be completed by the employee's health care provider and submitted to the Human Resources Department no later than 15 days following the request for FMLA leave.
  (see Attachment 2)

- **Certification for Family Member's Serious Health Condition Form** should be completed by the family member's health care provider when taking FMLA leave to provide care for a family member.
  (see Attachment 3)

- **Certification for Serious Health Condition of Covered Service Member Form** should be completed by an authorized health care provider as defined in the FMLA Military Caregiver Leave provisions. An Invitational Travel Order (ITO) or Invitational Travel Authorization (ITA) will also satisfy this certification requirement. Family members may also be required to provide confirmation of the family member's relationship to the seriously injured or ill service member.
  (see Attachment 4)

- **Certification of Qualifying Exigency For Military Family Leave Form** should be completed by the employee family member of the covered military service member. Employee family members will also be required to submit a copy of the covered military member's active duty orders and other documentation from the military certifying that the covered military member is on active duty (or has been notified of an impending call to active duty) in support of a contingency operation.
  (see Attachment 5)

Note: An employee may lose his/her protection under the law by failing to comply with applicable notice and/or certification requirements.

Notice to the Employee Regarding Eligibility for FMLA Leave.

Upon receipt of a request for FMLA Leave by the FMLA Administrator, the employee will receive a completed **Notice of Eligibility and Rights and Responsibilities Form.** This form will indicate whether the employee is eligible for FMLA leave, and if so, the rights and obligations of the employee and employer.
(see Attachment 6)

Notice to the Employee Regarding the Designation of FMLA Leave.

Once all required certifications/supporting documentation has been received and reviewed by the FMLA Administrator, the employee will receive a completed **FMLA Designation Notice Form,** which will indicate whether the employee's request for FMLA leave has been approved. The form will also specify additional requirements while on FMLA leave, or whether additional information is required to determine if the leave qualifies as FMLA leave.
(see Attachment 7)

DEFINITIONS

Family Members

- Spouse: as defined or recognized under New Hampshire state law;
- Child: a biological, adopted, or foster care child, a stepchild, a legal ward, or a child of a person standing in loco parentis, who is either under age 18, or age 18 or older and "incapable of self-care because of a mental or physical disability"; or
- Parent: a biological parent or an individual who stands or stood "in loco parentis" to an employee when the employee was a child. This does not include parents-in- law.
- In Loco Parentis: an individual who has/had day-to-day responsibility to care for and financially support that child. A biological or legal relationship is not necessary.
- Next of kin of a covered service member: the nearest blood relative other than the covered service member's spouse, parent, son, or daughter, in the following order of priority: Blood relatives who have been granted legal custody of the covered service member by court decree or statutory provisions, brothers and sisters, grandparents, aunts and uncles, and first cousins, unless the covered service member has specifically designated in writing another blood relative as his or her nearest blood relative for purposes of military caregiver leave under the FMLA.

Covered Service Member – Qualifying Exigency Leave

- A military member who is on active duty, or has been notified of an impending call or order to active duty, in support of a contingency operation as either of the following:
    - A member of a regular component of the Armed Forces, duty during the deployment of the member with the Armed Forces to a foreign country.
    - A member of a reserve component of the Armed Forces, duty during the deployment of the member with the Armed Forces to a foreign country under a call or order to active duty.

Covered Service Member – Military Caregiver Leave

- A ***covered service member*** is both of the following:

    - A member of the Armed Forces (including a member of the National Guard or Reserves) who is undergoing medical treatment, recuperation, or therapy, is

otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness.

- A veteran who is undergoing medical treatment, recuperation, or therapy, for a serious injury or illness and who was a member of the Armed Forces (including a member of the National Guard or Reserves) at any time during the period of five years preceding the date on which the veteran undergoes that medical treatment, recuperation, or therapy.

- A ***veteran*** is a person who served in the active military, naval, or air service, and who was discharged or released from such service under conditions other than dishonorable.

- A ***serious injury or illness*** is both of the following:

  - In the case of a member of the Armed Forces (including a member of the National Guard or Reserves), an injury or illness that was incurred by the member in line of duty on active duty in the Armed Forces (or existed before the beginning of the member's active duty and was aggravated by service in line of duty on active duty in the Armed Forces) and that may render the member medically unfit to perform the duties of the member's office, grade, rank, or rating.

  - In the case of a veteran who was a member of the Armed Forces (including a member of the National Guard or Reserves), at any time during the period of five years preceding the date on which the veteran undergoes medical treatment, recuperation, or therapy, has a qualifying injury or illness that was incurred by the member in line of duty on active duty in the Armed Forces (or existed before the beginning of the member's active duty and was aggravated by service in line of duty on active duty in the Armed Forces) and that manifested itself before or after the member became a veteran.

- ***Outpatient status*** means the status of a member of the Armed Forces assigned to either a military medical treatment facility as an outpatient, or a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients.

