

**FAMILY  
AND  
MEDICAL LEAVE ACT**

**CITY OF ASHLAND**

**Implementation Date: 1993  
Revised 2/21/1995  
Revised 8/7/2003  
Revised 11/2006  
Revised 10/2012**

## EMPLOYER COVERAGE

The FMLA applies to all public agencies, including state, local and federal employers, local education agencies (schools), and private-sector employers who employed 50 or more employees in 20 or more workweeks in the current or preceding calendar year, including joint employers and successors of covered employers.

## EMPLOYEE ELIGIBILITY

To be eligible for FMLA benefits, an employee **must**:

- work for a covered employer;
- have worked for the employer for a total of 12 months;
- have worked at least 1,250 hours over the previous 12 months; and
- work at a location in the United States or in any territory or possession of the United States where at least 50 employees are employed by the employer within 75 miles.

While the 12 months of employment need not be consecutive, employment periods prior to a break in service of seven years or more need not be counted unless the break is occasioned by the employee's fulfillment of his or her National Guard or Reserve military obligation (as protected under the Uniformed Services Employment and Reemployment Rights Act (USERRA)), or a written agreement, including a collective bargaining agreement, exists concerning the employer's intention to rehire the employee after the break in service.

## LEAVE ENTITLEMENT

A covered employer must grant an eligible employee up to a total of **12 workweeks** of **unpaid**, job-protected leave during any 12-month period for one or more of the following reasons:

- for the birth and care of a newborn child of the employee;
- for placement with the employee of a son or daughter for adoption or foster care;
- to care for a spouse, son, daughter, or parent with a serious health condition;
- to take medical leave when the employee is unable to work because of a serious health condition; **or**
- for qualifying exigencies arising out of the fact that the employee's spouse, son, daughter, or parent is on active duty or called to active duty status as a member of the National Guard or Reserves in support of a contingency operation. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal

arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

A covered employer also must grant an eligible employee who is a spouse, son, daughter, parent, or next of kin of a current member of the Armed Forces, including a member of the National Guard or Reserves, with a serious injury or illness up to a total of **26 workweeks** of **unpaid** leave during a single 12-month period to care for the servicemember.

Spouses employed by the same employer are limited in the **amount of** family leave they may take for the birth and care of a newborn child, placement of a child for adoption or foster care, or to care for a parent who has a serious health condition to a combined total of 12 workweeks (or 26 workweeks if leave to care for a covered servicemember with a serious injury or illness is also used). Leave for birth and care, or placement for adoption or foster care, must conclude within 12 months of the birth or placement.

Under some circumstances, employees may take FMLA leave intermittently—taking leave in separate blocks of time for a single qualifying reason—or on a reduced leave schedule—reducing the employee’s usual weekly or daily work schedule. When leave is needed for planned medical treatment, the employee must make a reasonable effort to schedule treatment so as not to unduly disrupt the employer’s operation. Use of intermittent leave is not a right if FMLA leave is for birth and care, or placement for adoption or foster care.

**“Serious health condition”** means an illness, injury, impairment, or physical or mental condition that involves either:

- inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical-care facility including any period of incapacity (i.e., inability to work, attend school, or perform other regular daily activities) or subsequent treatment in connection with such inpatient care; **or**
- continuing treatment by a health care provider which includes:
  - (1) A period of incapacity lasting more than three consecutive, full calendar days, and any subsequent treatment of period of incapacity relating to the same condition that also includes:
    - Treatment two or more times by or under the supervision of a health care provider (i.e., in-person visits, the first within 7 days and both within 30 days of the first day of incapacity); or
    - One treatment by a health care provider (i.e., an in-person visit within 7 days of the first day of incapacity) with a continuing regimen of treatment (e.g., prescription medication, physical therapy); or
  - (2) Any period of incapacity related to pregnancy or for prenatal care. A visit to the health care provider is not necessary for each absence; **or**

- (3) Any period of incapacity or treatment for a chronic serious health condition which continues over an extended period of times, requires periodic visits (at least twice a year) to a health care provider, and may involve occasional episodes of incapacity. A visit to a health care provider is not necessary for each absence; **or**
- (4) A period of incapacity that is permanent or long-term due to a condition for which treatment may not be effective. Only supervision by a health care provider is required, rather than active treatment, **or**
- (5) Any absences to receive multiple treatments for restorative surgery or for a condition that would likely result in a period of incapacity of more than three days if not treated.

