Procedure: 4.5.1p.
Family and Medical Leave Act Leave (FMLA)

Revised:	July 16, 2024; July 20, 2021; January 1, 2020; April 16, 2019; September 15, 2015; May 21, 2009; and October 3, 2001
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Adopted:	August 5, 1993

TCSG

I. PURPOSE:
The Family and Medical Leave Act (FMLA) allows eligible employees to take job-protected leave for specific reasons. The maximum amount of leave an employee may use is twelve (12) or twenty-six (26) weeks within a twelve (12) month period depending on the reasons for the leave.

II. RELATED AUTHORITY:
O.C.G.A. § 20-4-11 – Powers of Board
O.C.G.A. § 20-4-14 – TCSG Established; Powers and Duties
29 C.F.R. Part 825, Family and Medical Leave Act of 1993, State Personnel Board Rule 23, Family Medical Leave

III. APPLICABILITY:
All work units and Technical Colleges are associated with the Technical College System of Georgia.

IV. DEFINITIONS:
Child (son or daughter): a biological, adopted, or foster child, a stepchild, a legal ward, or a child of a person standing in loco parentis, who is either under age 18 or age 18 or older and incapable of self-care because of a mental or physical disability at the time that FMLA leave is to commence.

Child (son or daughter) of a Covered Servicemember: a biological, adopted, or foster child, a stepchild, a legal ward, or a child for whom the covered servicemember stood in loco parentis, regardless of age.

Covered Servicemember: is a member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list for a severe injury or illness that may render him/her medically unfit to perform the duties of the member's office, grade, rank, or rating.

Covered Military Member: the employee's spouse, son, daughter, or parent on active duty or call to active-duty status.

Health Care Provider: A Doctor of Medicine or osteopathy authorized to practice medicine or surgery (as appropriate) by the State in which the doctor practices or any other person determined

by the Secretary of Labor to be capable of providing health care services.

a. Others capable of providing health care services include:
    i. Podiatrists, dentists, clinical psychologists, optometrists, and chiropractors authorized to practice in the State and who are performing within the scope of their practice as defined in State Law;
    ii. Nurse practitioners, nurse-midwives, clinical social workers, and physicians' assistants are authorized to practice under State law and perform within the scope of their practice as defined under State Law.
    iii. Christian Science Practitioners listed with the First Church of Christ, Scientist in Boston, Massachusetts. In these instances, the System Office or Technical College may require a second and/or third opinion by a non-Christian Scientist practitioner;
    iv. any health care provider from whom the State of Georgia Health Benefit Plan will accept certification for the existence of a serious health condition to substantiate a claim for benefits; and,
    v. a health care provider as defined above who practices in a country other than the United States and who is licensed to practice in accordance with the laws and regulations of that country.

HIPAA: Health Insurance Portability and Accountability Act.

Immediate Supervisor: an individual charged with developing performance plans and managing and assessing the performance of employee(s) in those work unit(s) under their span of control.

Intermittent Leave: leave taken in separate periods of time due to a single illness or injury.

Need to Care For: the physical and/or psychological care of a family member or covered servicemember in the following situations:

a. The family member or covered service member is unable to care for their basic medical, hygiene, or nutritional needs, safety, or is unable to travel to the doctor, etc.
b. The family member or covered service member receives inpatient or home care, and the employee is needed to provide beneficial psychological comfort and reassurance.
c. An employee must substitute for others caring for the family member or make arrangements for changes in care, such as transfer to a nursing home.
d. The family member is or covered servicemember's need for care is intermittent; or,
e. an employee is needed only intermittently (e.g., other care is typically available, or care responsibilities are shared with another caregiver, etc.).

Next of Kin: is the nearest blood relative of a covered servicemember, other than the individual's spouse, parent, son, or daughter in the following order of priority: blood relatives who have been granted legal custody of the servicemember by court decree or statutory provisions; brothers and sisters; grandparents; aunts and uncles; and, first cousins, unless the servicemember has specifically designated, in writing, another blood relative as their nearest blood relative for Military Caregiver Leave.

Parent: a biological, adoptive, step or foster father or mother, or any other individual who stood in loco parentis to the employee when the employee was a son or daughter (as defined in the term "Child"). This term does not include parents "in law."

Parent of a Covered Servicemember: a biological, adoptive, step or foster father or mother, or any other individual who stood in loco parentis to the covered servicemember.

Qualifying Exigencies: include activities such as short-notice deployment, military events,

arranging alternative childcare, making financial and legal arrangements, etc., related to deployment, rest and recuperation, counseling, and post-deployment debriefings.

Reduced Schedule Leave: a leave schedule that reduces the number of hours in an employee's established work week or a typical workday.

Reviewing Manager: a manager charged with reviewing the performance plans and evaluations prepared by lower-level supervisor(s) in their direct line of supervision.

Serious Health Condition: is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility (i.e., inpatient care) or continuing treatment by a health care provider for a condition that prevents an employee from performing the functions of their job or prevents the qualified family member from participating in school or other daily activities. Subject to certain conditions, continuing treatment includes an incapacity of more than three consecutive, full calendar days and two visits to a health care provider within 30 days of the first day of incapacity or one visit to a health care provider and a continuing regiment of care; an incapacity caused by pregnancy or prenatal visits, a chronic condition, or permanent or long-term conditions; or absences due to multiple treatments.

Spouse: a husband or wife in a marriage recognized by the State in which it was entered. This includes common law marriages that are recognized in accordance with state law.

V. ATTACHMENTS:

Attachment: 4.5.1p.a1. Leave Request Form
Attachment: 4.5.1p.a2. Child's Birth, Adoption, or Foster Care Form
Attachment: 4.5.1p.a3. Certification of Health Care Provider for Family Member's Serious Health Condition under the Family and Medical Leave Act
Attachment: 4.5.1p.a4. Certification of Health Care Provider Form for Employee's Serious Health Condition
Attachment: 4.5.1p.a5. Certification for Serious Injury or Illness of Covered Servicemember for Military Family Leave
Attachment: 4.5.1p.a6. Certification of Qualifying Exigency for Military Family Leave
Attachment: 4.5.1p.a7. Notice of Eligibility and Rights and Responsibilities Form
Attachment: 4.5.1p.a8. FMLA Designation Notice
Attachment: 4.5.1p.a9. DOL Notice to Employees of Rights and Responsibilities under the FMLA

VI. PROCEDURE:

A. General Provisions

1. To be eligible for FLMA leave, an employee must
   a. have worked at least 12 months for any State of Georgia agency, department, board, bureau, etc., in the preceding seven (7) years except for any break-in-service occasioned by the fulfillment of an employee's National Guard or Reserve military service obligation.
   b. Have worked at least 1,250 hours for any State of Georgia agency, department, board, bureau, etc., during the twelve (12) months immediately preceding the date FMLA leave is to begin except that an employee returning from fulfilling their National Guard or Reserve military obligation shall be credited with the hours-of-service that could have been performed but for the period of military service in determining whether the employee worked the 1,250 hours of service.

2. FMLA leave may be taken for the following reasons:
   a. Birth of a child or to care for/bond with a newly born child (up to 12 weeks).
   b. Placement of a child with the employee for adoption or foster care (up to 12 weeks).

c. To care for (the employee's spouse, child, or parent) with a serious health condition (up to 12 weeks).
d. An employee's serious health condition makes them unable to perform one or more of the essential functions of their job (up to 12 weeks).
e. To care for a covered service member with a severe injury or illness related to certain types of military service (up to 26 weeks).
f. To manage qualifying exigencies arising because the employee's spouse, son, daughter, or parent is on active duty under a call or order to active duty in the Armed Forces (e.g., National Guard or Reserves) in support of a contingency operation (up to 12 weeks).