Health Care Provider

A health care provider is defined as a licensed doctor of medicine or osteopathy, authorized to practice medicine or surgery by the state in which the doctor practices; or any others capable of providing health care services including only: podiatrists, dentists, clinical psychologists, optometrists, and chiropractors (limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist) authorized to practice, and performing within the scope of his/her practice, under state law; or licensed nurse practitioners, nurse-midwives, physician assistants, and clinical social workers authorized to practice and performing within the scope of their practice as defined under state law; or Christian Science practitioners listed with the First Church of Christ, Scientist, in Boston, Massachusetts; or any health care provider from whom the City or the City's group health plans' benefits managers will accept certification of the existence of a serious health condition to substantiate a claim for benefits; and a health care provider listed above who practices in a country other than the United States, who is authorized to practice in accordance with the law of that country, and who is performing within the scope of his/her practice as defined under such law.

Serious Health Condition

For purposes of the FMLA, "serious health condition" entitling an employee to FMLA leave means an illness, injury, impairment, or physical or mental condition that involves:

1) Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity (for purposes of this section, defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment there for, or recovery there from), or any subsequent treatment in connection with such inpatient care; or

2) Continuing treatment by a health care provider. A serious health condition involving continuing treatment by a health care provider includes any one or more of the following:

    a) a period of incapacity (i.e., inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment there for, or recovery there from) of more than three consecutive calendar days from work, school, or other regular daily activities, and which also involve: (1) two visits to a health care provider, which must occur within 30 days of the beginning of the period of incapacity unless extenuating circumstances exist preventing a follow-up visit from occurring as planned by the health care provider; or (2), one visit to a health care provider and a regimen of continuing treatment such as a prescription. In both cases, the first (or only) in-person treatment must occur within seven (7) days of the first day of incapacity.

    b) any period of incapacity due to pregnancy, or for prenatal care.

    c) continuing treatment by (or under the supervision of) a health care provider for a chronic or long-term health condition that is incurable or so serious that, if left un-treated, would likely result in a period of incapacity of more than 3 calendar days. For chronic conditions requiring periodic visits for treatment, such visits must take place at least twice a year.

    d) an injury or illness incurred by a service member (including a member of the National Guard or Reserves) in the line of duty on active duty in the Armed forces that may render the member medically unfit to perform the duties of the member's office, grade, rank, or rating.

COBRA

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), enacted April 7, 1986, most employers who sponsor group health insurance plans are required to offer covered employees and their dependents the chance to extend their health coverage for a specified period of time at group rates under certain circumstances when insurance coverage would otherwise end.

Records Maintenance

The following records must be maintained:

1. Basic payroll and identifying employee data, including name, address, and occupation; rate or basis of pay and terms of compensation; daily and weekly hours worked per pay period; additions to or deductions from wages; and total compensation paid.

2. Dates FMLA leave is taken by FMLA eligible employees (e.g., available from time records, requests for leave, etc., if so designated). Leave must be designated in records as FMLA leave; leave so designated may not include leave required under State law or an employer plan which is not also covered by FMLA.

3. If FMLA leave is taken by eligible employees in increments of less than one full day, the hours of FMLA leave must be recorded.

4. Copies of employee notices of leave furnished to the employer under FMLA, if in writing, and copies of all general and specific written notices given to employees as required under FMLA and the associated regulations. Copies may be maintained in employee personnel files.

5. Any documents (including written and electronic records) describing employee benefits or employer policies and practices regarding the taking of paid and unpaid leaves.

6. Premium payments of employee benefits.

7. Records of any dispute between the employer and an eligible employee regarding designation of leave as FMLA leave, including any written statement from the employer or employee of the reasons for the designation and for the disagreement.

For employees not covered by or exempt from the Fair Labor Standards Act (FLSA), the City need not keep a record of actual hours worked provided that:

1. Eligibility for FMLA leave is presumed for any employee who has been employed for at least 12 months; and

2. With respect to employees who take FMLA leave intermittently or on a reduced leave schedule, the employer and employee agree on the employee's normal schedule or average hours worked each week and reduce their agreement to a written record.

Records and documents relating to medical certifications, recertifications or medical histories of employees or family members, created for purposes of FMLA, shall be maintained as confi- dential medical records in separate files/records from the usual personnel files, except that:

1. Supervisors and managers may be informed regarding necessary restrictions on the work or duties of an employee and necessary accommodations;

2. First aid and safety personnel may be informed (when appropriate) if the employee's physical or medical condition might require emergency treatment; and

3. Government officials investigating compliance with FMLA shall be provided relevant information upon request.

City of Manchester FMLA Policy
Responsibilities and Procedures

Purpose

To outline Employee, Department Head and Human Resources Department responsibilities relative to the City's Family and Medical Leave Policy.

