Medical Leave (FMLA & Non-FMLA) Procedures for Business Managers

For scheduled medical or family leaves of absences, plan to meet with the employee prior to the beginning of the leave. For maternity leaves of absences it is suggested that the meeting be approximately one month before the due date. For unexpected leaves of absence due to the illness or injury of the employee when no prior meeting is possible, simply mail or email the employee the necessary paperwork. Please be sure to forward a copy to the attention of the Chancery Human Resources Department.

In order to qualify for protected leave under the Family Medical Leave Act (FMLA), an employee must meet the following requirements:

- Employee must have been employed by any Archdiocese of Atlanta entity for at least 12 months prior to the start of the leave; and
- Employee must have worked at least 1,250 hours during the 12 month period prior to the start of the leave.

Every employee who takes an FMLA leave of absence should receive the following information (samples of each document are attached):

1. A Leave of Absence Application Form. This form must be completed and signed by the employee. The employee's immediate supervisor must also sign. A copy should be forwarded to the attention of the Human Resources Manager of the Chancery Human Resources Office.
2. A Certification of Health Care Provider for an Employee's Serious Health Condition Form (Form WH-380-E), which must be completed and signed by the physician and returned no later than **15** calendar days from the date received. The employee will be denied leave for failure to return form. If form is not returned (or returned incomplete) prior to leave, employee will be placed on unpaid status. You should contact the Human Resources Manager for further guidance.
3. For leaves of absence due to the serious health condition of a child, parent, or spouse, Certification of Health Care Provider for Family Member's Serious Health Condition Form (Form WH-380-F) must be completed and received by the Chancery Human Resources Office no later than 15 days of the leave request.
4. Recertification may be required no more frequently than every 30 days only when circumstances have changed significantly, or if the Archdiocese receives information which conflicts with the original documentation provided for the initial leave request. For intermittent leaves of absence, the Archdiocese may require recertification every six (6) months.
5. A copy of the completed Medical Certification Form should be forwarded to the Human Resources Manager. A letter should follow upon receipt of the completed form as a notification of approval (or denial). A copy of a sample letter may be requested from Human Resources.
6. The employee should be provided a copy of the Summary of Employee Rights under FMLA

Benefits during Leave:

1. While an employee is on leave under FMLA, the employee's benefits coverage should continue during the leave period at the same level and under the same conditions as if the employee had not taken a leave of absence.
2. While on paid leave under FMLA, the Archdiocese will continue to make payroll deductions to collect the employee's share of the premiums (including Life and Retirement payments). While on unpaid leave, the employee must continue to make this payment. Employee will receive an invoice from the Chancery Benefits Department during this period. Payments must be made in order to prevent loss of coverage.

The FMLA provides for 12 weeks of protected leave of absence per (rolling) year for an eligible employee. Leave is a combination of paid and unpaid leave. Following is a summary of the procedure for calculation of pay during an FMLA leave of absence.

Pay While on Leave:

1. During the **employee's own serious medical condition,** including worker's compensation (to the extent that it qualifies), employees are required to use accrued and unused sick time**.**
2. Leave while using accrued sick time runs concurrently with FMLA leave. If a holiday falls during the period of leave while accrued leave is being used, the holiday will be paid at 100% of the employee's normal pay. ***This does not apply to contracted teachers who are only paid for scheduled working days, according to the terms of their teaching contract.***
3. In the event an employee exhausts all accrued sick leave before the end of the employee's disability period, the employee may choose one of the following options:
    - ***a.*** Employee may be paid Short-term Disability Benefits of 60% of his/her normal salary. This salary continuation benefit will be paid through the normal payroll process up to the 90th consecutive calendar day of the disability leave period or until the employee returns to work, whichever occurs first; ***OR***
    - b. Employee may use vacation time up to the amount accrued during the present calendar year. If employee exhausts vacation hours prior to the end of the disability period, he/she will be paid Short-term Disability Benefits of 60% of his/her normal salary to cover that period up to the 90th day of continued disability (same as above).