3. The maximum leave that may be taken in 12 months for all reasons is 12 weeks, except leave to care for a covered servicemember, which carries a maximum combined leave entitlement of 26 weeks. In these instances, leave for all other reasons cannot constitute more than 12 of these 26 weeks.

4. The TCSG and its associated Technical Colleges measure the 12-month period in which leave is taken by the "rolling" 12-month method, measured backward from the date of any FMLA leave with one exception. For leave to care for a covered service member, the TCSG and its Technical Colleges calculate the 12 months beginning on the first day the eligible employee takes FMLA to leave to care for a covered service member and ends 12 months after that date. FMLA leave for the birth or placement of a child for adoption, or foster care must be concluded within 12 months of the birth or placement.

5. When medically necessary, eligible employees may take FMLA to leave in a single block of time, intermittently (in separate blocks of time), or by reducing their regular work schedule when medically necessary for the serious health condition of the employee or immediate family member, or the injury or illness of a covered servicemember. Eligible employees may also take intermittent or reduced-scheduled leave for military qualifying exigencies. Employees who require intermittent or reduced-schedule leave must attempt to schedule their leave so that it will not unduly disrupt System Office or Technical College operations.

6. Employees may use accrued paid leave concurrently with FMLA. Available annual, sick, or personal leave will be used in accordance with related TCSG procedures governing the use of paid leave for all absences designated as FMLA leave. When available, use of compensatory time (FLSA, Georgia, or holiday compensatory time) will be required. Paid parental leave must be used concurrently with FMLA leave taken at the same qualifying reasons, if the employee is eligible for FMLA.

7. The DOL Notice to Employees of Rights under the FMLA (Attachment: 4.5.1p.a9.) must be posted prominently so applicants and employees can readily see it. In addition, a copy of the notice should be provided to all newly hired employees.

8. In accordance with federal regulations, and as outlined in this procedure, the System Office and its associated Technical Colleges will inform an employee whether they are eligible for leave under the FMLA and designate all FMLA-protected leave. Upon returning from FMLA leave, an employee will typically be restored to their original job or an equivalent job with equivalent pay, benefits, and other employment terms and conditions.
9. The FMLA makes it unlawful for any employer to interfere with, restrain, or deny the exercise of any right provided under the FMLA or discharge or discriminate against any

person for opposing any practice made unlawful by the FMLA or for involvement in any proceeding under or relating to the FMLA. Accordingly, the TCSG and its Technical Colleges encourage employees to bring any concerns or complaints about compliance with the FMLA to the System Office or Technical College Office of Human Resources.

10. Medical information obtained from an employee's serious health condition and all medical information gathered during employment with the System Office, or Technical College is confidential. Access to this information, which is housed separately from work-related documents collected during the scope of an individual's employment and retained in an employee's personnel file, is restricted to System Office/Technical College representatives having a legitimate business reason to view the materials.

11. Employees who fail to return to work as scheduled after FMLA leave will be subject to disciplinary action consistent with State Board policy.

12. An employee providing false or misleading information or intentionally omitting material information concerning an FMLA leave will be subject to disciplinary action consistent with State Board policy.

B. Birth of a Child, Adoption, or Foster Care

1. An expectant mother is entitled to leave due to incapacity due to pregnancy, for prenatal care, or for her own serious health condition following the birth of a child.

2. FMLA leave for the placement or adoption of a child will begin on the date the employee's presence is needed for the placement process to begin or when the employee takes actual custody of the child.

3. FMLA leave taken for this reason must occur within 12 months from the date of birth or placement.

4. Spouses employed by a State of Georgia entity are entitled to a combined 12 weeks for bonding with a newborn or newly placed or adopted child.

C. Serious Health Condition of an Employee or a Family Member

1. FMLA leave for an employee's serious health condition will begin when the employee cannot perform the essential functions of their position. To qualify for FMLA leave, an employee must have a serious health condition defined in this procedure and related rules and regulations.

2. FMLA leave for a family member's serious health condition will begin when the employee's presence is necessary to provide care for the family member. The employee's family member must have a serious health condition as defined in this procedure and related rules and regulations.

3. An employee requesting FMLA leave for his or her serious health condition or the serious health condition of a family member must make a reasonable effort, subject to the approval of a health care provider, to schedule the treatment or supervision of the family member, so as not to unduly disrupt System Office or Technical College operations.

4. Spouses employed by a State of Georgia entity are entitled to a combined 12 weeks to care for a parent.

D. Military Caregiver Leave

1. Employees who are the spouse, child (son or daughter), parent, or next of kin of a covered service member may use FMLA leave to care for family members who have sustained severe injuries or illnesses while on active duty. The employee must meet all other eligibility requirements.

2. An eligible employee may take up to 26 work weeks of Military Caregiver Leave to care for a covered service member in 12 months. However, the rolling 12-month period may not coincide with the rolling 12-month period used for FMLA leave for other qualifying reasons.

3. Military Caregiver Leave applies on a per-injury basis for each service member. Therefore, an eligible employee may take separate periods of leave for each covered service member and/or for each severe injury or illness of the same covered service member. However, no more than 26 workweeks of leave may be taken in any single 12- month period.

4. Within the single 12-month period, an eligible employee may take a combined total of 26 weeks of FMLA leave, including up to 12 weeks of leave for any other FMLA-qualifying reason (e.g., the birth of a child, the serious illness of a family member, a qualifying exigency, etc.). For example, during the “single 12-month period”, an eligible employee may take up to 16 weeks of FMLA leave to care for a covered service member when combined with up to 10 weeks of FMLA leave to care for a newborn child.

E. Qualifying Exigency Leave

1. Employees who are the spouse, child (son or daughter), or parent of a covered military member called to active duty may take FMLA leave for the following qualifying exigencies:
    a. Short-notice deployment: to address any issue arising from short notice (within seven days or less) of an impending call or order to active duty.

    b. Military events and related activities: to attend any official military ceremony, program, or event related to active duty or a call to active-duty status or to attend specific family support or assistance programs and information briefings.

    c. Childcare and school activities: to arrange for alternative childcare; to provide childcare on an urgent, immediate need basis; to enroll a child in or transfer a child to a new school or daycare facility, or to attend meetings with staff at a school or daycare facility.

    d. Financial and legal arrangements: to make or update various financial or legal arrangements; or to act as the covered military member’s representative before a federal, State, or local agency in connection with service benefits.

    e. Counseling: to attend counseling (by someone other than a health care provider) for the employee, the covered military member, or for a child or dependent, when necessary, as a result of duty under a call or order to active duty.

    f. Rest and recuperation: to spend time with a covered military member on short-term, temporary rest and recuperation leave during deployment. Eligible employees may take up to five (5) days of leave for each instance of rest and recuperation.

g. Post-deployment activities: attend arrival ceremonies, reintegration briefings and events, and any other official ceremony or program sponsored by the military for up to 90 days following termination of the covered military member's active-duty status. This also encompasses leave to address issues that arise from the death of a covered military member while on active-duty status.

h. Parental leave: To arrange for alternative care for a parent of the military member when the parent is incapable of self-care; to admit to or transfer to a care facility a parent of the military; to attend meetings with staff at a care facility, such as meetings with hospice or social service providers for a parent of the military member, when such activities are necessary due to circumstances arising from the covered active duty or call to covered active-duty status of the military member

i. Additional activities: other events that arise from the close family member's duty under a call or order to active duty, provided that the System Office or Technical College and the employee agree that such leave shall qualify as an exigency and agree to both the timing and duration of such leave.

