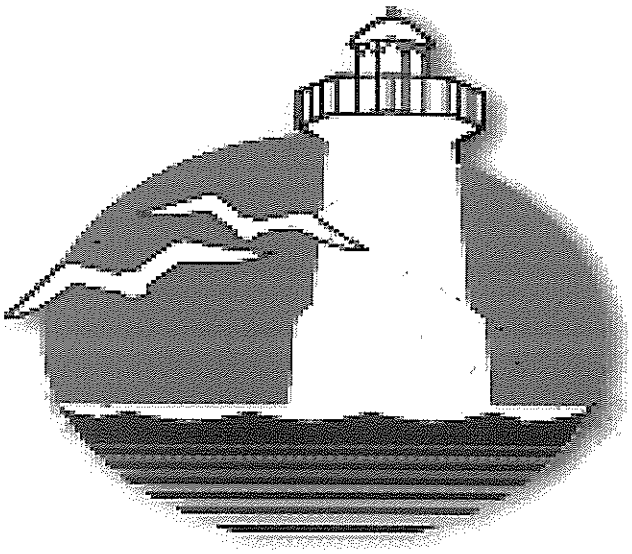
Fond du Lac County
Family and Medical Leave Policy



Effective August 1, 2009

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FOND DU LAC COUNTY

FAMILY AND MEDICAL LEAVE POLICY

PURPOSE

This policy sets forth family and medical leave provisions that comply with the Wisconsin and Federal Family and Medical Leave Acts (WFMLA) (FMLA). Should this policy conflict in any way with applicable State/Federal statutes or regulations, then the statutes or regulations will apply.

GENERAL LEAVE REQUIREMENTS

1. **Eligibility:** Employees who have been employed by Fond du Lac County for one (1) year and who have worked one thousand (1000) hours during the preceding fifty-two (52) weeks are eligible for leaves set forth in this policy.

2. **Family and Medical Leave Limits:** Employees are eligible for twelve (12) weeks of leave in a calendar year (defined as January thru December) for any one leave or combination of leaves for child rearing, family illness or employee illness. Should the leave qualify as a leave under both County policy and State and Federal leave provisions, the leave will run concurrently.

3. **Serious Health Conditions – Prerequisite for Family and Medical Leave**: Eligibility for family illness and employee medical leave is contingent upon the existence of a "serious health condition".

4. **Serious Medical Condition:** Under this policy, a "serious health condition" is considered to be a disabling physical or mental illness, injury, impairment or condition involving either:

   a. Inpatient care in a hospital, nursing home, hospice or residential medical facility, or

   b. Outpatient care that requires continuing treatment or supervision by a health care provider wherein the provider (after initial contact) directs and inspects continuously and at first-hand, the individual with the serious health condition.

   c. Period of incapacity due to pregnancy or for prenatal care.

   d. Chronic condition (i.e. asthma, diabetes, epilepsy) that requires periodic medical treatment; continues over an extended period of time and may cause episodes of incapacity.

e. Permanent/long-term condition that requires continuing supervision but not necessarily active treatment by a health care provider (i.e. Alzheimer's, severe stroke, terminal stages of a disease.)

f. Multiple treatments (i.e. chemotherapy, radiation, dialyses, physical therapy, restorative surgery after an accident or injury) by health care provider for condition which would likely result in incapacity for three (3) consecutive calendar days in absence of medical intervention.

Medical problems such as a common cold, flu, earaches, upset stomach, minor ulcers, non-migraine headaches and routine dental problems are not typically considered serious health conditions unless complications arise.

DOMESTIC PARTNER BENEFITS

1. **Rules:** The WFMLA requires employers with 50 or more employees to provide leave to eligible employees under the following circumstances:

   a. 2 weeks of unpaid leave to care for certain family members suffering from a "serious health condition";

   b. 2 weeks of unpaid leave for the employee's own serious health condition;

   c. 6 weeks of unpaid leave for the birth or adoption of a child.

2. **Definition of Family Member:** Family member now includes a domestic partner and the parents of the employee's domestic partner. However, the term "child" does not include the children of the employee's domestic partner. Thus, an employee may take WFMLA leave to care for his or her domestic partner or the parent but not to care for the child of a domestic partner. Even if the employee is jointly raising the child alongside the employee's own biological (or adopted) children, the employee cannot take WFMLA leave if he or she is not the legal parent of the child.