    ******If the employee may continue to be disabled after 90 days please inform the Human Resources Manager of the Chancery immediately. The Benefits Manager and Human Resources Manager of the Archdiocese will begin the Long-Term Disability Application process. We suggest that you inform the Human Resources Department after the 60th day of disability if it is suspected that the employee will be gone longer than 90 days. (Hartford may take up to 30 days to review an application to determine eligibility)******
4. Holidays that fall during the Short-term Disability period are paid at 60%. Leave while using accrued leave time runs concurrently with FMLA leave. If a holiday falls during the period of leave while accrued leave is being used, the holiday will be paid at 100% of the employee's normal pay (leave time is not docked). Holidays are unpaid if an employee is on unpaid status.
5. In the case of maternity leaves of absence, if the employee wishes to extend the leave beyond the period of disability (typically 6 weeks for a normal delivery or 8 weeks for a C-section), the remainder of the leave up to the maximum of 12 weeks would be unpaid.

    *******In the case of maternity leave you should inquire if the employee would like to have dependent coverage added upon the birth of the child. If so, please notify the Human Resources Department so that the proper application may be submitted. This must be completed within 30 days of the birth of the baby or placement of the baby within the home (adoption). ******
6. For leaves of absence **due to the placement of a child for adoption or foster care or to care for a child, spouse or parent with a serious health condition** employees are allowed to use up to a maximum of 80 hours of sick time and earned and unused vacation time to substitute part of the FMLA leave. This period of time will be designated as FMLA leave and counted toward the employee's 12-week entitlement. An employee will be placed on unpaid status if accrued leave is exhausted prior to the employee's return to work or until the end of the 12 weeks of leave. Holidays are handled in the same manner as described above. Leave may not be taken intermittently OR delayed.

Other Important Information:

1. Intermittent leave is available for cases when an employee or family member needs to take leave for periodic treatment on an ongoing basis.
2. An FMLA file should be established for each employee who takes a leave. A record or log of FMLA leave taken needs to be maintained so that the 12 week period can be tracked. The employee should indicate on his/her timesheet the FMLA leave time taken. While the employee is on leave the employee or supervisor should continue to complete time sheets clearly indicating the days which are FMLA leave.

3. No disciplinary action should be planned or taken without prior discussion with the Director or Manager of Human Resources during or before any anticipated leave of absence. In addition, the employee should return to work in his/her same or similar position so no changes in the employee's position should occur during (or immediately before or after) an FMLA leave period.
4. An employee is not considered to be on leave if work is being performed remotely.

Intermittent Leave or a Reduced Work Schedule:
The employee may take FMLA leave in 12 consecutive weeks, intermittently (take a day periodically when needed over the year) or, under certain circumstances, may use the leave to reduce the workweek or workday, resulting in a reduced hour schedule. In all cases, the leave may not exceed a total of 12 workweeks.

The Archdiocese may exercise its right to temporarily transfer an employee to an available alternative position with equivalent pay and benefits if the alternative position would better accommodate the intermittent or reduced schedule, in instances of when leave for the employee or employee's family member is foreseeable and for planned medical treatment, including recovery from a serious health condition or to care for a child after placement for adoption or foster care. This leave must be taken within one year of the placement of the child.

If the employee is taking leave for a serious health condition or because of the serious health condition of a family member, the employee should try to reach agreement with the immediate supervisor before taking intermittent leave or working a reduced hour schedule. If this is not possible, then the employee must prove that the use of the leave is medically necessary. Intermittent leave may be granted if medically necessary. The Archdiocese has the right to alter the employee's existing job or require the employee to transfer temporarily from his/her regular employment position to another position that better accommodates recurring periods of leave. The position must be one for which the employee is qualified, and it must provide equal pay and benefits

Leave due to the birth of a baby must be taken contemporaneously with the qualifying event and therefore cannot be delayed, taken intermittently or otherwise reserved to some point in the future.

Conclusion of Leave:
On a basis that does not discriminate against employees on FMLA leave, the employee may be required by the immediate supervisor to report periodically on the employee's status and intent to return to work.

An employee who takes leave under this policy for the employee's own illness is required to provide a fitness for duty (FFD) clearance from the health care provider upon return.

Employees who return within the prescribed time will be reinstated in the same or comparable position and at the same salary, benefits and working conditions as before they left.