2. Up to 12 weeks of Qualifying Exigency Leave is available in any 12 months.

3. Although Qualifying Exigency Leave may be combined with leave for other FMLA-qualifying reasons, the total of such leave cannot exceed 12 weeks in any 12 months, except for military caregiver leave referenced above.

4. A call to active duty refers to a federal call to active duty. According to applicable laws, a state called to active duty is not covered unless under the order of the President of the United States.

F. Requesting FMLA leave

1. An employee's notice of the need to take leave can be verbal and does not explicitly have to mention Family Medical Leave. However, the FMLA leave Request Form (Attachment 4.5.1pa1.) should also be submitted to supplement any verbal or written request.

2. In practice, the employee should provide at least 30 days' notice when the leave is foreseeable and as soon as practicable when the leave is not foreseeable.

3. If, when requesting leave, an employee makes statements indicating that the leave may qualify for designation as FMLA leave under the FMLA, further inquiries must be made. Again, supervisors and managers must consult with Human Resources to determine how to proceed in these instances.

G. Notice of Eligibility and Rights and Responsibilities

1. When an employee requests FMLA leave or when the System Office or Technical College acquires knowledge that an employee's leave may be for an FMLA-qualifying reason, the System Office or Technical College must notify the employee of the employee's eligibility by completing the Notice of Eligibility and Rights and Responsibilities (Attachment 4.51p.a7.).

2. The eligibility notice must be completed and provided to the employee within five business days, absent extenuating circumstances.

3. All FMLA absences for the same qualifying reason are considered a single leave, and

employee eligibility (as to the reason for leave) does not change during the applicable 12-month period.

4. The eligibility notice must be completed by the System Office or Technical College in its entirety and State whether the employee is eligible for FMLA leave. If the employee is not eligible, all reasons why must be noted.

H. Medical Certification (Employee or Family Member)

1. When requesting FMLA leave, an employee must provide medical certification supporting the need for leave due to a serious health condition affecting an employee or their immediate family member within 15 calendar days of the System Office or Technical College's request to provide the certification.

2. If the certification is incomplete or insufficient, the System Office or Technical College must notify the employee in writing regarding what information is necessary to make the certification complete and sufficient and provide the employee with seven calendar days to cure any deficiencies (unless this time period is not practicable despite the employee's diligent, good-faith efforts).

3. If the deficiencies are not resolved, the System Office or Technical College may contact the employee's health care provider for verification and clarification. It is not permitted to obtain additional information beyond that required by the certification form. Contact may be made by the System Office, Technical College Human Resources Director/Coordinator, or other Human Resources representative. The employee's immediate supervisor is not permitted to engage in these discussions.

4. If an employee fails to provide a complete certification, the System Office or Technical College may delay the commencement of leave, withdraw any designation of FMLA leave, or deny the leave and place the employee on leave without pay status consistent with TCSG State Board policy and State Personnel Board Rules.

5. An employee might be required to provide medical certification of their fitness for duty before returning to work if the leave was due to the employee's own serious health condition. The System Office or Technical College will require this certification to address whether an employee returning from a period of leave under these provisions can perform the essential functions of their position.

6. While an employee's permission is not needed to contact the healthcare provider purely for verification purposes, the System Office or Technical College must obtain the employee's authorization to clarify "individually identifiable" health information, consistent with HIPAA.

I. Designation Notice

1. Once the System Office or Technical College has sufficient information to determine whether the leave is FMLA-qualifying, the employee must be notified in writing of this decision within five business days using Attachment: 4.5.1p.a8., FMLA Designation Notice.

2. The Designation Notice must indicate this if an employee is required to provide a fitness-for-duty certificate from their health care provider before returning to work. In addition, a list of essential functions or a job description must be attached to the Designation Notice.

3. The designation notice need only be provided once for each qualifying reason during the

12 months.

4. The amount of leave (such as the number of hours, days, or weeks) to be counted against the FMLA entitlement must be specified if known at the time the System Office or Technical College designates the leave as FLMA qualifying. If this is not possible when the designation is made, the System Office or Technical College must provide this information upon request by the employee. The leave notice amount must be written in writing no later than the following payday.

5. If both military caregiver and the serious health condition of a family member qualifying reasons apply the System Office or Technical College must designate the leave as military caregiver leave to permit up to 26 weeks of leave.

6. Failure to provide required notice may constitute interference with, restraint of, or denial of the exercise of an employee's FMLA rights and subject the TCSG and its Technical Colleges to potential liability for compensation and benefits lost because of the violation.

7. The System Office or Technical College may retroactively designate leave, provided that the System Office or Technical College's failure to designate such leave promptly has not caused harm or injury to the employee. In all instances in which leave qualifies for FMLA protection, the System Office or Technical College and the employee may mutually agree to the retroactive designation.

J. Recertification of Medical Conditions

1. The System Office or Technical College Human Resources Director/Coordinator may require recertification (from the employee's health care provider) regarding the medical condition(s) that initially supported an employee's request for FMLA leave for their use.

2. If the initial recertification indicates the serious health condition will have a minimum duration of more than 30 days, recertification may not be requested until the initial period has expired.

3. Recertification may be requested at reasonable intervals, but not more often than every 30 days, unless the employee requests an extension of leave; circumstances described by the previous certification have significantly changed (e.g., the duration of the illness, the nature of the illness, complications, etc.); or the System Office or Technical College receives information that places doubt upon the continuing validity of the initial/most recent certification.

4. As with the initial certification, an employee has 15 calendar days to provide a requested certification. All requirements and consequences outlined in this Procedure will apply to requests for recertification. The employee will be responsible for all costs associated with the recertification, and no second or third opinions may be requested.

5. In instances in which the duration of an employee's condition is "lifetime" or "unknown," the System Office or Technical College may request a recertification every six months in conjunction with the employee's absence.

K. Second or Third Medical Opinions

1. If the System Office or Technical College has reason to doubt the validity of a submitted medical certification, the employee may be required to obtain a second opinion at the expense of the System Office or Technical College. Pending receipt of the medical opinion, the employee is provisionally entitled to the benefits of the Act.

2. The System Office or Technical College may designate the health care provider to furnish the second opinion, provided the selected health care provider is not employed regularly by the System Office or Technical College.

3. If the opinions of the employee's healthcare provider and the System Office or Technical College's designated healthcare provider differ, the System Office or Technical College may require the employee to obtain certification from a third healthcare provider at the expense of the System Office or Technical College. The third opinion is binding.

4. The third health care provider must be designated or approved jointly by the System Office or Technical College and the employee. Both parties must act in good faith in reaching this determination. If the System Office or Technical College does not attempt, in good faith, to reach an agreement, the System Office or Technical College will be bound by the first certification. If the employee does not attempt, in good faith, to reach an agreement, the employee will be bound by the second certification.

5. The System Office or Technical College must provide the employee with a copy of the second and third medical opinions upon request. Requested copies must be provided within five business days unless extenuating circumstances prevent such action.