Procedures

FMLA Administrator/Human Resources Department Responsibilities

- Review employee requests for FMLA leave and provide Employees and Department Heads with a determination on employee's eligibility for FMLA leave and if the leave qualifies for FMLA status.
- Provide Department Heads and others with up-to-date information and guidance on FMLA issues and/or changes in the law.
- Provide appropriate FMLA forms, fact sheets and posters to Departments for posting and/or employee use.
- Advise employees of their rights and obligations under the law, as well as the consequences of failing to meet obligations
- Within five business days of an employee requesting leave, absent extenuating circumstances, provide notification to the employee of their eligibility for FMLA leave.
- When the FMLA Administrator has enough information to determine whether the leave is being taken for a FMLA-qualifying reason (for example, after receiving a certification), notify the employee whether the leave will be designated and will be counted as FMLA leave within five business days, absent extenuating circumstances.
- If the leave is not granted, advise the employee of the reasons why the leave request was not granted
- Ensure that appropriate medical certification, recertification and fitness-for-duty certification is provided by the employee within the specified time periods, as outlined in the City's Family and Medical Leave Policy
- Maintain records and documents relating to medical certifications, recertifications, or other medical information for employees or employees' family members in files separate from employee personnel files/records. These records will be treated as confidential, except as provided for in the City's Family and Medical Leave Policy and will be maintained for at least 3 years.

- Inform other City Departments and others with a need to know, that leave has been designated as FMLA leave.

- Assure health benefits continue through the leave period.

  Assure the appropriate designation of leave on payroll records

- Provide notice to the employee on FMLA leave of any opportunity to change health plans or benefits, when such an opportunity exists.

Employing Department Responsibilities

- At the time leave is requested by the employee, or if an employee is absent from work more than 3 days due to his/her illness or injury, the Department Head, Division Manager and/or immediate supervisor must notify the Human Resources Department immediately so that a determination can be made as to whether the employee is eligible for FMLA leave and whether the leave qualifies as FMLA leave.

- Post FMLA notices that can be readily seen by employees, and make FMLA information and forms available to employees (such as request and certification forms).

- Reinstate the employee to his/her previous job or to an equivalent position, with the same pay, benefits and duties (or substantially the same duties), upon the employee's return to work from FMLA leave.

- Properly record all hours taken as approved FMLA leave in the Payroll system, including intermittent and/or reduced schedule FMLA leave.

Employee Responsibility

- An employee is required to complete the City of Manchester FMLA Request Form and submit it to his/her Department Head at least 30 days in advance whenever the leave is foreseeable, including planned medical treatment for serious injury or illness of a covered service member unless not practical. In the case of unforeseen leave, the employee is required to complete the FMLA Request Form as soon as possible, usually within one or two days of becoming aware of the need for FMLA leave. In the event that the employee does not provide 30 days notice, the FMLA Administrator may ask the employee to explain the reasons why providing such notice was not practicable. Late notice may be grounds for denial of requested FMLA leave. When foreseeable leave is due to a qualifying exigency, notice must be provided as soon as practicable regardless of how far in advance leave was foreseeable.

- An employee is required to provide medical certification showing that he/she or a family member has a serious health condition that qualifies for FMLA leave. The medical certification must be provided to the Human Resources Department/FMLA Administrator within 15 days from the date of the request for leave, or in the case of an emergency, as soon as practicable after the 15 days. The employee must also provide periodic recertification as noted in this policy during the course of the employee's leave. If the request for the leave is as a result of the employee's serious health condition, the employee's class specification (job description) will be attached to the certification form when it is submitted to the employee's health care provider for completion.

- An employee on FMLA leave must report, to his/her Department Head (or designee) and/or the FMLA Administrator, every 30 days regarding his/her leave status and intention as to when the employee will be returning to work.

- Prior to the start of work, the employee must provide his/her Department Head (or designee) and/or the FMLA Administrator with a "Fitness for Duty" letter from his/her health care provider, stating he/she is able to return to work.

- If the employee normally pays a portion of the health care premium(s) the City requires that the employee continues to pay the premium(s). If an employee fails to pay the premium for more than 30 days after the date the premium is due, health care coverage will be discontinued.

- An employee must notify his/her Department Head (or designee) immediately if he/she does not intend to return to work.

- When requesting intermittent leave or a reduced schedule work week, consult with the Department Head (or designee) prior to the scheduling of treatment or leave in order to work out a schedule which best suits the needs of both the Department and the employee, subject to the approval of the health care provider. The FMLA Administrator will provide guidance and assistance as requested.

ATTACHMENT 1

CITY OF MANCHESTER

REQUEST FOR FAMILY AND MEDICAL LEAVE

Employee Name:_____ Department:_____

Regular Work Schedule (indicate the days and hours worked):_____

I request a family and medical leave under the provisions of the Family and Medical Leave Act (FMLA) and the City of Manchester's Family and Medical Leave Policy. My reason for the request is (please check below:)

_____ The birth of my child (Please check the reason for the requested leave). I understand the City will require medical certification from a health care provider.

