REQUEST FOR FAMILY & MEDICAL LEAVE

Section 1: PERSONAL INFORMATION **(Employee completes Sections 1 and 2 and returns completed form to Supervisor/Manager)**		
Last Name:	First Name:	Employee No.
Home Address:	Phone (Work):	Department:
Date Submitted:	Phone (Home):	Job Title:
Signature:	E-Mail:	Hire Date:

Please review the following statement. For any questions call Employee Health at 793-8005.
If circumstances of your leave change and you're unable to return to work on expected date you will be required to provide EH and your department director/supervisor a status update as soon as you are made aware of the change. If this FMLA is for your illness, you will be required to provide EH with a work status with or without restrictions from your Healthcare Provider before being restored to employment and scheduled to work. If you agree to the terms and conditions listed above please sign:

____

Signature

Section 2: EMPLOYEE: Check the type of leave, supply the required information in writing, and provide attachments as indicated.

Family and Medical Leaves (required medical certifications must be returned within 15 days of the date on this form)

	Leave	Required
☐	Employee Illness	Certificate of Health Care Provider (Form 1002-E)
☐	Child/Parent/Spouse Illness	Certificate of Health Care Provider for Family Member's Illness/Injury (Form 1002-f)
☐	Maternity	Certificate of Health Care Provider (Form 1002-E)
☐	Paternity	Certificate of Health Care Provider (Form 1002-f) (Must be taken within one year of birth)
☐	Adoption/Placement of Foster Child	Letter of Placement (Must be taken within one year of Placement)
☐	Military Caregiver	Certification for Serious Illness or Injury of Covered Service Member (DOL WH-385-V)
☐	Military Exigency	Certification of Qualifying Exigency (DOL WH-384)

Personal Leaves - See Human Resources

I request that my leave begin on _______________ and end on ______________. (If necessary, give approximate dates.)

Section 3: SUPERVISOR/MANAGER/DEPARTMENT: Complete this section.

Name (Print):		Email:
Signature:	Phone:	Date:

Names(s) of any others to receive communication (Timekeeper/Manager/Supervisor):

Time Keeper Notified: ☐ YES ☐ NO Hours Worked in the Past 12 Months (Minimum 1250 worked): ___________

Section 4: ELIGIBILITY – EMPLOYEE HEALTH & WELLNESS REPRESENTATIVE: Complete this section.

Has Employee had absences counted towards FMLA entitlement in the past 12 months? ☐ NO ☐ YES

If yes, indicate dates/hours used: From ______________________ to _______________________
FMLA Benefit Hours Utilized to date: ______ FMLA Benefit Hours Remaining: ______ ☐ELIGIBLE ☐ NOT ELIGIBLE
If NOT eligible, list reason:

____ ____________________________________

Signature, Employee Health & Wellness Representative Date

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

U.S. Department of Labor
Wage and Hour Division

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

OMB Control Number: 1235-0003
Expires: 8/31/2021

SECTION I: For Completion by the EMPLOYER

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

Employer name and contact: ____

Employee's job title: _____________________________ Regular work schedule: _______________________

Employee's essential job functions: ____

____

Check if job description is attached: _____

SECTION II: For Completion by the EMPLOYEE

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

Your name: ____
First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. 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). Please be sure to sign the form on the last page.

Provider's name and business address: ____

Type of practice / Medical specialty: ____

Telephone: (________)_____________________________ Fax:(_________)______________________________

PART A: MEDICAL FACTS

1. Approximate date condition commenced: ____

   Probable duration of condition: ____

   Mark below as applicable:
   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
   ___No ___Yes. If so, dates of admission:

   ____

   Date(s) you treated the patient for condition:

   ____

   Will the patient need to have treatment visits at least twice per year due to the condition? ___No ___ Yes.

   Was medication, other than over-the-counter medication, prescribed? ___No ___Yes.

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
   ____No ____Yes. If so, state the nature of such treatments and expected duration of treatment:

   ____

2. Is the medical condition pregnancy? ___No ___Yes. If so, expected delivery date: ____________________

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

   Is the employee unable to perform any of his/her job functions due to the condition: ____ No ____ Yes.

   If so, identify the job functions the employee is unable to perform:

   ____

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

   ____

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   ____

   ____

   ____

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PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___No ___Yes.

   If so, estimate the beginning and ending dates for the period of incapacity: ________________________

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ___No ___Yes.

   If so, are the treatments or the reduced number of hours of work medically necessary?
   ___No ___Yes.

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

   ____

   Estimate the part-time or reduced work schedule the employee needs, if any:

   __________ hour(s) per day; __________ days per week from _____________ through _____________

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ____No ____Yes.

   Is it medically necessary for the employee to be absent from work during the flare-ups?
   ____ No ____Yes. If so, explain:

   ____

   ____

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

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

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

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

____

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____

____

____

CONTINUED ON NEXT PAGE

Signature of Health Care Provider **Date**

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

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