Employees who do not return shall be considered to have voluntarily resigned their position. In that event, the employee will have the same options as any other terminating employee with regard to continuing benefits. (See Long Term Disability Benefits and Extension of Benefits resources and tools). This applies even for medical leaves resulting from an on-the-job injury or illness for which Worker's comp claim has been filed. Insurance coverage that would have been provided had the employee not taken leave will be maintained.

Termination of Employment during leave:
Leaves taken without proper documentation and/or medical certification will be considered unauthorized leave, and will be subject to disciplinary action, including discharge.

If an employee's position is eliminated during FMLA leave due to a Reduction in Force, or the employee's employment would have otherwise been terminated anyway, the Archdiocese has no obligation to reinstate the employee and may discontinue FMLA leave. In addition the employee will not be entitled to any right, benefit, or position of employment other than any right, benefit or position which employee would have been entitled had leave not been taken.

MEDICAL LEAVE (NON FMLA)

Overview:

Eligible employees, who do not meet the requirements under the Family Medical Leave Act (FMLA), may request an extended medical leave of absence for a serious health condition which renders the employee unable to perform the essential functions of the employee's position.

Eligibility:

Eligible employees include full-time employees and part-time employees with at least 60 days of service and who are scheduled to work at least 20 hours per week on a year round basis (but no less than 1,040 hours annually) who are ineligible for leave under the Family Medical Leave Act (FMLA).

Required Documentation:

1. Employee should immediately discuss with the pastor, principal, or department head
2. Employee must complete an Application for Extended Leave and submit to the Chancery Office of Human Resources
3. Statement from the employee's health care provider verifying the following:
   - Employee's inability to perform the functions of the employee's position due to the medical condition
   - Duration of the leave

Paid Leave / Use of Accrued Leave:

Employees must use any accrued sick, vacation and personal leave during medical leave (in that order). Holidays are paid at 100% while using accrued sick, vacation or personal leave.

Short-term Disability:

If in the event an employee exhausts all accrued leave before the end of the employee's disability period, the employee will be paid Short-Term Disability Benefits of 60% of his or her salary. This salary continuation benefit will be paid through the normal payroll process up to the 90th day of the leave period or until the employee returns to work, whichever occurs first. Holidays are paid at 60% of the employee's normal pay during such time. Employees with enough accrued sick, vacation and/or personal leave time to cover the entire disability period are not entitled to Short-Term Disability Benefits.

Leaves of absence due to the birth of a child:

Employees on a leave of absence due to child birth are entitled to disability leave for up to six (6) weeks (or eight weeks due to a C-section).

The employee will be required to use sick leave up to the amount accrued at the onset of the leave period. Short-term Disability will apply once employee has exhausted accrued sick leave. Short-term Disability will be paid up to the end of the six week disability period (or eight weeks due to a C-section).

Employees who do not qualify for leave under FMLA may not extend leave beyond the disability period.

Request for an Extension:

A request for an extension must be submitted to the Chancery Office of Human Resources as soon as possible. Requests may be handled individually based on the circumstances.

Documentation from the employee's health care provider must be submitted to verify necessity of the extension. A Request for Reasonable Accommodation Form may be requested.

Conclusion of Leave:
An employee who takes leave under this policy must provide a fitness for duty (FFD) clearance from the health care provider upon return.

Employees who do not return from leave within the prescribed time shall be considered to have voluntarily resigned their position.

The Archdiocese reserves the right to terminate an employee if the required documentation is not submitted in order to validate the leave and/or if the term of absence is greater than 90 consecutive days.

Termination of Employment during leave:
Leaves taken without proper documentation will be considered unauthorized leave, and will be subject to disciplinary action, including discharge.

Depending on the needs of the Archdiocese and the length of the leave period, positions for employees who take leave under this policy may not be held.

If an employee's position is eliminated during leave due to a Reduction in Force, the Archdiocese has no obligation to reinstate the employee and may discontinue your leave. In addition the employee will not be entitled to any right, benefit, or position of employment other than any right, benefit or position which you would have been entitled had leave not been taken.

THE ROMAN CATHOLIC
ARCHDIOCESE OF ATLANTA
OFFICE OF HUMAN RESOURCES

Application for Leave of Absence (FMLA or Non-FMLA)

Name: _____ Location/Department: _____

Current Address: _____

Start Date of Anticipated Leave: _____

Reason for Leave (Explain): _____

_____

_____

_____

Note: An employee requesting leave for the employee's serious health condition or the serious health condition of the employee's spouse, child or parent must submit a verifying medical certification from a physician within 15 days of application of leave.