_____ Mother's pregnancy, delivery and post-partum recuperation
_____ Mother's or Father's care for and bonding with newborn child

Mother's due date:_____(or child's date of birth)

_____ The placement of a child with me for adoption or foster care. I understand that I must provide a copy of the legal documents certifying this placement.

Child's date of placement:_____(or anticipated date)

_____ The need to care for my (circle one) SPOUSE, CHILD, PARENT, BLOOD RELATIVE/WARD (living in same household) who has a serious health condition as defined under the FMLA. I understand the City will require medical certification from a health care provider.

_____ My own serious health condition as defined under the FMLA. I understand the City will require medical certification from a health care provider.

_____ To care for an injured or ill covered service member as defined under the FMLA. I understand the City will require medical certification from a health care provider.

_____ Exigencies as defined under the FMLA pertaining to a covered family member's spouse, child or parent on covered active duty or called to covered active duty with the armed forces, in support of a contingency operation as either of the following:

_____ A member of a regular component of the Armed Forces, duty during the deployment of the member with the Armed Forces to a foreign country. I understand the City will require certification of a qualifying exigency.

_____ A member of a reserve component of the Armed Forces, duty during the deployment of the member with the Armed Forces to a foreign country under a call or order to active duty. I understand the City will require certification of a qualifying exigency.

I understand that FMLA leave is unpaid, unless the employer requires that paid time off be taken prior to unpaid leave, and that I am entitled to take up to 12 weeks of FMLA leave (26 weeks for military caregiver leave), on a continuous or intermittent basis, during a 12 month period beginning on the first day of FMLA leave.

I am requesting a continuous leave of _____days or _____weeks, commencing on or about _____ and ending on _____.

I am requesting intermittent leave of _____ hours per day and/or _____ days per week, commencing on or about _____ and ending on _____.

I further understand that the City of Manchester FMLA Policy requires that I use all paid time (Sick, Vacation, Personal) prior to any unpaid FMLA leave. When FMLA leave is taken for my own or a family member's serious health condition, accumulated paid time will normally be taken in the order of Sick* (including Sick Bank credits if applicable), then Vacation, then Personal (if applicable). When FMLA leave is taken for parental bonding with a newborn child, the placement of a child due to adoption or foster care, or a qualifying military exigency, accumulated paid time will be taken in the order of Vacation, then Personal (if applicable).

* The City of Manchester FMLA Policy, per City Ordinance, provides for the option of using accumulated Sick leave, upon approval of the Department Head, for absence due to the illness or injury of a spouse, child, or other blood relative or ward residing in the same household, or using other accumulated paid leave such as Vacation or Personal time. Please indicate below the type of accumulated paid leave you are requesting for FMLA leave to provide care for a family member (blood relative) residing in your household (subject to approval of Department Head):

_____ SICK

_____ VACATION/PERSONAL

In order to continue my health benefits coverage while I am on FMLA leave I understand that I must continue to make the appropriate employee contributions. Information concerning when and how to make the contributions will be sent upon approval of FMLA leave.

This Request Form will not be considered valid unless signed by employee and Department Head (or designee).

_____ _____

Employee Signature Date

_____ _____

Department Head (or designee) Signature Date

Certification of Health Care Provider for Employee's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

U.S. Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 2/28/2015

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

Employer name and contact: _____

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions: _____

_____

Check if job description is attached: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: _____
First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____)_____ Fax:(_____)_____

CONTINUED ON NEXT PAGE

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

   Mark below as applicable:
   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
   ___No ___Yes. If so, dates of admission:

   _____

   Date(s) you treated the patient for condition:

   _____

   Will the patient need to have treatment visits at least twice per year due to the condition? ___No ___ Yes.

   Was medication, other than over-the-counter medication, prescribed? ___No ___Yes.

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
   ____No ____Yes. If so, state the nature of such treatments and expected duration of treatment:

   _____

2. Is the medical condition pregnancy? ___No ___Yes. If so, expected delivery date: _____

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

   Is the employee unable to perform any of his/her job functions due to the condition: ____ No ____ Yes.

   If so, identify the job functions the employee is unable to perform:

   _____

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

   _____

   _____

   _____

   _____

   _____

   _____

   _____

CONTINUED ON NEXT PAGE

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___No ___Yes.

   If so, estimate the beginning and ending dates for the period of incapacity: _____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ___No ___Yes.

   If so, are the treatments or the reduced number of hours of work medically necessary? ___No ___Yes.

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   _____

   Estimate the part-time or reduced work schedule the employee needs, if any:

   _____ hour(s) per day; _____ days per week from _____ through _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ____No ____Yes.