3. **Eligibility:** Employees can exercise the rights under the WFMLA as either a registered or unregistered domestic partner. Starting on August 3, 2009 partners can register as domestic partners with the Register of Deeds in their county of residence. Registered domestic partners must demonstrate or attest to the following:

   a. Each individual is at least 18 years old and capable of consenting to the domestic partnership;
   b. Neither individual is married or in a domestic partnership with another individual;
   c. The two individuals share a common residence;
   d. The two individuals are not nearer kin than second cousins; and

e. The individuals are of the same gender.

In order to exercise WFMLA rights as an individual in an unregistered domestic partnership, the employee must show that he or she (and his/her partner) satisfy the following criteria:

1. Each individual is at least 18 years old and otherwise competent to enter into a contract;
2. Neither individual is married or in a domestic partnership with another individual;
3. They share a common residence;
4. They are not related by blood in any way that would prohibit marriage under Wisconsin law;
5. They consider themselves to be members of each other's immediate family; and
6. They agree to be responsible for each other's basic living expenses.

While registered domestic partnership is reserved for individuals in a same-sex relationship, unregistered domestic partners can be in either a same sex or opposite sex relationship.

FAMILY LEAVE FOR BIRTH/ADOPTION/FOSTER CARE

1. **Rules:** Unpaid child rearing leave may be used within sixteen (16) weeks before or after (under WFMLA), or within twelve (12) months (under FMLA) following:

   a. The birth of the employee's natural child; or

   b. The placement of a child with the employee for adoption or as a precondition to adoption under Wisconsin Sec. 48.90(2), Stats.; or

   c. The placement of a child with the employee for 24-hour foster care that is made by agreement with a licensed child welfare agency or County Social Services agency.

2. **Length of Child Rearing Leave:** Child rearing leave is limited to twelve (12) weeks per calendar year under FMLA which is normally unpaid or six (6) weeks under WFMLA in which you have the right to substitute paid leave (see substitution below). Leave taken for the birth of a child is limited to twelve (12) weeks. Wherein the mother and father of a child are employed by the County, they are entitled to a combined total of twelve (12) weeks.

3. **Substitution:** An employee may choose to substitute up to **six (6) weeks accrued paid sick or other accrued leave for the first six (6) of the otherwise unpaid twelve (12) weeks leave period. After the first six (6) weeks, the employee may choose or may be required to use accrued vacation or holiday**

pay for all or part of the remaining leave period. Substitution of accrued sick leave for foster care placement is not permitted.

4. **Scheduling Child Rearing Leave:** Requests for child rearing leave must be submitted to their supervisor using Form ERD-10110 Family and Medical Leave Request (see page 10). The form must be submitted no less than fifteen (15) days prior to the start of the leave and must be scheduled after reasonable consideration of the needs of the County. If the birth, adoption or foster care placement requires that the leave begin sooner, the employee must give notice as soon as possible. The employee, in conjunction with the leave request, must indicate if and what type of paid accrued leave will be substituted during the leave period.

5. **Intermittent Leave:** Intermittent or partial absences may be permitted during the first six (6) weeks of the child rearing leave period provided that they do not unduly disrupt the County's operations and:

   a. The employee give the County a written schedule of the proposed intermittent or partial absences at least fifteen (15) days in advance;

   b. The proposed schedule is of sufficient definiteness so as to allow the County to schedule replacement employees, if necessary, to cover the absences.

FAMILY AND MEDICAL LEAVE (FML)

1. **Family Illness Leave:** Unpaid family illness leave may be used to care for an individual who has a "serious health condition" and is the employee's:

   - spouse
   - biological, adopted or foster child
   - child for which the employee stood "in loco parentis"
   - biological parent or parent who stood "in loco parentis" to employee
   - spouse's parent

   a. Family illness leave is limited to twelve (12) weeks per calendar year except in instances involving the "serious health condition" of the spouse's parent. In such case, the leave is limited to a maximum of two (2) weeks.

   b. An employee may substitute up to two (2) weeks accrued sick leave or other accrued leave for the first two (2) weeks of the otherwise unpaid leave. Use of accrued vacation or personal holiday time may be required for the remaining portion of the leave period.

c. An employee must consider the needs of the County when scheduling family illness leave.