I hereby authorize a representative of the Archdiocese of Atlanta to contact my physician to verify the reason for my requested leave.

I understand that a failure to return to work at the end of my leave period may be treated as a resignation unless an extension has been agreed upon and approved in writing by the Archdiocese of Atlanta.

Employee Signature: _____ Date: _____

APPROVED BY:

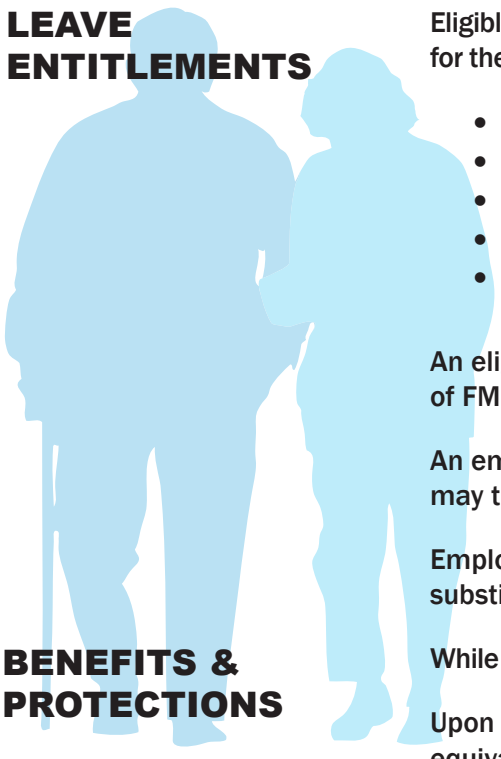
_____
Supervisor

_____
Human Resources

2401 Lake Park Drive, S.E. • Smyrna, Georgia 30080-8862
404-920-7480 • Fax 404-920-7481 • archatl.com

EMPLOYEE RIGHTS
UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION



LEAVE ENTITLEMENTS

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within one year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

BENEFITS & PROTECTIONS

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

ELIGIBILITY REQUIREMENTS

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

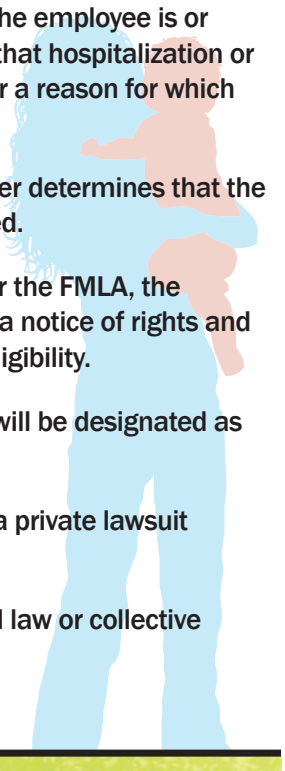
*Special "hours of service" requirements apply to airline flight crew employees.

REQUESTING LEAVE

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.



EMPLOYER RESPONSIBILITIES

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

ENFORCEMENT

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division

WAGE AND HOUR DIVISION

WH1420 REV 04/16

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

U.S. Department of Labor
Wage and Hour Division

WAGE AND HOUR DIVISION

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR. RETURN TO THE PATIENT.

OMB Control Number: 1235-0003
Expires: 6/30/2023

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. 29 U.S.C. §§ 2613, 2614(c)(3); 29 C.F.R. § 825.305. The employer must give the employee **at least 15 calendar days** to provide the certification. If the employee fails to provide complete and sufficient medical certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

SECTION I – EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, this form asks the health care provider for the information necessary for a complete and sufficient medical certification, which is set out at 29 C.F.R. § 825.306. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308.** Additionally, you **may not** request a certification for FMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care.

Employers must generally maintain records and documents relating to medical information, 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, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

(1) Employee name: _____
First *Middle* *Last*

(2) Employer name: _____ Date: _____ *(mm/dd/yyyy)*
(List date certification requested)

(3) The medical certification must be returned by _____ *(mm/dd/yyyy)*
(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee's diligent, good faith efforts.)