   Is it medically necessary for the employee to be absent from work during the flare-ups? ____ No ____Yes. If so, explain:

   _____

   _____

   Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency : _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or ___ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

CONTINUED ON NEXT PAGE

Signature of Health Care Provider **Date**

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**

Certification of Health Care Provider for Family Member's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

U.S. Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 2/28/2015

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

Employer name and contact: _____

_____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your family member or his/her medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a covered family member with a serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Your name: _____
First Middle Last

Name of family member for whom you will provide care: _____
First Middle Last

Relationship of family member to you: _____

If family member is your son or daughter, date of birth: _____

Describe care you will provide to your family member and estimate leave needed to provide care:

_____

_____

_____

_____ _____
Employee Signature Date

CONTINUED ON NEXT PAGE

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the patient needs leave. Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____) _____ Fax:(_____) _____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
   ___No ___Yes. If so, dates of admission: _____

   Date(s) you treated the patient for condition: _____

   Was medication, other than over-the-counter medication, prescribed? ___No ___Yes.

   Will the patient need to have treatment visits at least twice per year due to the condition? ___No ____ Yes

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
   ____ No ____Yes. If so, state the nature of such treatments and expected duration of treatment:

   _____

   _____

2. Is the medical condition pregnancy? ___No ___Yes. If so, expected delivery date: _____

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

_____

_____

_____

_____

CONTINUED ON NEXT PAGE

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ___No ___Yes.

   Estimate the beginning and ending dates for the period of incapacity: _____

   During this time, will the patient need care? __ No __ Yes.

   Explain the care needed by the patient and why such care is medically necessary:

   _____

   _____

   _____

   _____

   _____

5. Will the patient require follow-up treatments, including any time for recovery? ___No ___Yes.

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   _____

   Explain the care needed by the patient, and why such care is medically necessary: _____

   _____

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? __ No __ Yes.

   Estimate the hours the patient needs care on an intermittent basis, if any:

   _____ hour(s) per day; _____ days per week from _____ through _____

   Explain the care needed by the patient, and why such care is medically necessary:

   _____

   _____

   _____

   _____

CONTINUED ON NEXT PAGE

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ____No ____Yes.

   Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

   Frequency: _____ times per _____ week(s) _____ month(s)

   Duration: _____ hours or ___ day(s) per episode

   Does the patient need care during these flare-ups? ____ No ____ Yes.

   Explain the care needed by the patient, and why such care is medically necessary: _____

_____

_____

_____

_____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Health Care Provider **Date**

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210.
DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.

Certification for Serious Injury or Illness of Covered Servicemember - - for Military Family Leave (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 2/28/2015

Notice to the EMPLOYER INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a serious injury or illness of a covered servicemember to submit a certification providing sufficient facts to support the request for leave. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. § 825.310. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees or employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

SECTION I: For Completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the Employee Is Requesting Leave INSTRUCTIONS to the EMPLOYEE or COVERED SERVICEMEMBER: Please complete Section I before having Section II completed. The FMLA permits an employer to require that an employee submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a serious injury or illness of a covered servicemember. If requested by the employer, your response is required to obtain or retain the benefit of FMLA-protected leave. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to do so may result in a denial of an employee's FMLA request. 29 C.F.R. § 825.310(f). The employer must give an employee at least 15 calendar days to return this form to the employer.

SECTION II: For Completion by a UNITED STATES DEPARTMENT OF DEFENSE ("DOD") HEALTH CARE PROVIDER or a HEALTH CARE PROVIDER who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed on Page 2 has requested leave under the FMLA to care for a family member who is a member of the Regular Armed Forces, the National Guard, or the Reserves who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list for a serious injury or illness. For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty that may render the servicemember medically unfit to perform the duties of his or her office, grade, rank, or rating.

A complete and sufficient certification to support a request for FMLA leave due to a covered servicemember's serious injury or illness includes written documentation confirming that the covered servicemember's injury or illness was incurred in the line of duty on active duty and that the covered servicemember is undergoing treatment for such injury or illness by a health care provider listed above. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave.

CONTINUED ON NEXT PAGE

Certification for Serious Injury or Illness of Covered Servicemember - - for Military Family Leave (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

U.S. Wage and Hour Division

SECTION I: For Completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the Employee Is Requesting Leave: (This section must be completed first before any of the below sections can be completed by a health care provider.)

Part A: EMPLOYEE INFORMATION

Name and Address of Employer (this is the employer of the employee requesting leave to care for covered servicemember):

_____

Name of Employee Requesting Leave to Care for Covered Servicemember:

_____
First Middle Last

Name of Covered Servicemember (for whom employee is requesting leave to care):

_____
First Middle Last

Relationship of Employee to Covered Servicemember Requesting Leave to Care:
☐ Spouse ☐ Parent ☐ Son ☐ Daughter ☐ Next of Kin

Part B: COVERED SERVICEMEMBER INFORMATION

(1) Is the Covered Servicemember a Current Member of the Regular Armed Forces, the National Guard or Reserves? ☐ Yes ☐ No

If yes, please provide the covered servicemember's military branch, rank and unit currently assigned to:

_____

Is the covered servicemember assigned to a military medical treatment facility as an outpatient or to a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients (such as a medical hold or warrior transition unit)? ☐ Yes ☐ No If yes, please provide the name of the medical treatment facility or unit:

_____

(2) Is the Covered Servicemember on the Temporary Disability Retired List (TDRL)? ☐ Yes ☐ No

Part C: CARE TO BE PROVIDED TO THE COVERED SERVICEMEMBER

Describe the Care to Be Provided to the Covered Servicemember and an Estimate of the Leave Needed to Provide the Care:

_____

SECTION II: For Completion by a United States Department of Defense ("DOD") Health Care Provider or a Health Care Provider who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider. If you are unable to make certain of the military-related determinations contained below in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator). (Please ensure that Section I above has been completed before completing this section.) Please be sure to sign the form on the last page.

