LEAVE OF ABSENCE REQUEST

I, the undersigned employee, hereby request a leave of absence for the following reasons:

☐ Medical ☐ Surgical ☐ Personal ☐ Family ☐ Military ☐ Educational

☐ Other – Please explain _____

Should this leave of absence be granted, my last day worked will be ____/____/____ and I will return to work on ____/____/____.

I fully understand that this leave of absence may be extended by my written request within three (3) business days in advance of the expiration of this leave of absence. I also understand that said extension of leave of absence shall not be binding upon the agency until they have approved said extension and provided me a copy of same.

It is with clear knowledge that should I fail to return to work on the date specified above or on a subsequent extension date, I will be considered by the agency as having voluntarily resigned by job.

All statements above are fully understood.

_____ _____

Employee Signature Date

FOR OFFICE USE ONLY

☐ Leave of Absence **not** approved
☐ Non-paid/non-benefit Leave of Absence **approved**
☐ Paid Leave of Absence **approved**. Does not apply to Family Medical Leave Act.
☐ Leave of Absence approved – Applies to Family Medical Leave Act (12 weeks job protected leave). Use of accrued paid time and/or Short Term Disability Benefits apply.
☐ Non Paid Leave of Absence approved-Applies to Family Medical Leave Act (12 weeks job protected leave)

Comments:_____

_____

_____

_____ _____

Supervisor Signature Date

_____ _____

Administration Signature Date

cc: Employee Personnel File

For Administrative Use Only

____/____/____ 1st date of FMLA Leave ____/____/____ Roll forward date (12 months)

_____ # of Weeks taken this Leave

Family or Medical Leave Request and Response

PLEASE PRINT

This form contains medical-related information and must be maintained in files separate from employee personnel files, in locked cabinets with only designated persons having access.

To be Completed by Employee

Name _____ Title _____

Department _____ Employee Payroll # _____ Date ____/____/____

I am requesting ☐ Family/Medical leave due to
☐ Intermittent (partial day) Family/Medical leave due to

- ☐ the birth of my child or the placement of my adopted or foster child in my home.
- ☐ a serious health condition that I need care for.
- ☐ a serious health condition affecting my ☐ spouse ☐ child ☐ parent, for which I am needed to provide care.
- ☐ other _____

Leave to begin ____/____/____ until ____/____/____.
DATE DATE

Number of days of FMLA leave I have taken in the past 12 months _____

Under the Family and Medical Leave Act, if you have worked at least one year and at least 1,250 hours in the past 12 months, you are eligible for up to 12 weeks unpaid leave under specific circumstances. You are entitled to receive health benefits as if you were still working. When returning to work, you must be reinstated to the same or an equivalent job with the same pay, benefits and terms and conditions of employment. If you do not return to work following FMLA leave (for a reason other than the continuation, recurrence or onset of a serious health condition which would entitle you to FMLA leave or 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.

To be Completed by Employer

(check appropriate boxes; explain where indicated)

This is to inform you that:

1. ☐ You are eligible for leave under FMLA.
   ☐ You are not eligible for leave under FMLA for the following reason(s): _____

2. The requested leave ☐ will ☐ will not be counted against your annual FMLA leave entitlement.

3. ☐ You will not be required to furnish medical certification.
   ☐ You will be required to furnish medical certification of a serious health condition by ____/____/____ (at least 15 days after you are notified of this requirement) or, if the leave is not foreseeable, as soon as reasonably possible under the particular facts and circumstances. We may delay the start of your leave until certification is submitted. If certification is not provided, leave may be denied.

4. You may choose to substitute accrued paid leave for unpaid FMLA leave or we may require substitution of paid leave.

   ☐ We will not require substitution of paid leave.
   ☐ We will require that you substitute accrued paid leave for unpaid FMLA leave according to these terms: _____

5. If you normally pay a portion of the premiums for your health insurance, we have the option of paying your share of the premiums during your leave, and recovering those payments from you when you return to work.
   - ☐ We will pay your share of health insurance premiums and recover those payments from you when you return to work.
   - ☐ We will not pay your share of health insurance premiums. We have discussed this with you and agree that you will make payments according to these dates and terms: _____

   _____

   _____

   You have a minimum 30-day grace period in which to make payment. If applicable, we will extend your grace period to _____ days. If payment is more than 30 days late, your group health insurance may be canceled, provided we notify you in writing at least 15 days before the date your health coverage will lapse.