6. The System Office or Technical College must reimburse the employee for all reasonable expenses for obtaining the second and third medical opinion.

7. Unlike other medical certification forms, the System Office or Technical College may not require a second or third opinion or recertification of military caregiver-leave medical certifications.

VII. RECORD RETENTION:

Medically related documents associated with a short- or long-term leave/leave of absence (with or without pay) taken pursuant to the FMLA must be maintained in an employee's medical file for seven years after they departs from state employment. Other time and leave documents/records not kept in an employee's personnel file should be retained for three years after they departs from state employment.

Attachment: 4.5.1p.a1. Technical College System of Georgia

FAMILY AND MEDICAL LEAVE ACT
LEAVE REQUEST FORM

Employee's Name:_____ Employee ID#: _____

Work Location: _____

Dates of Leave Requested: _____ through _____

Reason for FMLA Leave (check all that apply):

- ☐ Birth of a child and to care for the newly born child or placement of a child with the employee for adoption or foster care.
- ☐ To care for an immediate family member (employee's spouse, child, or parent) with a severe health condition
- ☐ Your serious health condition
- ☐ Because of a qualifying exigency arising out of the fact that your ☐ spouse; ☐ son or daughter; ☐ or parent is on active duty or called 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; ☐ or next of kin of a covered servicemember with a serious injury or illness

☐

Type and Number of Hours of Leave Requested for The Purpose Identified Above (check all that apply, if available):

- ☐ Annual Leave: _____hours ☐Unpaid family and medical leave
- ☐ Sick Leave: _____hours ☐Personal Leave: _____hour

To receive paid leave during all or part of an FMLA leave, employees must satisfy the State Board policy governing the use of leave and applicable State Personnel Board Rules.

Is intermittent leave or a reduced work schedule requested? If yes, explain why it is needed and the leave schedule proposed:

_____

_____

Intention To Return to Work When the Leave Ends (select one):

- ☐ The employee will <u>not</u> be returning to work.
- ☐ However, the employee intends to return to work.

Authorization, Certification, and Signatures:

Who provided the information to complete the form (other than the employee)? _____

Name of the person who completed the form:_____ Date: _____

I certify that the above information is accurate and correct to the best of my knowledge. I understand that any misrepresentation concerning the above facts can result in the delivery of disciplinary action pursuant to the Positive Discipline Policy.

_____ _____

Employee's Signature Date

_____ _____

Supervisor's Signature Date

Attachment: 4.5.1p.a2. Family and Medical Leave Act

Documentation of Child's Birth, Adoption, or Foster Care

Employee:	Employee ID #:

For Birth of a Child:

Physician/ Provider:	
Address:	
Phone No.:	
Mother's Name:	
☐ This is to certify that the mother named above is expected to give birth on: _____ (date)	☐ This is to certify that the mother named above gave birth on: _____ (date)
Health Care Provider's Signature: (No Stamp, Please)	Date:

For Adoption/ Foster Care:

Foster Care of Adoption Agency/ Attorney:	
Address:	
Phone No.:	
☐ This is to certify that the child will be placed for adoption with the employee named above on: _____ (date)	☐ This is to certify that the child will be placed for foster care with the employee named above on: _____ (date)
Child Placement Agency Representative/ Attorney Signature: (No Stamp Please)	Date:

Attachment: 4.5.1p.a3.

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

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.

Attachment: 4.5.1p.a4.

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

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 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.

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.

Certification for Serious Injury or Illness of a Current Servicemember for Military Caregiver Leave under the Family and Medical Leave Act

The Family and Medical Leave Act (FMLA) provides that eligible employees may take FMLA leave to care for a covered servicemember with a serious illness or injury. The FMLA allows an employer to require an employee seeking FMLA leave for this purpose to submit a medical certification. 29 U.S.C. §§ 2613, 2614(c)(3). The employer must give the employee **at least 15 calendar days** to provide the certification. If the employee fails to provide complete and sufficient certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313.

SECTION I - EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, it asks the health care provider for the information necessary for a complete and sufficient medical certification. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. § 825.310**. **Recertifications are not allowed for FMLA leave to care for a covered servicemember. Where medical certification is requested by an employer, an employee may not be held liable for administrative delays in the issuance of military documents, despite the employee's diligent, good-faith efforts to obtain such documents.** An employer requiring an employee to submit a certification for leave to care for a covered servicemember **must** accept as sufficient certification invitational travel orders (ITOs) or invitational travel authorizations (ITAs) issued to any family member to join an injured or ill servicemember at the servicemember's bedside. An ITO or ITA is sufficient certification for the duration of time specified in the ITO or ITA.

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) This 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 and/or CURRENT SERVICEMEMBER

Please complete all Parts of Section II before having the servicemember's health care provider complete Section III. The FMLA allows an employer to require that an employee submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a serious injury or illness of a covered servicemember. If requested by your employer, your response is required to obtain or retain the benefit of FMLA-protected leave.

PART A: EMPLOYEE INFORMATION

(1) Name of the current servicemember for whom employee is requesting leave:_____

Employee Name: _____

(2) Select your relationship to the current servicemember. You are the current servicemember's:

☐ Spouse ☐ Parent ☐ Child ☐ Next of Kin

Spouse means a husband or wife as defined or recognized in the state where the individual was married, including 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 a covered servicemember 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 covered servicemember for whom the employee has assumed the obligations of a parent. No biological or legal relationship is necessary. "Next of kin" is the servicemember's nearest blood relative, other than the spouse, parent, son, or daughter, in the following order of priority: (1) a blood relative as designated in writing by the servicemember for purposes of FMLA leave, (2) blood relatives granted legal custody of the servicemember, (3) brothers and sisters, (4) grandparents, (5) aunts and uncles, and (6) first cousins.

PART B: SERVICEMEMBER INFORMATION AND CARE TO BE PROVIDED TO THE SERVICEMEMBER

(3) The servicemember (☐ is / ☐ is not) a current member of the Regular Armed Forces, the National Guard or Reserves. If yes, provide the servicemember's military branch, rank and unit currently assigned to: _____

_____

(4) The servicemember (☐ is / ☐ is not) assigned to a military medical treatment facility as an outpatient or to a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients, such as a medical hold or warrior transition unit. If yes, provide the name of the medical treatment facility or unit: _____

(5) The servicemember (☐ is / ☐ is not) on the Temporary Disability Retired List (TDRL).

(6) Briefly describe the care you will provide to the servicemember: *(Check all that apply)*

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

☐ Psychological Comfort ☐ Physical Care

☐ Transportation ☐ Other: _____

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

_____

(8) If a reduced work schedule is necessary to provide the care described, give your **best estimate** of the reduced work 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).*

SECTION III - HEALTH CARE PROVIDER

Please provide your contact information, complete all Parts of this Section fully and completely, and sign the form below. The employee listed at Section I has requested leave under the FMLA to care for a family member who is a current member of the Regular Armed Forces, the National Guard, or the Reserves who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list for a serious injury or illness. Note: For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty in the Armed Forces or that existed before the beginning of the member's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces that may render the servicemember medically unfit to perform the duties of the servicemember's office, grade, rank, or rating. "Need for care" includes both physical and psychological care. It includes situations where, for example, due to his or her serious injury or illness, the servicemember is not able to care for his or her own basic medical, hygienic, or nutritional needs or safety, or needs transportation to the doctor. It also includes providing psychological comfort and reassurance which would be beneficial to the servicemember who is receiving inpatient or home

Employee Name: _____

care. A complete and sufficient certification to support a request for FMLA leave due to a current servicemember's serious injury or illness includes written documentation confirming that the servicemember's injury or illness was incurred in the line of duty on active duty or if not, that the current servicemember's injury or illness existed before the beginning of the servicemember's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces, and that the current servicemember is undergoing treatment for such injury or illness by a health care provider listed above.