Part A: HEALTH CARE PROVIDER INFORMATION

Health Care Provider's Name and Business Address:

_____

Type of Practice/Medical Specialty: _____

Please state whether you are either: (1) a DOD health care provider; (2) a VA health care provider; (3) a DOD TRICARE network authorized private health care provider; or (4) a DOD non-network TRICARE authorized private health care provider: _____

Telephone: ( ) _____ Fax: ( ) _____ Email: _____

PART B: MEDICAL STATUS

(1) Covered Servicemember's medical condition is classified as (Check One of the Appropriate Boxes):

☐ **(VSI) Very Seriously Ill/Injured** – Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

☐ **(SI) Seriously Ill/Injured** – Illness/injury is of such severity that there is cause for immediate concern, but there is no imminent danger to life. Family members are requested at bedside. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

☐ **OTHER Ill/Injured** – a serious injury or illness that may render the servicemember medically unfit to perform the duties of the member's office, grade, rank, or rating.

☐ **NONE OF THE ABOVE** (Note to Employee: If this box is checked, you may still be eligible to take leave to care for a covered family member with a "serious health condition" under § 825.113 of the FMLA. If such leave is requested, you may be required to complete DOL FORM WH-380 or an employer-provided form seeking the same information.)

(2) Was the condition for which the Covered Service member is being treated incurred in line of duty on active duty in the armed forces? ☐ Yes ☐ No

(3) Approximate date condition commenced: _____

(4) Probable duration of condition and/or need for care: _____

(5) Is the covered servicemember undergoing medical treatment, recuperation, or therapy? ☐ Yes ☐ No. If yes, please describe medical treatment, recuperation or therapy:

PART C: COVERED SERVICEMEMBER'S NEED FOR CARE BY FAMILY MEMBER

(1) Will the covered servicemember need care for a single continuous period of time, including any time for treatment and recovery? ☐ Yes ☐ No
If yes, estimate the beginning and ending dates for this period of time: _____

(2) Will the covered servicemember require periodic follow-up treatment appointments?
☐ Yes ☐ No If yes, estimate the treatment schedule: _____

(3) Is there a medical necessity for the covered servicemember to have periodic care for these follow-up treatment appointments? ☐ Yes ☐ No

(4) Is there a medical necessity for the covered servicemember to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)? ☐ Yes ☐ No If yes, please estimate the frequency and duration of the periodic care:

_____

_____

Signature of Health Care Provider: _____ **Date:** _____

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years, in accordance with 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution AV, NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE PATIENT.**

Certification of Qualifying Exigency For Military Family Leave (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 2/28/2015

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a qualifying exigency to submit a certification. Please complete Section I before giving this form to your employee. Your response is voluntary, and while you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. § 825.309.

Employer name: _____

Contact Information: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II fully and completely. The FMLA permits an employer to require that you submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a qualifying exigency. Several questions in this section seek a response as to the frequency or duration of the qualifying exigency. Be as specific as you can; terms such as "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Your response is required to obtain a benefit. 29 C.F.R. § 825.310. While you are not required to provide this information, failure to do so may result in a denial of your request for FMLA leave. Your employer must give you at least 15 calendar days to return this form to your employer.

Your Name: _____
First Middle Last

Name of covered military member on active duty or call to active duty status in support of a contingency operation:

_____
First Middle Last

Relationship of covered military member to you: _____

Period of covered military member's active duty: _____

A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes written documentation confirming a covered military member's active duty or call to active duty status in support of a contingency operation. Please check one of the following:

- ☐ A copy of the covered military member's active duty orders is attached.
- ☐ Other documentation from the military certifying that the covered military member is on active duty (or has been notified of an impending call to active duty) in support of a contingency operation is attached.
- ☐ I have previously provided my employer with sufficient written documentation confirming the covered military member's active duty or call to active duty status in support of a contingency operation.

CONTINUED ON NEXT PAGE

PART A: QUALIFYING REASON FOR LEAVE

1. Describe the reason you are requesting FMLA leave due to a qualifying exigency (including the specific reason you are requesting leave):

_____

_____

_____

_____

_____

_____

2. A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes any available written documentation which supports the need for leave; such documentation may include a copy of a meeting announcement for informational briefings sponsored by the military, a document confirming an appointment with a counselor or school official, or a copy of a bill for services for the handling of legal or financial affairs. Available written documentation supporting this request for leave is attached. ☐ Yes ☐ No ☐ None Available

PART B: AMOUNT OF LEAVE NEEDED

1. Approximate date exigency commenced: _____

   Probable duration of exigency: _____

2. Will you need to be absent from work for a single continuous period of time due to the qualifying exigency? ☐ No ☐ Yes.

