



CITY OF CARSON
INTEROFFICE MEMORANDUM

TO:

FROM: KARA MUSICK, HUMAN RESOURCES SPECIALIST

SUBJECT: YOUR RIGHTS UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA) OF 1993

DATE:

These are federal regulations concerning FMLA:

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to "eligible" employees for certain family and medical reason. Employees are eligible if they have worked for a covered employer for at least one year, and for 1,250 hours over the previous 12 months. The 12-month period means a rolling 12-month period measured backward from the date leave is taken and continuous with each additional leave taken.

In most cases, an employee's leave entitlement for 12 weeks of FMLA/CFRA leave will run concurrently (see attached memo re: California Family Care and Medical Leave Act and Pregnancy Disability Leave).

1. **REASONS FOR TAKING LEAVE:** FMLA unpaid leave must be granted for any of the following reasons:
 - To care for the employee's child after birth; or placement for adoption or foster care;
 - To care for the employee's spouse, son or daughter, or parent, who has a serious health condition; or
 - For a serious health condition that makes the employee unable to perform the employee's job

2. At the employee's or employer's option, certain kinds of paid leave may be substituted for unpaid leave. If an employee takes a leave of absence for any reason which is FMLA/CFRA-qualifying, the City of Carson may designate that non-FMLA/CFRA leave as running concurrently with the employee's 12-week FMLA/CFRA leave entitlement. The only exception is for peace officers who are on leave pursuant to Labor Code 4850.

While on leave under this policy an employee may elect to concurrently use paid accrued leaves. Similarly, the City of Carson may require an employee to concurrently use paid accrued leaves after requesting FMLA and/or CFRA leave, and may also require an employee to use family and medical care leave concurrently with a non-FMLA/CFRA leave which is FMLA/CFRA-qualifying.

3. ADVANCE NOTICE AND MEDICAL CERTIFICATION: The employee is required to provide advance notice and medical certification. Taking of leave may be denied if requirements are not met.

- The employee ordinarily must provide 30 days' advance notice when leave is foreseeable,
- The City of Carson requires medical certification to support a request for leave because of a serious health condition, and may require second or third opinions (at the employer's expense) and a fitness-for-duty report to return to work. In the event the leave is for the employee's dependent, a medical verification is required.

4. JOB BENEFITS AND PROTECTION:

- For the duration of FMLA/CFRA leave, the employer must maintain the employee's health coverage under any group health plan.
- Upon return from FMLA/CFRA leave, most employees must be restored to their original or equivalent positions with equal pay, benefits, and other employment terms.
- The use of FMLA/CFRA leave cannot result in the loss of employment benefit that accrued (vision, medical, dental) prior to the start of an employee's leave.

Leave under this policy is unpaid. While on leave, employees will continue to be covered by the City of Carson's group health insurance to the same extent that coverage is provided while the employee is on the job. However, employees will not continue to be covered under the City of Carson's group term life insurance, supplemental group term life insurance, and long term disability (LTD) insurance plans.

Employees may make the appropriate contributions for continued coverage under the preceding non-health benefits plan by payroll deductions or direct payments made to these plans. Depending on the particular plan, the City of Carson will inform you whether the premiums should be paid to the carrier or to the City of Carson. Your coverage on a particular plan may be dropped if your premium payment is not paid by a certain date. Employee contribution rates are subject to change in rates that occurs while the employee is on leave.



CITY OF CARSON
INTEROFFICE MEMORANDUM

TO:

FROM: KARA MUSICK, HUMAN RESOURCES SPECIALIST

SUBJECT: CALIF FAMILY CARE AND MEDICAL LEAVE ACT (CFRA LEAVE) AND PREGNANCY DISABILITY LEAVE (PDL)

DATE:

These are the State's regulations regarding CFRA and PDL.

The following notice published by the FEHC in its regulations represents the minimum requirement under CFRA.