6. Regarding payment of premiums for other benefits such as life insurance, disability insurance, etc.
   - ☐ We will pay your share of premiums while you are on leave. You are not expected to reimburse us.
   - ☐ We will pay your share of premiums for other benefits and recover those payments from you when you return to work.
   - ☐ We will not pay your share of premiums for other benefits. We have discussed this with you and agree that you will make payments according to these dates and terms: _____

   _____

   _____

7. ☐ Pursuant to our uniformly applied policy, you will be required to present a fitness-for-duty certificate before returning to work. Your return may be delayed until certification is provided. The certification need only be a simple statement of your ability to return to work, and should apply only to the condition for which you took leave (not applicable to intermittent leave).
   - ☐ Pursuant to our uniformly applied policy, you will not be required to present a fitness-for-duty certificate.

8. ☐ You are not considered a "key employee" as described* in FMLA regulations §825.17 and §825.218.
   - ☐ You are considered a "key employee" as described* in FMLA regulations §825.17 and §825.218.

   Therefore:
   - ☐ If it is determined that the reinstatement of your position and benefits upon completion of Family or Medical leave may be denied on the grounds that such reinstatement would cause substantial and grievous injury to us, we will furnish written notice of such, as determined by §825.219 of the FMLA regulations.
   - ☐ We have determined that restoration of your employment would not cause substantial and grievous injury to us.

9. ☐ You will be required
   - ☐ You will not be required

   to provide reports of your status and intent to return to work every _____ days while on FMLA Leave. If the circumstances of your leave change, enabling you to return to work earlier than the date specified in the first section of this form, you ☐ will ☐ will not be required to notify us at least two working days before you intend to return to work.

10. ☐ You will be required (explanation below)
    - ☐ You will not be required

    to furnish us with recertification for a serious health condition every 30 days.

    _____

    _____

Signature _____ Title _____ Date ____/____/____

* A salaried FMLA-eligible employee who is among the highest paid ten percent of all the employees employed by the employer within 75 miles of the employee's worksite.

Physician Certification for Family or Medical Leave

PLEASE PRINT

This form contains medical-related information and must be maintained in files separate from employee personnel files, in locked cabinets with only designated persons having access.

To be Completed by Employee

Name_____ Title_____

Department _____ Employee Payroll # _____

Status: ☐ Full-Time ☐ Part-Time ☐ Temporary Date ____/____/____

I am requesting family or medical leave from work with_____
NAME OF EMPLOYER

The physician or health care provider is treating _____
NAME OF PATIENT

The Patient is: ☐ Self ☐ Spouse ☐ Parent ☐ Child

☐ I am requesting leave from ____/____/____ until ____/____/____ or an intermittent or reduced schedule on the following dates:_____

_____

☐ (If applicable) I will be providing the following care/services for a family member with a serious health condition on the following dates:

_____

_____

_____

☐ (If applicable) The essential functions of my job are (or attach job description).

_____

_____

_____

_____

The remainder of this form is to be completed by an authorized health care provider in order to verify the necessity of Family or Medical Leave as requested by the above employee. Under the Family and Medical Leave law, an authorized health care provider is:

- any health care provider recognized by the employer or the employer's group health plan
- a doctor of medicine or osteopathy authorized to practice medicine or surgery by the state in which he or she practices
- podiatrists, dentists, clinical psychologists, optometrists and chiropractors (limited to manual manipulation of the spine to correct a subluxation found by X-ray to exist) authorized to practice, and performing within the scope of their practice, under state law
- nurse practitioners, nurse-midwives 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, MA.

The information sought on this form relates only to the condition for which the employee is taking FMLA leave.

Please read the six definitions beginning on page three before completing this form.
After receiving this completed form, the employer is not permitted to contact the health care provider for additional information. A health care provider representing the employer may contact the health care provider for clarification of information contained on this form.

To be Completed by Physician or Authorized Health Care Provider

1. Pages three and four describe what is meant by a "serious health condition" under the Family and Medical Leave Act. Does the patient's condition qualify under any of the categories described? If so, please check the applicable category.
   ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 or ☐ None of the above

2. Describe the medical facts which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories: _____

   _____

   _____

3. a. State the approximate date the condition commenced and the probable duration of the condition (and the probable duration of patient's incapacity, if different): _____

   _____

   _____

   b. Will it be necessary for the employee to work only intermittently or to work on a less than full schedule as a result of the condition (including for treatment described in item #4)? ☐ Yes ☐ No
   If yes, give probable duration: _____

   c. If the condition is a chronic condition (Category #4) or pregnancy, state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity (see page 3): _____

   _____

4. a. If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments: _____

   b. If any of these treatments are going to be provided by another provider of health services (e.g., physical therapist), please state the nature of treatments: _____