(4) Employee's job title: _____ Job description (☐ is / ☐ is not) attached.
Employee's regular work schedule: _____
Statement of the employee's essential job functions: _____
_____
(*The essential functions of the employee's position are determined with reference to the position the employee held at the time the employee notified the employer of the need for leave or the leave started, whichever is earlier.)*

SECTION II - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form. Your patient has requested leave under the FMLA. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of the employee. For FMLA purposes, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves *inpatient care* or *continuing treatment by a health care provider*. For more information about the definitions of a serious health condition under the FMLA, see the chart on page 4.

You may, but are **not required** to, provide other appropriate medical facts including symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment. Please note that some state or local laws may not allow disclosure of private medical information about the patient's serious health condition, such as providing the diagnosis and/or course of treatment.

Employee Name: _____

Health Care Provider's name: *(Print)* _____

Health Care Provider's business address: _____

Type of practice / Medical specialty: _____

Telephone: (___) _____ Fax: (___) _____ E-mail: _____

PART A: Medical Information

Limit your response to the medical condition(s) for which the employee is seeking FMLA leave. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. **After completing Part A, complete Part B to provide information about the amount of leave needed.** Note: For FMLA purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

(1) State the approximate date the condition started or will start: _____ *(mm/dd/yyyy)*

(2) Provide your **best estimate** of how long the condition lasted or will last: _____

(3) Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

☐ **Inpatient Care**: The patient (☐ has been / ☐ is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): _____

☐ **Incapacity plus Treatment**: *(e.g. outpatient surgery, strep throat)*
Due to the condition, the patient (☐ has been / ☐ is expected to be) incapacitated for *more than* three consecutive, full calendar days from _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*.

The patient (☐ was / ☐ will be) seen on the following date(s): _____
_____

The condition (☐ has / ☐ has not) also resulted in a course of continuing treatment under the supervision of a health care provider *(e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment)*

☐ **Pregnancy**: The condition is pregnancy. List the expected delivery date: _____ *(mm/dd/yyyy)*.

☐ **Chronic Conditions**: *(e.g. asthma, migraine headaches)* Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

☐ **Permanent or Long Term Conditions**: *(e.g. Alzheimer's, terminal stages of cancer)* Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

☐ **Conditions requiring Multiple Treatments**: (*e.g. chemotherapy treatments, restorative surgery)* Due to the condition, it is medically necessary for the patient to receive multiple treatments.

☐ **None of the above**: If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed. Go to page 4 to sign and date the form.

Employee Name: _____

(4) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. *(e.g., use of nebulizer, dialysis*) _____

_____

PART B: Amount of Leave Needed

For the medical condition(s) checked in Part A, complete all that apply. 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.

(5) Due to the condition, the patient (☐ had / ☐ will have) **planned medical treatment(s)** (scheduled medical visits) *(e.g. psychotherapy, prenatal appointments)* on the following date(s): _____

_____

(6) Due to the condition, the patient (☐ was / ☐ will be) **referred to other health care provider(s)** for evaluation or treatment(s).

State the nature of such treatments: *(e.g. cardiologist, physical therapy)* _____

Provide your **best estimate** of the beginning date _____ *(mm/dd/yyyy)* and end date _____ *(mm/dd/yyyy)* for the treatment(s).

Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery *(e.g. 3 days/week)*

_____

(7) Due to the condition, it is medically necessary for the employee to work a **reduced schedule**.

Provide your **best estimate** of the reduced schedule the employee is able to work. From _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)* the employee is able to work: *(e.g., 5 hours/day, up to 25 hours a week)*

_____

(8) Due to the condition, the patient (☐ was / ☐ will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.

Provide your **best estimate** of the beginning date _____ *(mm/dd/yyyy)* and end date _____ *(mm/dd/yyyy)* for the period of incapacity.

(9) Due to the condition, it (☐ was / ☐ is / ☐ will be) medically necessary for the employee to be absent from work on an **intermittent basis** (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, episodes of incapacity are estimated to occur _____ times per (☐ day / ☐ week / ☐ month) and are likely to last approximately _____ (☐ hours / ☐ days) per episode.