PART A: HEALTH CARE PROVIDER INFORMATION

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

Health Care Provider's business address: _____

Type of practice/Medical specialty: _____

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

Please select the type of FMLA health care provider you are:

- ☐ DOD health care provider
- ☐ VA health care provider
- ☐ DOD TRICARE network authorized private health care provider
- ☐ DOD non-network TRICARE authorized private health care provider
- ☐ Health care provider as defined in 29 C.F.R. § 825.125

PART B: MEDICAL INFORMATION

Please provide appropriate medical information of the patient as requested below. Limit your responses to the servicemember's condition for which the employee is seeking leave. If you are unable to make some of the military-related determinations contained below, you are permitted to rely upon determinations from an authorized DOD representative, such as a DOD recovery care coordinator. 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).

(1) Patient's Name: _____

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

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

(4) The servicemember's injury or illness: *(Select as appropriate)*

- ☐ Was incurred in the line of duty on active duty.
- ☐ Existed before the beginning of the servicemember's active duty and was aggravated by service in the line of duty on active duty.
- ☐ None of the above.

(5) The servicemember (☐ is / ☐ is not) undergoing medical treatment, recuperation, or therapy for this condition.
If yes, briefly describe the medical treatment, recuperation or therapy: _____

Employee Name: _____

(6) The current servicemember's medical condition is classified as: *(Select as appropriate)*

- ☐ **(VSI) Very Seriously Ill/Injured** Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately. *Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.*
- ☐ **(SI) Seriously Ill/Injured** Illness/injury is of such severity that there is cause for immediate concern, but there is no imminent danger to life. Family members are requested at bedside. *Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.*
- ☐ **OTHER Ill/Injured** A serious injury or illness that may render the servicemember medically unfit to perform the duties of the member's office, grade, rank, or rating.
- ☐ **NONE OF THE ABOVE.** *Note to Employee: If this box is checked, you may still be eligible to take leave to care for a covered family member with a "serious health condition" under 29 C.F.R. § 825.113 of the FMLA. If such leave is requested, you may be required to complete DOL FORM WH-380-F or an employer-provided form seeking the same information.*

PART C: AMOUNT OF LEAVE NEEDED

For the medical condition checked in Part B, complete all that apply. Some 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.

(7) Due to the condition, the servicemember will need care for a **continuous period of time**, including any time for treatment and recovery. Provide your **best estimate** of the beginning date _____ *(mm/dd/yyyy)* and end date _____ *(mm/dd/yyyy)* for this period of time.

(8) Due to the condition, it is medically necessary for the servicemember to attend **planned medical treatment** appointments (scheduled medical visits). Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery _____ *(e.g. 3 days/week)*

(9) Due to the condition, it is medically necessary for the servicemember to receive care on an **intermittent basis** (periodically), such as the care needed because of episodic flare-ups of the condition or assisting with the servicemember's recovery. Provide your **best estimate** of how often (frequency) and how long (the duration) the intermittent episodes will likely last.

Over the next 6 months, intermittent care is 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)*

Attachment: 4.5.1p.a6.

Certification for Military Family Leave for Qualifying Exigency under the Family and Medical Leave Act

The Family and Medical Leave Act (FMLA) provides that eligible employees may take FMLA leave for a qualifying exigency while the employee's spouse, child, or parent (the military member) is on covered active duty or has been notified of an impending call or order to covered active duty. The FMLA allows an employer to require an employee seeking FMLA leave due to a qualifying exigency to submit a certification. 29 U.S.C. §§ 2613, 2614(c)(3). The employer must give the employee **at least 15 calendar days** to provide the certification. 29 C.F.R. § 825.305(b). If the employee fails to provide complete and sufficient certification, the employee's FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at http://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, it asks the employee for the information necessary for a complete and sufficient qualifying exigency certification, which is set out at 29 C.F.R. § 825.309. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. § 825.309.**

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

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

(3) This 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 all Parts of Section II and sign the form before returning it to your employer. The FMLA allows an employer to require that you submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a qualifying exigency. If requested by your employer, your response is required to obtain the benefits and protections of the FMLA**.** 29 C.F.R. § 825.309. Failure to provide a complete and sufficient certification may result in a denial of your FMLA leave request. A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes written documentation confirming a military member's covered active duty or call to covered active duty status. **You are responsible for making sure the certification is provided to your employer within the time frame requested, which must be at least 15 calendar days.** 29 C.F.R. § 825.313.

(1) Provide the name of the military member on covered active duty or call to covered active duty status:

_____
First *Middle* *Last*

(2) Select your relationship of the military member. The military member is your:

☐ Spouse ☐ Parent ☐ Child, of any age

Spouse means a husband or wife as defined or recognized in the state where the individual was married, including 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 for a qualifying exigency related a military member who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave for a qualifying exigency related a military member for whom the employee has assumed the obligations of a parent. No legal or biological relationship is necessary.

Employee Name: _____

PART A: COVERED ACTIVE DUTY STATUS

Covered active duty or call to covered active duty in the case of a member of the Regular Armed Forces means duty during the deployment of the member with the Armed Forces to a foreign country. Covered active duty or call to covered active duty in the case of a member of the Reserve components means duty during the deployment of the member with the Armed Forces to a foreign country under a Federal call or order to active duty in support of a contingency operation pursuant to: Section 688 of Title 10 of the United States Code; Section 12301(a) of Title 10 of the United States Code; Section 12302 of Title 10 of the United States Code; Section 12304 of Title 10 of the United States Code; Section 12305 of Title 10 of the United States Code; Section 12406 of Title 10 of the United States Code; chapter 15 of Title 10 of the United States Code; or, any other provision of law during a war or during a national emergency declared by the President or Congress so long as it is in support of a contingency operation. 10 U.S.C. § 101(a)(13)(B).

An employer may require the employee to provide a copy of the military member's active duty orders or other documentation issued by the military which indicates that the military member is on covered active duty or call to covered active duty status, and the dates of the military member's covered active duty service. **This information need only be provided to the employer once, unless additional leave is needed for a different military member or different deployment**.

(3) Provide the dates of the military member's covered active duty service: _____

(4) Please check one of the following and attach the indicated written document to support that the military member is on covered active duty or call to covered active duty status:

- ☐ A copy of the military member's covered active duty orders
- ☐ Other documentation from the military indicating that the military member is on covered active duty or has been notified of an impending call to covered active duty, such as official military correspondence from the military member's chain of command
- ☐ I have previously provided my employer with sufficient written documentation confirming the military member's covered active duty or call to covered active duty status

PART B: APPROPRIATE FACTS

Under the FMLA, leave can be taken for a number of qualifying exigencies. 29 C.F.R. § 825.126(b). Complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes available written documentation which supports the need for leave such as a copy of a meeting announcement for informational briefings sponsored by the military, a document confirming the military member's Rest and Recuperation leave, or other documentation issued by the military which indicates that the military member has been granted Rest and Recuperation leave, or a document confirming an appointment with a third party (*e.g.*, a counselor or school official, or staff at a care facility, a copy of a bill for services for the handling of legal or financial affairs). Please provide appropriate facts related to the particular qualifying exigency to support the FMLA leave request, including information on the type of qualifying exigency and any available written documentation of the exigency event.