   _____

   c. If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment): _____

   _____

   _____

5. a. If medical leave is required for the employee's absence from work because of the employee's own condition (including absences due to pregnancy or a chronic condition), is the employee unable to perform work of any kind? ☐ Yes ☐ No

   b. If able to perform some work, is the employee unable to perform any one or more of the essential functions of the employee's job? (The employee or the employer should supply you with information about the essential job functions.) ☐ Yes ☐ No
   If yes, please list the essential functions the employee is unable to perform: _____

   _____

   _____

   c. If neither a. nor b. applies, is it necessary for the employee to be absent from work for treatment? ☐ Yes ☐ No

6. a. If a leave is required to care for a family member of the employee with a serious health condition, does the patient require assistance with medical, personal, safety, or transportation needs? ☐ Yes ☐ No

   b. If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery? ☐ Yes ☐ No

   c. If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need:

_____

_____ / / _____

Physician or Authorized Health Care Provider Signature Date Type of Practice

_____

Physician or Authorized Health Care Provider Printed Name

Office Mailing Address _____

_____

_____ Phone #( )

FMLA: What is a "Serious Health Condition"?

A "Serious Health Condition" means an illness, injury, impairment, or physical or mental condition that involves the following:

1. **Hospital Care**
   Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care. **Incapacity, for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom.**

2. **Absence Plus Treatment**
   Treatment includes examinations to determine if a serious health condition exists and evaluation of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations. A period of incapacity of more than three consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:
   a. Treatment two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or
   b. Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider. A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications, such as aspirin, antihistamines or salves; or bedrest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

3. **Pregnancy**
   Any period of incapacity due to pregnancy or for prenatal care.

4. **Chronic Conditions Requiring Treatments**
   A chronic condition which:
   a. Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;

b. Continues over an extended period of time (including recurring episodes of a single underlying condition); and
c. May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.) but, does not necessarily require a visit to a physician at the time of occurrence. For example, a patient with asthma who has been advised to stay home when pollen count is high or a pregnant woman with morning sickness.

5. **Permanent/Long-Term Conditions Requiring Supervision**
A period of incapacity which is permanent or long term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, a severe stroke or the terminal stages of a disease.

6. **Multiple Treatments (Non-Chronic Conditions)**
Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy) and kidney disease (dialysis).

FMLA FACTS

What is FMLA?

The Family and Medical Leave Act became effective August 5, 1993. Final revisions were published in the January 6, 1995 Federal Register. The purpose of the Act is to help balance the demands of the workplace with the needs of families by allowing eligible employees to take up to 12 weeks of unpaid, job-protected leave for specific family emergencies such as serious illness or the birth of a child.

What does the FMLA law cover?

The law spells out what employers are covered, which employees are eligible and entitled to leave, maintenance of health benefits during leave and job restoration after leave. It also covers notice of leave and certification of need, protection of employees who request leave, and employers' record keeping requirements.

The United States Department of Labor Employment Standards Administration, Wage and Hour Division administers and enforces the law, including the investigation of complaints. The law prohibits a covered employer from interfering with, restraining, or denying any right provided by FMLA. It also prohibits an employer from discharging or discriminating against any individual for opposing any practice, or because of involvement in any proceeding, related to FMLA.

If violations cannot be satisfactorily resolved, the U.S. Dept. of Labor may bring action in court to compel compliance. An eligible employee may also bring a private civil action against an employer for violations.

The FMLA does not affect any other federal or state law which prohibits discrimination, nor supersede any state or local law which provides greater family or medical leave protection. It does not affect an employer's obligation to provide greater leave rights under a collective bargaining agreement or employment benefit plan.

What employers are covered?

Employers who have 50 or more employees working 20 or more workweeks in the current or preceding calendar year and who are engaged in commerce (or an activity affecting commerce). Also public agencies, including governmental agencies and schools. Special rules apply to schools. Generally, they provide for FMLA leave to be taken in blocks of time when intermittent leave is needed or the leave is required near the end of the school term.

How am I eligible for FMLA benefits?

To be eligible, you must:

- work for a covered employer for at least 12 months,
- have worked at least 1,250 hours during the past 12 months, and
- work at a location where at least 50 employees of your employer are working within 75 miles.

When am I entitled to FMLA leave?