The annual 12-month period shall commence and be measured forward from the date the employee first uses the leave set forth above.

### **SUBSTITUTION OF PAID LEAVE FOR UNPAID LEAVE**

The City of Ashland requires employees to exhaust accrued paid leave for all or part of the FMLA period. Employees must comply with normal paid leave policies. Use of sick leave may be restricted according to applicable City policy (i.e., the serious health condition of a parent is a qualifying reason for FMLA leave, but may not necessarily qualify for use of sick leave).

No employee shall lose seniority during the period of paid time off which is attributable to FMLA. Unpaid time off shall not accrue seniority.

Benefits accrual, such as vacation, sick leave and holiday benefits will continue according to City guidelines during the paid period attributed to approved FMLA leave. Unpaid time off shall not accrue benefits.

In the event that the employee has paid benefits to apply toward FMLA leave, certification of an employee's serious health condition will be required at the time those benefits are exhausted.

### **LEAVE FOR THE BIRTH OF A CHILD**

The City of Ashland will limit use of sick leave benefits during leave for the birth of a child as follows:

For the birth mother:

- (1) All time under doctor's care, generally 4–6 weeks, may be covered by accrued sick leave.

- (2) Additional time away may be covered by other accrued benefits or unpaid leave up to the full 12 weeks.

For the primary care giver:

- (1) Absence due to a healthy birth may be covered by sick leave for the time of hospitalization plus 2 calendar days after returning home. Additional time away may be covered by the use of other accrued benefits or if exhausted, by unpaid leave up to the full 12 weeks of FMLA.
- (2) In the event of complications of pregnancy or birth, all days verified to be necessary use of sick leave by the doctor of record may be covered by sick leave. The general standard will be to cover the days in the hospital plus 5 additional calendar days by sick leave in the case of a caesarian birth. Additional time away may be covered by the use of other accrued benefits if exhausted, by unpaid leave up to the full 12 weeks of FMLA.

Leave for the birth of a child or for the placement of a child in foster care may not be taken on an intermittent or reduced schedule.

## **MAINTENANCE OF HEALTH BENEFITS**

A covered employer is required to maintain group health insurance coverage for an employee on FMLA leave whenever such insurance was provided before the leave was taken and on the same terms as if the employee had continued to work. If applicable, arrangements will need to be made for employees to pay their share of health insurance premiums while on leave. In some instances, the employers may recover premiums if paid to maintain health coverage for an employee who fails to return to work from FMLA leave.

Employees in unpaid leave status are obligated to pay the employee share of health care premiums on the regular pay day.

## **JOB RESTORATION**

Upon return from FMLA leave, an employee must be restored to the employee's original job, or to an equivalent job with equivalent pay, benefits, and other terms and conditions of employment. An employee's use of FMLA leave cannot result in the loss of any employment benefit that the employee earned or was entitled to before using FMLA leave, nor be counted against the employee under a "no fault" attendance policy. If a bonus or other payment, however, is based on the achievement of a specified goal such as hours worked, products sold, or perfect attendance, and the employee has not met the goal due to FMLA leave, payment may be denied unless it is paid to an employee on equivalent leave status for a reason that does not qualify as FMLA leave.

An employee has no greater right to restoration or to other benefits and conditions of employment than if the employee had been continuously employed.