Employee Name: _____

PART C: Essential Job Functions

If provided, the information in Section I question #4 may be used to answer this question. If the employer fails to provide a statement of the employee's essential functions or a job description, answer these questions based upon the employee's own description of the essential job functions. An employee who must be absent from work to receive medical treatment(s), such as scheduled medical visits, for a serious health condition is considered to be *not able* to perform the essential job functions of the position during the absence for treatment(s).

(10) Due to the condition, the employee (☐ was not able / ☐ is not able / ☐ will not be able) to perform *one or more* of the essential job function(s). Identify at least one essential job function the employee is not able to perform:

_____

_____

Signature of Health Care Provider _____ **Date** _____ *(mm/dd/yyyy)*

Definitions of a Serious Health Condition *(See 29 C.F.R. §§ 825.113-.115)*
Inpatient Care
• An overnight stay in a hospital, hospice, or residential medical care facility. • Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.
Continuing Treatment by a Health Care Provider (any one or more of the following)
Incapacity Plus Treatment: A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either: o Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or, o At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.
Pregnancy: Any period of incapacity due to pregnancy or for prenatal care.
Chronic Conditions: Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.
Permanent or Long-term Conditions: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.
Conditions Requiring Multiple Treatments: Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.

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 under the Family and Medical Leave Act

U.S. Department of Labor
Wage Hour Division

WAGE AND HOUR DIVISION

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR.
RETURN TO THE PATIENT.

OMB Control Number: 1235-0003
Expires: 6/30/2023

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave to care for a family member with a serious health condition to submit a medical certification issued by the family member's health care provider. 29 U.S.C. §§ 2613, 2614(c)(3); 29 C.F.R. § 825.305. The employer must give the employee **at least 15 calendar days** to provide the certification. If the employee fails to provide complete and sufficient medical certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

SECTION I - EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, this form asks the health care provider for the information necessary for a complete and sufficient medical certification, which is set out at 29 C.F.R. § 825.306. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308**. Additionally, you **may not** request a certification for FMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care.

Employers must generally maintain records and documents relating to medical information, 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, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

(1) Employee name: _____
First *Middle* *Last*

(2) Employer name: _____ Date: _____ *(mm/dd/yyyy)*
(List date certification requested)

(3) The medical certification must be returned by _____ *(mm/dd/yyyy)*
(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee's diligent, good faith efforts.)

SECTION II - EMPLOYEE

Please complete and sign Section II before providing this form to your family member or your family member's health care provider. The FMLA allows an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of your family member. If requested by your employer, your response is required to obtain or retain the benefit of the FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). **You are responsible for making sure the medical certification is provided to your employer within the time frame requested, which must be at least 15 calendar days.** 29 C.F.R. §§ 825.305-825.306. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA leave request. 29 C.F.R. § 825.313.

(1) Name of the family member for whom you will provide care: _____

(2) Select the relationship of the family member to you. The family member is your:

☐ Spouse ☐ Parent ☐ Child, under age 18
☐ Child, age 18 or older and incapable of self-care because of a mental or physical disability

Spouse means a husband or wife as defined or recognized in the state where the individual was married, including in a common law marriage or same-sex marriage. The terms "child" and "parent" include *in loco parentis* relationships in which a person assumes the obligations of a parent to a child. An employee may take FMLA leave to care for an individual who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave to care for a child for whom the employee has assumed the obligations of a parent. No legal or biological relationship is necessary.

Employee Name: _____

(3) Briefly describe the care you will provide to your family member: (*Check all that apply)*

☐ Assistance with basic medical, hygienic, nutritional, or safety needs ☐ Transportation

☐ Physical Care ☐ Psychological Comfort ☐ Other: _____

(4) Give your **best estimate** of the amount of leave needed to provide the care described: _____

_____

(5) If a **reduced work schedule** is necessary to provide the care described, give your **best estimate** of the reduced schedule you are able to work. From _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy),* I am able to work _____ (*hours per day*) _____ (*days per week).*

Employee Signature _____ **Date** _____ *(mm/dd/yyyy)*

SECTION III - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form below. A family member of your patient has requested leave under the FMLA to care for your patient. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a family member with a serious health condition. For FMLA purposes, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that *involves inpatient care* or *continuing treatment by a health care provider*. For more information about the definitions of a serious health condition under the FMLA, see the chart at the end of the form.