   If so, estimate the beginning and ending dates for the period of absence:

   _____.

3. Will you need to be absent from work periodically to address this qualifying exigency? ☐ No ☐ Yes.

   Estimate schedule of leave, including the dates of any scheduled meetings or appointments:_____

   _____

   _____

   _____

   Estimate the frequency and duration of each appointment, meeting, or leave event, including any travel time (i.e., 1 deployment-related meeting every month lasting 4 hours):

   Frequency: _____ times per _____ week(s) _____ month(s)

   Duration: _____ hours ___ day(s) per event.

CONTINUED ON NEXT PAGE

PART C:

If leave is requested to meet with a third party (such as to arrange for childcare, to attend counseling, to attend meetings with school or childcare providers, to make financial or legal arrangements, to act as the covered military member's representative before a federal, state, or local agency for purposes of obtaining, arranging or appealing military service benefits, or to attend any event sponsored by the military or military service organizations), a complete and sufficient certification includes the name, address, and appropriate contact information of the individual or entity with whom you are meeting (i.e., either the telephone or fax number or email address of the individual or entity). This information may be used by your employer to verify that the information contained on this form is accurate.

Name of Individual: _____ Title: _____

Organization: _____

Address: _____

Telephone: (_____) _____ Fax: (_____) _____

Email: _____

Describe nature of meeting: _____

_____

_____

_____

_____

_____

_____

_____

_____

PART D:

I certify that the information I provided above is true and correct.

_____ _____

Signature of Employee Date

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution AV, NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE EMPLOYER.**

Notice of Eligibility and Rights & Responsibilities (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

U.S. Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 2/28/2015

In general, to be eligible an employee must have worked for an employer for at least 12 months, have worked at least 1,250 hours in the 12 months preceding the leave, and work at a site with at least 50 employees within 75 miles. While use of this form by employers is optional, a fully completed Form WH-381 provides employees with the information required by 29 C.F.R. § 825.300(b), which must be provided within five business days of the employee notifying the employer of the need for FMLA leave. Part B provides employees with information regarding their rights and responsibilities for taking FMLA leave, as required by 29 C.F.R. § 825.300(b), (c).

[Part A – NOTICE OF ELIGIBILITY]

TO: _____
Employee

FROM: _____
Employer Representative

DATE: _____

On _____, you informed us that you needed leave beginning on _____ for:

_____ The birth of a child, or placement of a child with you for adoption or foster care;

_____ Your own serious health condition;

_____ Because you are needed to care for your ____ spouse; _____child; _____ parent due to his/her serious health condition.

_____ Because of a qualifying exigency arising out of the fact that your ____ spouse: _____son or daughter; _____ parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves.

_____ Because you are the ____ spouse; _____son or daughter; _____ parent; _____ next of kin of a covered servicemember with a serious injury or illness.

This Notice is to inform you that you:

_____ Are eligible for FMLA leave (See Part B below for Rights and Responsibilities)

_____ Are **not** eligible for FMLA leave, because (only one reason need be checked, although you may not be eligible for other reasons):

_____ You have not met the FMLA's 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately ___ months towards this requirement.

_____ You have not met the FMLA's 1,250-hours-worked requirement.

_____ You do not work and/or report to a site with 50 or more employees within 75-miles.

If you have any questions, contact _____ or view the FMLA poster located in _____.

[PART B-RIGHTS AND RESPONSIBILITIES FOR TAKING FMLA LEAVE]

As explained in Part A, you meet the eligibility requirements for taking FMLA leave and still have FMLA leave available in the applicable 12-month period. **However, in order for us to determine whether your absence qualifies as FMLA leave, you must return the following information to us by** _____. (If a certification is requested, employers must allow at least 15 calendar days from receipt of this notice; additional time may be required in some circumstances.) If sufficient information is not provided in a timely manner, your leave may be denied.

____ Sufficient certification to support your request for FMLA leave. A certification form that sets forth the information necessary to support your request ____**is**/____ **is not** enclosed.

____ Sufficient documentation to establish the required relationship between you and your family member.

____ Other information needed: _____

_____

_____

____ No additional information requested

CONTINUED ON NEXT PAGE

If your leave does qualify as FMLA leave you will have the following **responsibilities** while on FMLA leave (only checked blanks apply):

____ Contact _____ at _____ to make arrangements to continue to make your share of the premium payments on your health insurance to maintain health benefits while you are on leave. You have a minimum 30-day (or, indicate longer period, if applicable) grace period in which to make premium payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse, or, at our option, we may pay your share of the premiums during FMLA leave, and recover these payments from you upon your return to work.

