DIVISION OF ADMINISTRATION (DOA)

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

SECTION I: For Completion by 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

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**

SECTION III: For Completion by 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:

   _____ hours(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**

DIVISION OF ADMINISTRATION (DOA) **(Form #1)**

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

This notification/designation must be provided to the employee within five (5) business days of the employee notifying the employer (or the employer otherwise becoming aware) of the need for FMLA leave.

To: _____ Personnel #: _____
Employee

From: _____ Section: _____
Employer Representative

Date: _____

A. NOTICE OF ELIGIBILITY

I. On _____, we became aware that you needed leave beginning on _____ for:

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

_____ Your own serious health condition;

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

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

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

II. This Notice is to inform you that you:

_____ Are eligible for FMLA leave, provided the appropriate documentation requirements are met.

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

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

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

III. As indicated in Section II above, you meet the eligibility requirements for taking FMLA leave and still have FMLA leave available in the applicable 12-month period. **However, in order for us to determine whether your absence qualifies as FMLA leave, you are required to furnish a *Certification of Health Care Provider* form.** You must furnish the completed form to _____ by _____. (If a certification is requested, employers must allow at least 15 calendar days from receipt of this notice; additional time may be required in some circumstances.) If sufficient information is not provided in a timely manner, it may not be designated as FMLA qualifying and therefore would not be job-protected.

____ Sufficient certification to support your request for FMLA leave. A certification form that sets forth the information necessary to support your request is enclosed.

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

____ Other information needed: _____

____ No additional information requested.

____ **Not Applicable** (Employee does not meet eligibility requirements for taking FMLA leave.)
Explain: _____

B. DESIGNATION NOTICE

_____ Based on the information we have, we believe this absence qualifies under the FMLA. Your absence will be counted against and deducted from your FMLA leave entitlement. Your absence will also be charged against (and deducted from) any balance you maintain of accrued compensatory, sick or annual leave, as appropriate. The deduction will be made against whichever leave is appropriate under current leave rules and policies. If it is later determined that this leave doesn't qualify under FMLA you will be notified and all leave charged to your FMLA entitlement will be restored.

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

_____ Provided there is no deviation from your anticipated leave schedule, the following number of hours, days, or weeks will be counted against your leave entitlement: _____

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

C. RIGHTS AND RESPONSIBILITIES FOR TAKING FMLA LEAVE

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

- You have a right under the FMLA for up to12 weeks of unpaid leave in a 12-month period, with one exception. If you and your spouse are both employed by the Division of Administration, and the reason for your leave is the birth or placement of a child or to care for a sick child, you and your spouse are entitled to a **total** of 12 weeks of FMLA leave for that event.

- You have a right under the FMLA for up to 26 weeks of unpaid leave in a single 12-month period to care for a covered servicemember with a serious injury or illness. This single 12-month period commenced on _____.

- You must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA-protected leave. (If your leave extends beyond the end of your FMLA entitlement, you do not have return rights under FMLA.)

- Your group health and/or life insurance benefits which are sponsored by the state must be maintained during any period of FMLA leave under the same conditions as if you continued to work.

- If you do not return to work following FMLA leave for a reason other than: 1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; 2) the continuation, recurrence, or onset of a covered servicemember's serious injury or illness which would entitle you to FMLA leave; or 3) other circumstances beyond your control, you will be required to reimburse the state for premiums paid on your behalf for your group health and/or life insurance during your FMLA leave.

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

- The Division of Administration will continue to pay the state's portion of your group health and/or life insurance premiums while you are on leave with or without pay. While you are on **paid leave** (compensatory, sick, annual), your portion of the premium will continue to be automatically deducted from your paycheck. If you are on **leave without pay** you must make arrangements for payment of your portion with staff in the Office of Human Resources. If you fail to pay your portion of the premium, the DOA will pay your portion of the premium on your behalf. You will be required to reimburse the state for the premium paid on your behalf upon your return to work.

- If you pay other **benefits which are payroll deducted from your paycheck but are not state sponsored**, (e.g., disability insurance, cancer insurance, dental insurance, life insurance other than State sponsored life insurance, etc.), you must make arrangement for payment of those premiums with the administrator of the policy. If you need a telephone number for the administrator you may contact the Office of Human Resources.

- You will be required to use your available accrued compensatory, sick, or annual leave during your FMLA absence, as appropriate. This means that you will receive your paid leave and the leave will also be considered protected FMLA leave and counted against your FMLA leave entitlement. If you do not have sufficient accrued paid leave, the remaining FMLA absence will be unpaid leave.

Additional responsibilities may include (only check blanks that apply):

____ While on leave, you will be required to furnish us with periodic reports of your status and intent to return to work: _____ once a week, _____ once every two weeks, _____once a month. Specifically, you will be expected to notify your immediate supervisor.

____ If the circumstances of your leave change and you are able to return to work earlier than the date initially indicated, you will be required to notify us at least two work days prior to the date you intend to report to work.

____ If further certification is needed, you will be required to furnish an updated completed health care provider's certification relating to a serious health condition. We will send you a blank health care provider's certification form two weeks in advance of the date the completed form will be due in our office.

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

DIVISION OF ADMINISTRATION **(Form #2)**

Final Confirmation Notice of FMLA Use (Family and Medical Leave Act)

EMPLOYEE NAME: PN # SECTION:

EMPLOYER REPRESENTATIVE: DATE:

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

_____ **Your leave request is complete and FMLA protection will be applied according to federal regulations and DOA policy.**

We understand that you need this leave beginning on _____, and that you:

_____ Expect leave to continue until on or about _____.

_____ Do not know how long you will be unable to report to work.

_____ Will be able to report to work on an intermittent basis.

_____ Please note that entitlement will be exhausted on or about _____.

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

_____ The certification you have provided is not complete and sufficient to determine whether the FMLA applies to your leave request. You must provide the following information no later than _____, unless it is not practicable under the particular circumstance despite your diligent good faith efforts, or your leave may be denied.

_____

(Specify information needed to make the certification complete and sufficient)

_____

_____ We are exercising our right to have you obtain a second or third opinion medical certification at our expense, and will provide further details at a later time.

NOTE: This form will be completed by the Office of Human Resources (OHR) and forwarded to the employee's section. The section will forward a copy of this form to the employee as soon as possible.

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, 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 whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status 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 service-member during a single 12-month period. A covered servicemember is: (1) a current 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*; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness.*

***The FMLA definitions of "serious injury or illness" for current servicemembers and veterans are distinct from the FMLA definition of "serious health condition".**

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 12 months, have 1,250 hours of service in the previous 12 months*, and if at least 50 employees are employed by the employer within 75 miles.

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

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 pro vided under FMLA; and
- 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. Regulation 29 C.F.R. § 825.300(a) may require additional disclosures.