Under the California Family Rights Act of 1993 (CFRA), if you have more than 12 months of service with us and have worked at least 1,250 hours in the 12-month period before the date you want to begin your leave, you may have a right to an unpaid family care or medical leave (CFRA leave). This leave may be up to 12 workweeks in a 12-month period for the birth, adoption, or foster care placement of your child or for your own serious health condition or that of your child, parent, registered domestic partner or spouse.

Even if you are not eligible for CFRA leave, if you are disabled by pregnancy, childbirth or related medical conditions, you are entitled to take a pregnancy disability leave of up to four months, depending on your period(s) of actual disability. If you are CFRA-eligible, you have certain rights to take BOTH a pregnancy disability leave and a CFRA leave after the birth of your child. Both leaves contain guarantee of reinstatement to the same or comparable position at the end of the leave, subject to any defense allowed under the law.

If possible, you must provide at least 30 days' advance notice for foreseeable events (such as the expected birth of your child or a planned medical treatment for yourself or family member). For events which are unforeseeable, we need you to notify us, at least verbally, as soon as you learn of the need for the leave.

Failure to comply with these notice rules is grounds for, and may result in, deferral of the request leave until you comply with the notice policy.

We may require certification from your health care provider or the health care provider of your child, parent, registered domestic partner or spouse who has a serious health condition before allowing you to leave for your serious health condition or take care of that family member. When medically necessary, leave may be taken on an intermittent or reduced leave schedule.

If you are taking a leave for the birth, adoption, or foster care placement of a child, the basic minimum duration of the leave is two weeks and you must conclude the leave within the year of the birth or placement for the adoption or foster care.

Taking a family care or pregnancy disability leave may impact certain benefits of yours (such as Long Term Disability and life insurance) and your seniority date. If you want more information regarding your eligibility for a leave and/or the impact of the leave on your seniority and benefits please contact me.

**“NOTICE B”****FAMILY CARE AND MEDICAL LEAVE AND PREGNANCY DISABILITY LEAVE**

- Under the California Family Rights Act of 1993 (CFRA), if you have more than 12 months of service with your employer and have worked at least 1,250 hours in the 12-month period before the date you want to begin your leave, you may have a right to an unpaid family care or medical leave (CFRA leave). This leave may be up to 12 workweeks in a 12-month period for the birth, adoption, or foster care placement of your child or for your own serious health condition or that of your child, parent or spouse.
- Even if you are not eligible for CFRA leave, if disabled by pregnancy, childbirth or related medical conditions, you are entitled to take pregnancy disability leave (PDL) of up to four months, or the working days in one-third of a year or 17½ weeks, depending on your period(s) of actual disability. Time off needed for prenatal or postnatal care; doctor-ordered bed rest; gestational diabetes; pregnancy-induced hypertension; preeclampsia; childbirth; postpartum depression; loss or end of pregnancy; or recovery from childbirth or loss or end of pregnancy would all be covered by your PDL.
- Your employer also has an obligation to reasonably accommodate your medical needs (such as allowing more frequent breaks) and to transfer you to a less strenuous or hazardous position if it is medically advisable because of your pregnancy.
- If you are CFRA-eligible, you have certain rights to take BOTH PDL and a separate CFRA leave for reason of the birth of your child. Both leaves guarantee reinstatement to the same or a comparable position at the end of the leave, subject to any defense allowed under the law. If possible, you must provide at least 30 days advance notice for foreseeable events (such as the expected birth of a child or a planned medical treatment for yourself or a family member). For events that are unforeseeable, you must to notify your employer, at least verbally, as soon as you learn of the need for the leave.
- Failure to comply with these notice rules is grounds for, and may result in, deferral of the requested leave until you comply with this notice policy.
- Your employer may require medical certification from your health care provider before allowing you a leave for:
 - your pregnancy;
 - your own serious health condition; or
 - to care for your child, parent, or spouse who has a serious health condition.