(5) Select the appropriate **Qualifying Exigency Category** and, if needed, provide additional information related to the event:

- ☐ Short notice deployment (*i.e.,* deployment within seven or fewer days of notice)
- ☐ Military events and related activities *(e.g., official ceremonies or events, or family support and assistance programs):*

  _____
- ☐ Childcare related activities for the child of the military member *(e.g., arranging for alternative childcare):*

  _____

Employee Name: _____

- ☐ Care for the military member's parent *(e.g., admitting or transferring the parent to a new care facility):*

  _____

- ☐ Financial and legal arrangements related to the deployment *(e.g., obtaining military identification cards)*
- ☐ Counseling related to the deployment (*i.e.*, counseling provided by someone other than a health care provider)
- ☐ Military member's short-term, temporary Rest and Recuperation leave (R&R) (leave for this reason is limited to 15 calendar days for each instance of R&R)
- ☐ Post deployment activities *(e.g., arrival ceremonies, or reintegration briefings and events):*_____

  _____

- ☐ Any other event that the employee and employer agree is a qualifying exigency: _____

  _____

(6) **Available written documentation** supporting this request for leave is (☐ attached / ☐ not attached / ☐ not available).

PART C: AMOUNT OF LEAVE NEEDED

Provide information concerning the amount of leave that will be needed. Several questions in this section seek a response as to the frequency or duration of the qualifying exigency leave needed. Be as specific as you can; terms such as "*unknown"* or *"indeterminate"* may not be sufficient to determine FMLA coverage.

(7) List the approximate date exigency started or will start: _____ *(mm/dd/yyyy)*

(8) Provide your best estimate of how long the exigency lasted or will last:

From _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*

(9) Due to a qualifying exigency, I need to work a **reduced schedule**. Provide 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 _____
(e.g., 5 hours/day, up to 25 hours a week)

(10) Due to a qualifying exigency, I will need to be absent from work for a **continuous period of time**. Provide your **best estimate** of the beginning and ending dates for the period of absence:

From _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*

Employee Name: _____

(11) Due to a qualifying exigency, I will need to be absent from work on an **intermittent basis** (periodically).

Provide your **best estimate** of the frequency (how often) and duration (how long) of each appointment, meeting, or leave event, including any travel time.

Over the next 6 months, absences on an **intermittent basis** are estimated to occur: _____ times per (☐ day / ☐ week / ☐ month) and are likely to last approximately _____ (☐ hours / ☐ days) per episode.

(12) My leave is due to a qualifying exigency that involves **Rest and Recuperation leave** (R & R) of the military member (leave for this reason is limited to 15 calendar days for each instance of R & R leave).

List the dates of the military member's R &R leave:

From _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*

PART D: THIRD PARTY INFORMATION

If applicable, please provide information below that may be used by your employer to verify meetings or appointments with a third party related to the qualifying exigency. Examples of meetings with third parties include: arranging for childcare or parental care, to attend non-medical counseling, to attend meetings with school, childcare or parental care providers, to make financial or legal arrangements, to act as the military member's representative before a federal, state, or local agency for purposes of obtaining, arranging or appealing military service benefits, or to attend any event sponsored by the military or military service organizations. This information may be used by your employer to verify that the information contained on this form is accurate.

Individual *(e.g., name and title)* or Entity / Organization: _____

Address: _____

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

Describe purpose of meeting: _____

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

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 THE COMPLETED FORM TO THE DEPARTMENT OF DEPARTMENT OF LABOR. RETURN FORM TO THE EMPLOYER.

Attachment: 4.5.1p.a7.

Notice of Eligibility & Rights and Responsibilities under the Family and Medical Leave Act

In general, to be eligible to take leave under the Family and Medical Leave Act (FMLA), an employee must have worked for any State of Georgia agency, department, etc. for at least 12 months and must have worked at least 1,250 hours in the 12 months preceding the leave.

Date: _____

From: _____ To: _____

On _____, we learned that you need leave *(beginning on)* _____
for one of the following reasons: *(Select as appropriate)*

- ☐ The birth of a child, or placement of a child with you for adoption or foster care, and to bond with the newborn or newly-placed child
- ☐ Your own serious health condition
- ☐ You are needed to care for your family member due to a serious health condition. Your family member is your:
  - ☐ Spouse ☐ Parent ☐ Child under age 18 ☐ Child 18 years or older and incapable of self-care because of a mental or physical disability
- ☐ A qualifying exigency arising out of the fact that your family member is on covered active duty or has been notified of an impending call or order to covered active duty status. Your family member on covered active duty is your:
  - ☐ Spouse ☐ Parent ☐ Child of any age
- ☐ You are needed to care for your family member who is a covered servicemember with a serious injury or illness. You are the servicemember's:
  - ☐ Spouse ☐ Parent ☐ Child ☐ Next of kin

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.

SECTION I – NOTICE OF ELIGIBILITY

This Notice is to inform you that you are:

- ☐ **Eligible** for FMLA leave. *(See Section II for any Additional Information Needed and Section III for information on your Rights and Responsibilities.)*
- ☐ **Not eligible** for FMLA leave because: *(Only one reason need be checked)*
  - ☐ 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: _____ towards this requirement.
    (months)
  - ☐ You have not met the FMLA's 1,250 hours of service requirement. As of the first date of requested leave, you will have worked approximately: _____towards this requirement.
    (hours of service)

Employee Name: _____

☐ You are an airline flight crew employee and you have not met the special hours of service eligibility requirements for airline flight crew employees as of the first date of requested leave (i.e., worked or been paid for at least 60% of your applicable monthly guarantee, and worked or been paid for at least 504 duty hours.)

☐ You do not work at and/or report to a site with 50 or more employees within 75-miles as of the date of your request.

If you have any questions, please contact: _____ *(Name of employer representative)*

at _____ *(Contact information).*

SECTION II – ADDITIONAL INFORMATION NEEDED

As explained in Section I, you meet the eligibility requirements for taking FMLA leave. Please review the information below to determine if additional information is needed in order for us to determine whether your absence qualifies as FMLA leave. Once we obtain any additional information specified below we will inform you, **within 5 business days**, whether your leave will be designated as FMLA leave and count towards the FMLA leave you have available. **If complete and sufficient information is not provided in a timely manner, your leave may be denied.**

(Select as appropriate)

☐ No additional information requested. If no additional information requested, go to Section III.

☐ We request that the leave be supported by a certification, as identified below.

- ☐ Health Care Provider for the Employee
- ☐ Health Care Provider for the Employee's Family Member
- ☐ Qualifying Exigency
- ☐ Serious Illness or Injury *(Military Caregiver Leave)*

Selected certification form is ☐ attached / ☐ not attached.

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

☐ We request that you provide reasonable documentation or a statement to establish the relationship between you and your family member, including *in loco parentis* relationships (as explained on page one). The information requested must be returned to us by _____ *(mm/dd/yyyy).* You may choose to provide a simple statement of the relationship or provide documentation such as a child's birth certificate, a court document, or documents regarding foster care or adoption-related activities. Official documents submitted for this purpose will be returned to you after examination.

☐ Other information needed *(e.g. documentation for military family leave*): _____.