2. **Employee Medical Leave:** Unpaid medical leave may be used by an employee who has a "serious health condition" which makes him/her unable to perform his/her job duties.

a. Employee medical leave is limited to twelve (12) weeks per calendar year.

b. An employee may substitute accrued sick leave or other accrued leave for part or all of the otherwise unpaid leave. After the first two (2) weeks, the employee will be required to use accrued sick leave, vacation, personal holiday for the remainder of the leave period.

c Employee medical leaves shall be scheduled in accordance with medical necessity.

d. No blanket-Family/Medical Leave will be issued for employees with chronic conditions. Employees will be required to submitted a request for FML for each illness and state at the time they call-in that this absence is an FML event. Employees with chronic conditions will be required to provide updated medication verification every 6 months.

3. **Scheduling Family and Medical Leave:** If an employee intends to take family and medical leave for planned medical treatment or supervision, the employee must:

a. Submit a Family and Medical Request Form ERD-10110 to their supervisor at least fifteen (15) day advance written notice of the intent to take such leave, the reason for such leave and the planned dates of the leave. (This fifteen (15) day requirement may be waived if the need for the leave is the result of an emergency.)

b. Indicate if and what type of paid accrued leave is to be substituted (if applicable).

c. Provide the County with a proposed schedule for the leave with reasonable promptness after learning of the probable necessity of the leave. Such schedule (for planned medical treatment or supervision) must not unduly disrupt the County's operations and must be sufficiently definite so as to allow the County to schedule a replacement employee, if necessary.

d. Provide the required medical certification using the appropriate form-Form WH-380-F for Serious Health Condition of a Family Member or

Form-380-E for the Employee's Serious Health Condition (forms included on pages 15-18).

Family and medical leave may be taken on an intermittent or partial leave basis if it is medically necessary to do so and provided that it does not unduly disrupt the County's operations. Such requests are subject to the approval of the County and the employee must provide the County with a proposed schedule of the partial absences. Absences must be in increments of no less than one-half (1/2) of a day.

4. **Medical Certification:** Requests for family and medical leave must be accompanied by a properly completed Medical Certification Form (Form WH-380-F for Serious Health Condition of a Family Member or Form-380-E for the Employee's Serious Health Condition). This form must be completed by the employee and the health care provider treating the family member (family illness leave) or employee (employee medical leave). The County may request a second health care provider opinion at the County's expense. Approval for family and medical leave will not be granted without a properly completed medical certification form.

MILITARY FAMILY LEAVE

Unpaid Military Leave is available for the following reasons: for an employee's own serious health condition; to care for a parent, son or daughter, or spouse with a serious health condition; or for birth, adoption, or foster care placement; or for a qualifying exigency related to active military duty. In no event will an employee be entitled to more Federal and/or State family or medical leave than the maximum number of weeks provided for in one calendar year by Federal or State FMLA statutes. The weeks of Federal and State FMLA leave will be considered concurrent. Employees may combine leaves for different purposes (i.e., six weeks of family leave for the birth of a child and two weeks of family leave to care for a seriously ill child) if circumstances qualify. Current State law provides for six (6) weeks of family leave related to birth, adoption, or foster care placement; two (2) weeks of family leave to care for an employee's parent, son or daughter, or spouse who has a serious health condition; and two (2) weeks of medical leave for an employee's own serious health condition. Note, however, that current Federal law provides for a total of twelve weeks of FMLA leave for any and all of these reasons, and 26 weeks to care for a family member with a serious health condition related to military service.

An unpaid County-provided Medical Leave of Absence may be available to an employee who has exhausted his or her vacation, and/or compensatory time, and/or sick leave benefit, and who is unable to return to work due to illness or injury. The County-provided medical leave of absence, generally up to six (6) months in duration.

An unpaid County-provided General Leave of Absence may be available to an employee who makes a written request for same. The County-provided general leave of absence, generally up to six (6) months in duration.