If an employee fails to return to work after his/her leave entitlement has been exhausted or expires, the City of Carson shall have the right to recover its share of health plan premiums for the entire leave period, unless the employee does not return because of the continuation, recurrence, or onset of a serious health condition of the employee or his/her family member which would entitle the employee to leave, or because of circumstances beyond the employee's control. The City of Carson shall have the right to recover premiums through deduction from any sums due to the City of Carson (e.g. unpaid wages, vacation pay, etc.).

Taking a family care or pregnancy disability leave may impact certain benefits of yours (such as Long Term Disability and life insurance) and your seniority date. If you want more information regarding your eligibility for a leave and/or the impact of the leave on your seniority and benefits, please contact me.

5. **REQUIRED FORMS:** Employees must fill out the applicable forms in connection with leave under this policy:
 1. "Request for Family or Medical Leave Form" application form to be eligible for leave. **NOTE: EMPLOYEES WILL RECEIVE A CITY OF CARSON RESPONSE TO THEIR REQUEST WHICH WILL SET FORTH CERTAIN CONDITIONS OF THIS LEAVE ENTITLEMENT. ALL FORMS MUST BE RETURNED TO HUMAN RESOURCES;**
 2. Medical Certification – either for the employee's own serious health condition or for the serious health condition of a child, parent or spouse; and
 3. Authorization for payroll deductions for benefit plan coverage continuation.

To the extent not already provided under current leave policies and provisions, the City of Carson will provide family and medical care leave for eligible employees as required by state and federal law. The preceding provisions set forth certain of the rights and obligations with respect to such leave. Rights and obligations which are not specifically set forth are set forth in the Department of Labor regulations implementing the Federal Family Leave and Medical Leave Act of 1993 (FMLA) and the regulations of the California Family Rights Act (CFRA). Unless otherwise provided by this article, "Leave" under this article means leave pursuant to the FMLA and CFRA.

Any period of incapacity due to pregnancy or for prenatal care entitles the employee to FMLA leave, but not CFRA leave. Under California law, an employee disabled by pregnancy is entitled to pregnancy disability leave.

NOTICE B
FAMILY CARE AND MEDICAL LEAVE AND PREGNANCY DISABILITY LEAVE
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- See your employer for a copy of a medical certification form to give to your health care provider to complete.
- When medically necessary, leave may be taken on an intermittent or a reduced work schedule. If you are taking a leave for the birth, adoption or foster care placement of a child, the basic minimum duration of the leave is two weeks and you must conclude the leave within one year of the birth or placement for adoption or foster care.
- Taking a family care or pregnancy disability leave may impact certain of your benefits and your seniority date. Contact your employer for more information regarding your eligibility for a leave and/or the impact of the leave on your seniority and benefits.

This notice is a summary of your rights and obligations under the Fair Employment and Housing Act (FEHA). The FEHA prohibits employers from denying, interfering with, or restraining your exercise of these rights. For more information about your rights and obligations, contact your employer, visit the Department of Fair Employment and Housing's Web site at www.dfeh.ca.gov, or contact the Department at (800) 884-1684. The text of the FEHA and the regulations interpreting it are available on the Department's Web site.

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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 servicemember 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 provided 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.



For additional information:
1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627
WWW.WAGEHOUR.DOL.GOV

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



WHD Publication 1420 Revised February 2015

**City of Carson
REQUEST FOR LEAVE OF ABSENCE**

NAME: _____ DEPARTMENT: _____
 POSITION: _____ ID#: _____ PHONE: _____
 HOME ADDRESS: _____ CITY: _____ ZIP: _____
 SUPERVISOR'S NAME: _____ HIRE DATE: _____

REASON FOR LEAVE REQUESTED:

- Continuous period of leave for Employee's own serious health condition that makes the employee unable to perform the functions of his/her position. *(Must attach completed Physician Medical Certification - Employee form.)
- Continuous period of leave to care for immediate family member who has a serious health condition. Circle one: CHILD – SPOUSE – PARENT. * (Must attach completed Physician Medical Certification - Family Member form.)
- Intermittent period of leave for a serious health condition of Self OR Family member.* (Must attach Physician Medical Certification - Employee form for employee OR Family Member form for family member.)
- Birth or adoption of a child and/or to care for such child.* (Requires proof of birth or adoption.)
- Military (Attach copy of military leave orders/paperwork.)
- Military Caregiver Leave.* Circle one: CHILD – SPOUSE – PARENT – NEXT OF KIN (Attach Physician Medical Certification – Military Family Leave form, Invitational Travel Order, or Invitational Travel Authorization.)
- Qualifying Exigency Leave. * Circle one: CHILD – SPOUSE – PARENT (Attach copy of active duty orders and certification providing facts related to qualifying exigency for which leave is sought.)
- Personal Leave - Reason: _____

DATE LEAVE IS TO BEGIN: ____ / ____ / ____ DATE LEAVE IS TO END: ____ / ____ / ____

*Approval of leave will run concurrent with Family Medical Leave Act (FMLA) and California Family Rights Act (CFRA) if employee qualifies.

PLEASE READ CAREFULLY:

1. If you would like your union representative notified that you are applying for disability benefits through Cigna please initial _____.
2. If you are unable to return to work on the scheduled date, you must submit a request to extend the leave of absence two working days prior to the leave ending date.
3. For an unpaid leave of absence over a certain number of days, you will not continue to receive benefits which accrue with service time (i.e., vacation, sick leave, seniority) during that time. If you choose to use your accrued time there will be no change in your accrual of time related benefits. You must contact the Human Resources Department to be advised on how your insurance and time related benefits may be impacted.

I have read and understand the instructions and procedures regarding leaves of absence and that I am attesting that all information contained herein is truthful to the best of my knowledge. I further understand if I provide misinformation I may be disciplined, up to and including termination. I am aware that any selections made cannot be changed retroactively.

Employee Signature: _____ Date you provided notice of leave to your supervisor (May be written or verbal): ____ / ____ / ____

Department Acknowledgement	Comments: _____
_____ Supervisor	_____ Date
_____ Department Director	_____ Date

DEPARTMENTS: PLEASE TIME & DATE STAMP FORM UPON RECEIPT FROM EMPLOYEE

CITY OF CARSON

CERTIFICATION OF HEALTH CARE PROVIDER

* EMPLOYEE'S OWN SERIOUS HEALTH CONDITION *

Under the Family and Medical Leave Act (FMLA), California Family Rights Act (CFRA),
Pregnancy Disability Leave Law (PDL) and/or applicable City Leave Policies

I. EMPLOYEE'S INFORMATION

Employee's Name	Employee's Date of Birth	Employee's Identification Number
Employee's Department	Employee's Job Title	Employee's Regular Work Schedule

II. EMPLOYEE'S SERIOUS HEALTH CONDITION

A. Nature of the Serious Health Condition (Select One):

1. Inpatient Hospital Care
(An overnight stay in a hospital, hospice or residential care facility, including periods of incapacity associated with this stay)
2. Incapacity and Treatment
(Treatment two or more times following a period of incapacity of more than three consecutive full calendar days)
3. Pregnancy, Due Date ____/____/____ Actual Estimated
(Any period of incapacity due to a pregnancy or recovery from childbirth, including pre- and post-natal care)
4. Chronic Condition
(A period of incapacity or treatment for a condition requiring regular provider visits/treatment, and continuing for an extended time)
5. Permanent or Long-Term Condition
(A period of incapacity or treatment due to a long-term condition under the continuing supervision of a provider)
6. Multiple Treatments for a Non-Chronic Condition
(A period of absence to receive multiple treatments for restorative surgery or a condition that would result in incapacity if not treated)
7. None of the Above - Explain:

B. Medical Facts about the Serious Health Condition

(such as nature of incapacity, regimen of continuing treatment or follow-up appointments, etc. DO NOT INCLUDE DIAGNOSIS)

If chiropractor, is the treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray? Yes No

Is the employee able to perform work of any kind? If "NO", skip the next question.
 No Yes