The information requested must be returned to us by _____ *(mm/dd/yyyy).*

If you have any questions, please contact: _____ *(Name of employer representative)*

at _____ *(Contact information).*

SECTION III – NOTICE OF RIGHTS AND RESPONSIBILITIES

Part A: FMLA Leave Entitlement

You have a right under the FMLA to take unpaid, job-protected FMLA leave in a 12-month period for certain family and medical reasons, including up to **12 weeks** of unpaid leave in a 12-month period for the birth of a child or placement of a child for adoption or foster care, for leave related to your own or a family member's serious health condition, or for certain qualifying exigencies related to the deployment of a military member to covered active duty. You also have a right

Employee Name: _____

under the FMLA to take up to **26 weeks** of unpaid, job-protected FMLA leave in a single 12-month period to care for a covered servicemember with a serious injury or illness (*Military Caregiver Leave*).

The 12-month period for FMLA leave is calculated as: *(Select as appropriate)*

- ☐ The calendar year (January 1st - December 31st)
- ☐ A fixed leave year based on _____
  (e.g., a fiscal year beginning on July 1 and ending on June 30)
- ☐ The 12-month period measured forward from the date of your first FMLA leave usage.
- ☐ A "rolling" 12-month period measured backward from the date of any FMLA leave usage. *(Each time an employee takes FMLA leave, the remaining leave is the balance of the 12 weeks not used during the 12 months immediately before the FMLA leave is to start.)*

If applicable, the single 12-month period for *Military Caregiver Leave* started on _____ *(mm/dd/yyyy)*.

You (☐ are / ☐ are not) considered a key employee as defined under the FMLA. Your FMLA leave cannot be denied for this reason; however, we may not restore you to employment following FMLA leave if such restoration will cause substantial and grievous economic injury to us.

We (☐ have / ☐ have not) determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic harm to us. Additional information will be provided separately concerning your status as key employee and restoration.

Part B: Substitution of Paid Leave – When Paid Leave is Used at the Same Time as FMLA Leave

You have a right under the FMLA to request that your accrued paid leave be substituted for your FMLA leave. This means that you can request that your accrued paid leave run concurrently with some or all of your unpaid FMLA leave, provided you meet any applicable requirements of our leave policy. Concurrent leave use means the absence will count against both the designated paid leave and unpaid FMLA leave at the same time. If you do not meet the requirements for taking paid leave, you remain entitled to take available unpaid FMLA leave in the applicable 12-month period. Even if you do not request it, the FMLA allows us to require you to use your available sick, vacation, or other paid leave during your FMLA absence.

(Check all that apply)

- ☐ **Some or all of your FMLA leave will not be paid.** Any unpaid FMLA leave taken will be designated as FMLA leave and counted against the amount of FMLA leave you have available to use in the applicable 12-month period.
- ☐ **You have requested to use some or all of your available paid leave** *(e.g., sick, vacation, PTO)* during your FMLA leave. Any paid leave taken for this reason will also be designated as FMLA leave and counted against the amount of FMLA leave you have available to use in the applicable 12-month period.
- ☐ **We are requiring you to use some or all of your available paid leave** *(e.g., sick, vacation, PTO)* during your FMLA leave. Any paid leave taken for this reason will also be designated as FMLA leave and counted against the amount of FMLA leave you have available to use in the applicable 12-month period.
- ☐ **Other:** *(e.g., short- or long-term disability, workers' compensation, state medical leave law, etc.)*_____
  Any time taken for this reason will also be designated as FMLA leave and counted against the amount of FMLA leave you have available to use in the applicable 12-month period.

The applicable conditions for use of paid leave include: _____.

For more information about conditions applicable to sick/vacation/other paid leave usage please refer to _____

_____ available at: _____.

Employee Name: _____

Part C: Maintain Health Benefits

Your health benefits must be maintained during any period of FMLA leave under the same conditions as if you continued to work. During any paid portion of FMLA leave, your share of any premiums will be paid by the method normally used during any paid leave. During any unpaid portion of FMLA leave, you must continue to make any normal contributions to the cost of the health insurance premiums. To make arrangements to continue to make your share of the premium payments on your health insurance while you are on any unpaid FMLA leave, contact _____ at _____.

You have a minimum grace period of (☐ 30-days or ☐ _____ *indicate longer period, if applicable)* in which to make premium payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse, or, at our option, we may pay your share of the premiums during FMLA leave, and recover these payments from you upon your return to work.

You may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave if you do not return to work following **unpaid** FMLA leave for a reason other than: the continuation, recurrence, or onset of your or your family member's serious health condition which would entitle you to FMLA leave; or the continuation, recurrence, or onset of a covered servicemember' s serious injury or illness which would entitle you to FMLA leave; or other circumstances beyond your control.

Part D: Other Employee Benefits

Upon your return from FMLA leave, your other employee benefits, such as pensions or life insurance, must be resumed in the same manner and at the same levels as provided when your FMLA leave began. To make arrangements to continue your employee benefits while you are on FMLA leave, contact _____ at _____.

Part E: Return-to-Work Requirements

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. An equivalent position is one that is virtually identical to your former position in terms of pay, benefits, and working conditions. At the end of your FMLA leave, all benefits must also be resumed in the same manner and at the same level provided when the leave began. You do not have return-to-work rights under the FMLA if you need leave beyond the amount of FMLA leave you have available to use.

Part F: Other Requirements While on FMLA Leave

While on leave you (☐ will be / ☐ will not be) required to furnish us with periodic reports of your status and intent to return to work every _____.

(Indicate interval of periodic reports, as appropriate for the FMLA leave situation).

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

Attachment: 4.5.1p.a8.
Designation Notice
under the Family and Medical Leave Act
For Completion by the System Office or Technical College

Leave covered under the Family and Medical Leave Act (FMLA) must be designated as FMLA-protected and the employer must inform the employee of the amount of leave that will be counted against the employee's FMLA leave entitlement. In order to determine whether leave is covered under the FMLA, the System Office or Technical College may request that the leave be supported by a certification. If the certification is incomplete or insufficient, the employer must state in writing what additional information is necessary to make the certification complete and sufficient.

SECTION I - EMPLOYER

The employer is responsible in **all** circumstances for designating leave as FMLA-qualifying and giving notice to the employee. Once an eligible employee communicates a need to take leave for an FMLA-qualifying reason, an employer may not delay designating such leave as FMLA leave, and neither the employee nor the employer may decline FMLA protection for that leave.

Date: _____

From: _____ To: _____

On _____we received your most recent information to support your need for leave due to: *(Select as appropriate)*

- ☐ The birth of a child, or placement of a child with you for adoption or foster care, and to bond with the newborn or newly-placed child
- ☐ Your own serious health condition
- ☐ The serious health condition of your spouse, child, or parent
- ☐ A qualifying exigency arising out of the fact that your spouse, child, or parent is on covered active duty or has been notified of an impending call or order to covered active duty with the Armed Forces
- ☐ A serious injury or illness of a covered servicemember where you are the servicemember's spouse, child, parent, or next of kin *(Military Caregiver Leave)*

We have reviewed information related to your need for leave under the FMLA along with any supporting documentation provided and decided that your FMLA leave request is: *(Select as appropriate)*

☐ **Approved.** All leave taken for this reason will be designated as FMLA leave. Go to Section III for more information.