A covered employer must grant an eligible employee up to a total of 12 workweeks of unpaid leave during any 12-month period. The employer can choose to use a 12-month fiscal or fixed "leave year," or the calendar year, or the 12 months before or after the start of a leave to define the 12-month period. Eligible employees are entitled to leave for the following reasons:

- For the birth and care of a newborn child of the employee;
- For the placement of a son or daughter with the employee for adoption or foster care;
- To care for a spouse, parent or child with a serious health condition; or
- When the employee is unable to work because of a serious health condition.

Spouses who work for the same employer are jointly entitled to a combined total of 12 weeks when leave is taken for reasons other than his or her own serious health condition.

Leave for birth or placement of a child must be taken within one year of birth or placement.

What does "serious health condition" mean?

A "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves either

a) any period of incapacity or treatment connected with inpatient care (i.e., an overnight stay) in a hospital, hospice or residential medical-care facility, and any additional treatment in connection with that inpatient care, or

b) continuing treatment by a health care provider which includes any period of incapacity (i.e., inability to work, attend school or perform other regular daily activities) due to:

- A health condition (including treatment or recovery) lasting more than three consecutive days and any later treatment or incapacity (absence from work) relating to the same condition that also includes treatment two or more times by a health care provider or treatment one time by a health care provider with a continuing regimen of treatment.

- Pregnancy or prenatal care. A visit to the health care provider is not necessary for each absence.
- A chronic serious health condition which continues over time, requires periodic visits to a health care provider, and may involve occasional absences from work (for example, asthma or diabetes). A visit to the health care provider is not necessary for each absence.
- A permanent or long-term condition for which treatment may not be effective (for example, a severe stroke or cancer). Only supervision by a health care provider is required, rather than active treatment. Or,
- Any absences to receive treatments for restorative surgery or for a condition which would likely result in a period of incapacity if not treated (for example, chemotherapy or radiation treatments for cancer).

What is intermittent leave?

Intermittent leave means taking leave in blocks of time rather than a continuous leave. It also means reducing a normal daily or weekly work schedule. The employer can choose whether to grant intermittent leave for birth or placement. It can be taken whenever medically necessary for a serious health condition.

When leave is needed for planned medical treatment, the employee must try to schedule treatment so as not to unduly disrupt the employer's workplace.

What is a "health care provider"?

The term for FMLA purposes includes doctors of medicine or osteopathy authorized to practice medicine or surgery by the state in which they practice. Also podiatrists, dentists, clinical psychologists, optometrists and chiropractors (limited to manual manipulation of the spine to correct a subluxation found by X-ray to exist) authorized to practice, and performing within the scope of their practice, under state law. Also nurse practitioners, nurse-midwives 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, MA.

Will my health benefits continue while I'm on leave?

The employer is required to maintain group health insurance coverage whenever such insurance was provided before the leave, and on the same terms as if the employee were still working. If applicable, your employer will make arrangements with you for payment of your share of health insurance premiums during leave. In some cases, the employer may recover premiums paid for an employee who fails to return to work from FMLA leave.

Will I be able to return to my same job when I return from leave?

Generally, an employee must be restored to his or her original job, or to an equivalent job with equivalent pay, benefits and other terms and conditions of employment.

In addition, taking of FMLA leave cannot result in the loss of benefits that the employee earned or was entitled to before using FMLA leave, and the leave cannot be counted against the employee under a "no fault" attendance policy.

Under specified and limited circumstances where restoration to employment will cause substantial and grievous economic injury to its operations, an employer may refuse to reinstate certain highly-paid "key" employees after using FMLA leave (during which health coverage was maintained). A "key" employee is a salaried, eligible employee who is among the highest paid 10% of employees within 75 miles of the work site.

In order to refuse reinstatement, an employer must notify the employee of his or her status as a key employee in response to the employee's notice of intent to take FMLA leave, notify the employee as soon as the decision is made to deny job restoration and explain the reasons for the decision, then offer the employee a reasonable opportunity to return to work. Also, the employer must make a final determination as to whether reinstatement will be denied at the end of the leave, if the employee then requests restoration.

What type of notice or certification is necessary?

Employees seeking FMLA leave are required to provide 30-day advance notice when the need is foreseeable and such notice is practicable. Employers may also require employees to provide:

- Medical certification of the need for leave due to a serious health condition (employee's or family member's).
- Second or third medical opinions (at the employer's expense) and periodic recertification.
- Periodic reports during FMLA leave regarding the employee's status and intent to return to work.

Employers must also inform employees of their rights and responsibilities under FMLA, including specific written information on what is required of the employee and what might happen in certain circumstances, such as if the employee does not return to work after FMLA leave.

What if I need more information?

Contact your company's human resources representative if you have any questions, or if you would like to request leave under FMLA.