1. **Eligibility:**

a. County provided Medical Leave of Absence and General Leave of Absence is available to an employee who meets the requirements of this policy or by labor agreement.

b. An employee is eligible for Federal and State Family and Medical Leave of Absence if the leave is for a reason listed in below:

1. Has a serious health condition which makes the employee unable to perform his or her job duties, or

2. Is needed to care for a parent, son or daughter, or spouse who has a serious health condition, or

3. Desires to take leave due to:

a) The birth of their child, and to care for the newborn child, or
b) Due to the placement with the employee of a child for adoption (or as a pre-condition to adoption, but not both) or foster care, and to care for the newly placed child, or

4. Employee is needed to care for a spouse, parent, son or daughter, or next of kin who is 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"(see form WF-385 Certification for Serious Injury or Illness of Covered Service member) (H.R. 4986, National Defense Authorization Act for FY 2008), or

5. Employee is needed for "any qualifying exigency (as the Secretary [of Labor] shall, by regulation, determine) arising out of the fact that the spouse, or a son, daughter, or parent of the employee is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation" (see Form WH-384 Certification of Qualify Exigency).

INSURANCE, ACCRUAL OF BENEFITS AND RETURNS FROM LEAVE

1. **Group Health Insurance:** Continuance of group health insurance benefits and County contribution toward the cost of providing coverage is maintained while an employee is on family and medical leave. In such instance, the employee is required to pay his/her normal portion of the premium in accordance with prescribed procedures.

Provision of this benefit will cease if:

a. The employee on leave informs the County that he/she will not be returning to work at the end of the leave period; or

b. The employee decides to terminate employment upon conclusion of the leave.

Under (a) and (b) above, the employee will be required to repay the total amount of health insurance premium contribution made by the County on his/her behalf during the period of unpaid leave. This repayment obligation will not apply wherein the employee:

c. Terminates employment after having returned to work for thirty (30) or more calendar days; or

d. Is unable to return to work due to continuation or recurrence of his/her serious health condition (medical certification may be required), or other circumstances beyond the control of the employee.

2. **Accrual of Benefits:** Accrual of benefits continues for any period of the leave during which paid leave is substituted.

3. **Returns from Leave:** The following conditions apply when an employee returns to work from a leave. An employee:

a. Employee's returning from employee medical leave is required to obtain medical certification ("fitness for duty" certificate) from the health care provider that he/she is able to resume work with or without restrictions.

b. Returning from leave as provided under this policy can return to his/her prior position if vacant at the time the employee returns to work. In the event the position is not vacant, the employee will be offered an equivalent position with equivalent benefits, pay, and other terms and conditions of employment.

c. Requesting to return to work prior to the scheduled end of the leave will be returned to his/her previous position or an equivalent position within a reasonable time after the request to return to work is made.

State of Wisconsin
Department of Workforce Development
Equal Rights Division
Civil Rights Bureau

Family and Medical Leave Request

Personal information you provide may be used for secondary purposes. [See Section15.04 (1)(m), Wisconsin Statutes for details.]

Employee Name		
Reason and Amount of Leave Requested		
☐ Birth, adoption or as a pre-condition to adoption of employee's child for:		
Number of Weeks	Number of Days	Number of Hours
☐ Serious illnesses of employee's child, spouse or parent		
Number of Weeks	Number of Days	Number of Hours
☐ For my own serious illness:		
Number of Weeks	Number of Days	Number of Hours
Date leave will begin		
Date employee will return		

Notes:

1. If you are unable to return on the date noted, you must notify the employer prior to that date.
2. If your leave schedule is not yet known or other arrangements are necessary, please explain on the reverse side what must be done before your schedule can be confirmed.
3. If you are requesting intermittent leave, please attach a schedule. Leave may be taken in the smallest increment allowed by the employer for any other type of leave.

Employee's Signature
Date Signed

(This suggested form may be reproduced by employers)

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

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division

OMB Control Number: 1215-0181
Expires: 12/31/2011

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:(_____) _____

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):

   _____

   _____

   _____

   _____

   _____

   _____

   _____

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.

_____

_____

_____

_____

_____

_____

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
Employment Standards Administration
Wage and Hour Division

OMB Control Number: 1215-0181
Expires: 12/31/2011

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):

_____

_____

_____

_____

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:

   _____

   _____

   _____

   _____

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
Employment Standards Administration
Wage and Hour Division

OMB Control Number: 1215-0181
Expires: 12/31/2011

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.

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

U.S. Department of Labor
Employment Standards Administration
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
Employment Standards Administration
Wage and Hour Division

OMB Control Number: 1215-0181
Expires: 12/31/2011

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.

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.**

EMPLOYEE RIGHTS AND RESPONSIBILITIES
UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement
FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements
Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections
During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements
Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition
A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave
An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave
Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities
Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities
Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers
FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement
An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.