☐ **Not Approved**: *(Select as appropriate)*
- ☐ The FMLA does not apply to your leave request.
- ☐ As of the date the leave is to start, you do not have any FMLA leave available to use.
- ☐ Other _____

☐ **Additional information** is needed to determine if your leave request qualifies as FMLA leave. *(Go to Section II for the specific information needed. If your FMLA leave request is approved and no additional information is needed, go to Section III.)*

SECTION II – ADDITIONAL INFORMATION NEEDED

We need additional information to determine whether your leave request qualifies under the FMLA. Once we obtain the additional information requested, we will inform you **within 5 business days** if your leave will or will not be designated as FMLA leave and count towards the amount of FMLA leave you have available. **Failure to provide the additional information as requested may result in a denial of your FMLA leave request**.

If you have any questions, please contact: _____at_____
(Name of employer FMLA representative) *(Contact information)*

Incomplete or Insufficient Certification
The certification you have provided is incomplete and/or insufficient to determine whether the FMLA applies to your leave request. *(Select as applicable)*

☐ The certification provided is incomplete and we are unable to determine whether the FMLA applies to your leave request. *"Incomplete" means one or more of the applicable entries on the certification have not been completed.*

Employee Name: _____

☐ The certification provided is insufficient to determine whether the FMLA applies to your leave request. *"Insufficient" means the information provided is vague, unclear, ambiguous or non-responsive.*

Specify the information needed to make the certification complete and/or sufficient: _____

You must provide the requested information no later than *(provide at least 7 calendar days)* _____ *(mm/dd/yyyy),* unless it is not practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied.

Second and Third Opinions

☐ We request that you obtain a (☐ second / ☐ third opinion) medical certification at our expense, and we will provide further details at a later time. *Note: The employee or the employee's family member may be requested to authorize the health care provider to release information pertaining only to the serious health condition at issue.*

SECTION III – FMLA LEAVE APPROVED

As explained in Section I, your FMLA leave request is approved. All leave taken for this reason will be designated as FMLA leave and will count against the amount of FMLA leave you have available to use in the applicable 12-month period. The FMLA requires that you notify us as soon as practicable if the dates of scheduled leave change, 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 the total **amount of FMLA leave** you have available to use in the applicable 12-month period: *(Select as appropriate)*

☐ Provided there is no change from your **anticipated FMLA 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).

Please be advised: *(check all that apply)*

☐ **Some or all of your FMLA leave will not be paid.** Any unpaid FMLA leave taken will be designated as FMLA leave and counted against the amount of FMLA leave you have available to use in the applicable 12-month period.

☐ **Based on your request, some or all of your available paid leave** *(e.g., sick, vacation, PTO)* **will be used during your FMLA leave.** Any paid leave taken for this reason will also be designated as FMLA leave and counted against the amount of FMLA leave you have available to use in the applicable 12-month period.

☐ **We are requiring you to use some or all of your available paid leave** *(e.g., sick, vacation, PTO)* **during your FMLA leave.** Any paid leave taken for this reason will also be designated as FMLA leave and counted against the amount of FMLA leave you have available to use in the applicable 12-month period.

☐ **Other:** _____
(e.g., Short- or long-term disability, workers' compensation, state medical leave law, etc.) Any time taken for this reason will also be designated as FMLA leave and counted against the amount of FMLA leave you have available to use in the applicable 12-month period.

Return-to-work requirements. To be restored to work after taking FMLA leave, you (☐ will be / ☐ will not be) required to provide a certification from your health care provider (fitness-for-duty certification) that you are able to resume work. This request for a fitness-for-duty certification is *only* with regard to the particular serious health condition that caused your need for FMLA leave. **If such certification is not timely received, your return to work may be delayed until the 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 the essential job functions.

Attachment: 4.5.1p.a9.

Your Employee Rights Under the Family and Medical Leave Act

What is FMLA leave?

The Family and Medical Leave Act (FMLA) is a federal law that provides eligible employees with **job-protected leave** for qualifying family and medical reasons. The U.S. Department of Labor's Wage and Hour Division (WHD) enforces the FMLA for most employees.

Eligible employees can take **up to 12 workweeks** of FMLA leave in a 12-month period for:

- The birth, adoption or foster placement of a child with you,
- Your serious mental or physical health condition that makes you unable to work,
- To care for your spouse, child or parent with a serious mental or physical health condition, and
- Certain qualifying reasons related to the foreign deployment of your spouse, child or parent who is a military servicemember.

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

You have the right to use FMLA leave in **one block of time**. When it is medically necessary or otherwise permitted, you may take FMLA leave **intermittently in separate blocks of time, or on a reduced schedule** by working less hours each day or week. Read Fact Sheet #28M(c) for more information.

FMLA leave is **not paid leave**, but you may choose, or be required by your employer, to use any employer-provided paid leave if your employer's paid leave policy covers the reason for which you need FMLA leave.

Am I eligible to take FMLA leave?

You are an **eligible employee** if **all** of the following apply:

- You work for a covered employer,
- You have worked for your employer at least 12 months,
- You have at least 1,250 hours of service for your employer during the 12 months before your leave, and
- Your employer has at least 50 employees within 75 miles of your work location.

Airline flight crew employees have different "hours of service" requirements.

You work for a **covered employer** if **one** of the following applies:

- You work for a private employer that had at least 50 employees during at least 20 workweeks in the current or previous calendar year,
- You work for an elementary or public or private secondary school, or
- You work for a public agency, such as a local, state or federal government agency. Most federal employees are covered by Title II of the FMLA, administered by the Office of Personnel Management.

How do I request FMLA leave?

Generally, **to request FMLA leave you must**:

- Follow your employer's normal policies for requesting leave,
- Give notice at least 30 days before your need for FMLA leave, or
- If advance notice is not possible, give notice as soon as possible.

You **do not have to share a medical diagnosis** but must provide enough information to your employer so they can determine whether the leave qualifies for FMLA protection. You **must also inform your employer if FMLA leave was previously taken** or approved for the same reason when requesting additional leave.

Your **employer may request certification** from a health care provider to verify medical leave and may request certification of a qualifying exigency.

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.

State employees may be subject to certain limitations in pursuit of direct lawsuits regarding leave for their own serious health conditions. Most federal and certain congressional employees are also covered by the law but are subject to the jurisdiction of the U.S. Office of Personnel Management or Congress.

What does my employer need to do?

If you are eligible for FMLA leave, your **employer must**:

- Allow you to take job-protected time off work for a qualifying reason,
- Continue your group health plan coverage while you are on leave on the same basis as if you had not taken leave, and
- Allow you to return to the same job, or a virtually identical job with the same pay, benefits and other working conditions, including shift and location, at the end of your leave.

Your **employer cannot interfere with your FMLA rights** or threaten or punish you for exercising your rights under the law. For example, your employer cannot retaliate against you for requesting FMLA leave or cooperating with a WHD investigation.

After becoming aware that your need for leave is for a reason that may qualify under the FMLA, your **employer must confirm whether you are eligible** or not eligible for FMLA leave. If your employer determines that you are eligible, your **employer must notify you in writing**:

- About your FMLA rights and responsibilities, and
- How much of your requested leave, if any, will be FMLA-protected leave.

Where can I find more information?

Call **1-866-487-9243** or visit **dol.gov/fmla** to learn more.

If you believe your rights under the FMLA have been violated, you may file a complaint with WHD or file a private lawsuit against your employer in court. **Scan the QR code to learn about our WHD complaint process**.

WAGE AND HOUR DIVISION
UNITED STATES DEPARTMENT OF LABOR

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