____ You will be required to use your available paid _____ **sick**, _____ **vacation**, and/or _____**other leave** during your FMLA absence. This means that you will receive your paid leave and the leave will also be considered protected FMLA le ave and counted against your FMLA leave entitlement.

____ Due to your status within the company, you are considered a "key employee" as defined in the FMLA. As a "key employee," restoration to employment may be denied following FMLA leave on the grounds that such restoration will cause substantial and grievous economic injury to us. We ___**have**/____ **have not** determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic harm to us.

____ While on leave you will be required to furnish us with periodic reports of your status and intent to return to work every _____. (Indicate interval of periodic reports, as appropriate for the particular leave situation).

If the circumstances of your leave change, and you are able to return to work earlier than the date indicated on the reverse side of this form, you will be required to notify us at least two workdays prior to the date you intend to report for work.

If your leave does qualify as FMLA leave you will have the following **rights** while on FMLA leave:

- You have a right under the FMLA for up to 12 weeks of unpaid leave in a 12-month period calculated as:

  _____ the calendar year (January – December).

  _____ a fixed leave year based on _____.

  _____ the 12-month period measured forward from the date of your first FMLA leave usage.

  _____ a "rolling" 12-month period measured backward from the date of any FMLA leave usage.

- You have a right under the FMLA for up to 26 weeks of unpaid leave in a single 12-month period to care for a covered servicemember with a serious injury or illness. This single 12-month period commenced on _____.
- Your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work.
- You must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA-protected leave. (If your leave extends beyond the end of your FMLA entitlement, you do not have return rights under FMLA.)
- If you do not return to work following FMLA leave for a reason other than: 1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; 2) the continuation, recurrence, or onset of a covered servicemember's serious injury or illness which would entitle you to FMLA leave; or 3) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave.
- If we have not informed you above that you must use accrued paid leave while taking your unpaid FMLA leave entitlement, you have the right to have ____ **sick,** ____**vacation,** and/or ___ **other leave** run concurrently with your unpaid leave entitlement, provided you meet any applicable requirements of the leave policy. Applicable conditions related to the substitution of paid leave are referenced or set forth below. If you do not meet the requirements for taking paid leave, you remain entitled to take unpaid FMLA leave.

  ____For a copy of conditions applicable to sick/vacation/other leave usage please refer to _____ available at: _____.

  ____Applicable conditions for use of paid leave:_____

  _____

  _____

  _____

  _____

Once we obtain the information from you as specified above, we will inform you, within 5 business days, whether your leave will be designated as FMLA leave and count towards your FMLA leave entitlement. If you have any questions, please do not hesitate to contact:

_____at _____.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

It is mandatory for employers to provide employees with notice of their eligibility for FMLA protection and their rights and responsibilities. 29 U.S.C. § 2617; 29 C.F.R. § 825.300(b), (c). It is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 10 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.**

ATTACHMENT 7

Designation Notice (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

U.S. Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 2/28/2015

Leave covered under the Family and Medical Leave Act (FMLA) must be designated as FMLA-protected and the employer must inform the employee of the amount of leave that will be counted against the employee's FMLA leave entitlement. In order to determine whether leave is covered under the FMLA, the employer may request that the leave be supported by a certification. If the certification is incomplete or insufficient, the employer must state in writing what additional information is necessary to make the certification complete and sufficient. While use of this form by employers is optional, a fully completed Form WH-382 provides an easy method of providing employees with the written information required by 29 C.F.R. §§ 825.300(c), 825.301, and 825.305(c).

To: _____

Date: _____

We have reviewed your request for leave under the FMLA and any supporting documentation that you have provided. We received your most recent information on _____ and decided:

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

The FMLA requires that you notify us as soon as practicable if dates of scheduled leave change or are extended, or were initially unknown. Based on the information you have provided to date, we are providing the following information about the amount of time that will be counted against your leave entitlement:

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

Please be advised (check if applicable):

_____ You have requested to use paid leave during your FMLA leave. Any paid leave taken for this reason will count against your FMLA leave entitlement.

_____ We are requiring you to substitute or use paid leave during your FMLA leave.

_____ You will be required to present a fitness-for-duty certificate to be restored to employment. If such certification is not timely received, your return to work may be delayed until certification is provided. A list of the essential functions of your position ___ **is** ___ **is not** attached. If attached, the fitness-for-duty certification must address your ability to perform these functions.

_____ **Additional information is needed to determine if your FMLA leave request can be approved:**

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

_____ Your FMLA Leave request is Not Approved.
_____ The FMLA does not apply to your leave request.
_____ You have exhausted your FMLA leave entitlement in the applicable 12-month period.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

It is mandatory for employers to inform employees in writing whether leave requested under the FMLA has been determined to be covered under the FMLA. 29 U.S.C. § 2617, 29 C.F.R. §§ 825.300(d), (e). It is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 10 – 30 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.**