You also may, but are **not required** to, provide other appropriate medical facts including symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment. Please note that some state or local laws may not allow disclosure of private medical information about the patient's serious health condition, such as providing the diagnosis and/or course of treatment.

Health Care Provider's name: *(Print)* _____

Health Care Provider's business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____) _____ Fax: (____) _____ E-mail: _____

PART A: Medical Information

Limit your response to the medical condition for which the employee is seeking FMLA leave. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. **After completing Part A, complete Part B to provide information about the amount of leave needed.** Note: For FMLA purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

(1) Patient's Name: _____

(2) State the approximate date the condition started or will start: _____ *(mm/dd/yyyy)*

(3) Provide your **best estimate** of how long the condition lasted or will last: _____

(4) For FMLA to apply, care of the patient must be medically necessary. Briefly describe the type of care needed by the patient (*e.g., assistance with basic medical, hygienic, nutritional, safety, transportation needs, physical care, or psychological comfort).*

_____

_____

Employee Name: _____

(5) Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

☐ **Inpatient Care**: The patient (☐ has been / ☐ is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): _____

☐ **Incapacity plus Treatment**: *(e.g. outpatient surgery, strep throat)*
Due to the condition, the patient (☐ has been / ☐ is expected to be) incapacitated for *more than* three consecutive, full calendar days from _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*.

The patient (☐ was / ☐ will be) seen on the following date(s): _____

_____

The condition (☐ has / ☐ has not) also resulted in a course of continuing treatment under the supervision of a health care provider *(e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment)*

☐ **Pregnancy**: The condition is pregnancy. List the expected delivery date: _____ *(mm/dd/yyyy)*.

☐ **Chronic Conditions**: *(e.g. asthma, migraine headaches)* Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

☐ **Permanent or Long Term Conditions**: *(e.g. Alzheimer's, terminal stages of cancer)* Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

☐ **Conditions requiring Multiple Treatments**: (*e.g. chemotherapy treatments, restorative surgery)* Due to the condition, it is medically necessary for the patient to receive multiple treatments.

☐ **None of the above**: If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed. Go to page 4 to sign and date the form.

(6) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. *(e.g., use of nebulizer, dialysis)* _____

_____

PART B: Amount of Leave Needed

For the medical condition(s) checked in Part A, complete all that apply. 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 if the benefits and protections of the FMLA apply.

(7) Due to the condition, the patient (☐ had / ☐ will have) **planned medical treatment(s)** (scheduled medical visits) *(e.g. psychotherapy, prenatal appointments)* on the following date(s): _____

_____

(8) Due to the condition, the patient (☐ was / ☐ will be) **referred to other health care provider(s)** for evaluation or treatment(s).

State the nature of such treatments: *(e.g. cardiologist, physical therapy)* _____

Provide your **best estimate** of the beginning date _____ *(mm/dd/yyyy)* and end date _____ *(mm/dd/yyyy)* for the treatment(s).

Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery

_____ *(e.g. 3 days/week)*

Employee Name: _____

(9) Due to the condition, the patient (☐ was / ☐ will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.

Provide your **best estimate** of the beginning date: _____ *(mm/dd/yyyy)* and end date _____ *(mm/dd/yyyy)* for the period of incapacity.

(10) Due to the condition it, (☐ was / ☐ is / ☐ will be) medically necessary for the employee to be absent from work to provide care for the patient on an **intermittent basis** (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, episodes of incapacity are estimated to occur _____ times per (☐ day / ☐ week / ☐ month) and are likely to last approximately _____ (☐ hours / ☒ days) per episode.

Signature of
Health Care Provider _____ **Date** _____ *(mm/dd/yyyy)*

Definitions of a Serious Health Condition *(See 29 C.F.R. §§ 825.113-.115)*
Inpatient Care
• An overnight stay in a hospital, hospice, or residential medical care facility. • Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.
Continuing Treatment by a Health Care Provider (any one or more of the following)
Incapacity Plus Treatment: A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either: o Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or, o At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.
Pregnancy: Any period of incapacity due to pregnancy or for prenatal care.
Chronic Conditions: Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.
Permanent or Long-term Conditions: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.
Conditions Requiring Multiple Treatments: Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.

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 15 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 Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR. RETURN TO THE PATIENT.