Is the employee unable to perform any one or more of the essential functions of his/her position? Answer after reviewing statement from employer of essential functions, or if none provided, after discussing with the employee.
 No Yes

CITY OF CARSON

III. REQUESTED TIME OFF WORK:

- A. Will the employee be incapacitated for a single continuous period of time, including time for treatment and recovery.
 No Yes - provide start and end dates, below:

Leave Start Date Expected Leave End Date Expected Return to work date

- B. Will the employee need intermittent time off due to this serious health condition?
 No Yes - if Yes, are these absences medically necessary? No Yes, if so provide details below:

Intermittent Period Intermittent Period Frequency: _____ times per _____ week(s) _____ month(s)
Start Date End Date Duration: _____ hours or _____ day(s) per episode
Will these absences be consecutive? No Yes
-If yes, up to _____ days in a row.

*if period end date is not known, please provide an estimated date that re-evaluation will occur.

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

Dates of Appointments Time Required Per Appointment Recovery Period Required

- C. Will the employee need to work part-time or a reduced work schedule due to this serious health condition?
 No Yes - if yes, is this schedule medically necessary? No Yes, if so provide details below:

_____ hours per work day, _____ days per workweek

Reduced Schedule Reduced Schedule
Start Date End Date

IV. Limited Authorization for Release of Health Care Information

Employee's Name Employee's Date of Birth

I authorize the release of any medical information necessary to complete this form. Knowingly providing false information directly, or through another party, may result in adverse action against the employee.

Employee's Signature Date

CERTIFICATION BY PROVIDER: *By signing below you are certifying that the information you have provided is accurate and complete, and that this information is based on your personal knowledge of the patient's condition.*

Provider's Printed Name and Credentials Type of Practice Telephone Number

Provider's Office Address (Street, City, State, Zip Code) Best times & Days to Call

Provider's Signature (No stamps or Proxy Seals Accepted) Date

CITY OF CARSON

HUMAN RESOURCES DEPARTMENT

REQUEST FOR BONDING LEAVE

Under the Family and Medical Leave Act (FMLA), California Family Rights Act (CFRA)
and/or applicable City Leave Policies

EMPLOYEE NAME: _____ DATE: _____

EMPLOYEE NUMBER: _____ DEPARTMENT: _____

I AM REQUESTING BONDING LEAVE FOR THE FOLLOWING REASON*:

- Birth Of A Child. Child's Date Of Birth: ___/___/___
- Adoption Of A Child. Date Of Placement: ___/___/___
- Placement Of A Foster Care Child. Date Of Placement: ___/___/___

REQUESTED LEAVE PERIOD(S):

From: ___/___/___ To: ___/___/___

From: ___/___/___ To: ___/___/___

SIGNATURE: _____ DATE: _____

***Please attach verification of the date of birth and/or placement of the child (eg. Hospital birth record, birth certificate, DCFS 129, etc.). If you are requesting leave for the birth of a child not yet born, you may be approved for leave for FMLA/CFRA but your leave dates will not be Designated until such verification is received.**

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

U.S. Department of Labor
Wage and Hour Division



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

OMB Control Number: 1235-0003

Expires: 8/31/2021

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: _____

SECTION II: For Completion by the EMPLOYEE

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

Your name: _____
First Middle Last

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

Relationship of family member to you: _____

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

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

Employee Signature _____ Date _____

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the patient needs leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e). Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

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

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

Probable duration of condition: _____

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

No Yes. If so, dates of admission: _____

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

Was medication, other than over-the-counter medication, prescribed? No Yes.

Will the patient need to have treatment visits at least twice per year due to the condition? No Yes

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?

No Yes. If so, state the nature of such treatments and expected duration of treatment:

2. Is the medical condition pregnancy? No Yes. If so, expected delivery date: _____

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

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

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ___ No ___ Yes.

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

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

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

5. Will the patient require follow-up treatments, including any time for recovery? ___ No ___ Yes.

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

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

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

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

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

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

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ___ No ___ Yes.

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

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

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

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

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

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

Signature of Health Care Provider

Date

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

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

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