## **NOTICE AND CERTIFICATION**

### Employee Notice

Employees seeking to use FMLA leave are required to provide 30-day advance notice of the need to take FMLA leave when the need is foreseeable and such notice is practicable. If leave is foreseeable less than 30 days in advance, the employee must provide notice as soon as practicable—generally, either the same or next business day. When the need for leave is not foreseeable, the employee must provide notice to the employer as soon as practicable under the facts and circumstances of the particular case. Absent unusual circumstances, employees must comply with the employer's usual and customary notice and procedural requirements for requesting leave.

Employees must provide sufficient information for an employer reasonably to determine whether the FMLA may apply to the leave request. Depending on the situation, such information may include that the employee is incapacitated due to pregnancy, has been hospitalized overnight, is unable to perform the function of the job, and/or that the employee or employee's qualifying family member is under the continuing care of a health care provider.

When an employee seeks leave for a FMLA-qualifying reason for the first time, the employee need not expressly assert FMLA rights or even mention the FMLA. When an employee seeks leave, however, due to a FMLA-qualifying reason for which the employer has previously provided the employee FMLA-protected leave, the employee must specifically reference either the qualifying reason for leave or the need for FMLA leave.

### Employer Notice

Covered employers must post a notice approved by the Secretary of Labor explaining rights and responsibilities under the FMLA. An employer that willfully violates this posting requirement may be subject to a civil money penalty of up to \$110 for each separate offense. Additionally, employers must either include this general notice in employee handbooks or other written guidance to employees concerning benefits, or must distribute a copy of the notice to each new employee upon hiring.

When an employee requests FMLA leave or the employer acquires knowledge that leave may be for a FMLA purpose, the employer must notify the employee of his or her eligibility to take leave, and inform the employee of his/her rights and responsibilities under the FMLA. When the employer has enough information to determine that leave is being taken for a FMLA-qualifying reason, the employer must notify the employee that

the leave is designated and will be counted as FMLA leave. Forms WH-381 and WH-382 will be used to meet these notification requirements.

### Certification

Employers may require that an employee's request for leave due to a serious health condition affecting the employee or a covered family member be supported by a certification from a health care provider. An employer may require second or third medical opinions (at the employers' expense) and periodic recertification of a serious health condition. An employer may use a health care provider, a human resource professional, a leave administrator, or a management official—but not the employee's direct supervisor—to authenticate or clarify a medical certification of a serious health condition. An employer may have a uniformly-applied policy requiring employees returning from leave for their own serious health condition to submit a certification that they are able to resume work. If reasonable safety concerns exist, an employer may, under certain circumstances, require such a certification for employees returning from intermittent FMLA leave.

### **RETURN TO WORK**

The City of Ashland requires a "fitness for work" medical certification prior to reinstatement to the employee's regularly held position when the leave was granted due to personal serious health condition.

A two-week advanced notice of the date the employee intends to return to work is required.

When the 12-week FMLA leave period is exhausted, in the event that the FMLA leave is greater than the employee's accrued benefits, the employee will be reinstated to the same position, if it is available, or to an equivalent position for which the employee is qualified.

If an employee fails to report to work promptly at the end of the approved leave period, the City will assume that the employee has resigned.

An employee who is physically unable to return to work following injury or illness, whether work related or personal, and is unable to perform the functions of his/her position for a period of not less than ninety (90) days and is unable to provide a reasonable point in time at which he/she may be able to return to full duty, may be subject to Involuntary Disability Separation.

An Involuntary Disability Separation Hearing will be scheduled, at which time the employee may present evidence, or may be given an agreed upon period of time, but not greater than 14 days, to submit evidence that he/she is fit for duty and able to perform all functions of his/her position.

The City may request a review of all documentation or a Fitness for Duty Evaluation by a physician of the City's choice both related to physical and mental Fitness for Duty.

Failure to receive full release to duty by a reputable physician in a related field of expertise may result in Involuntary Disability Separation.

The employee will be eligible to receive payment of all accrued benefits per his/her bargaining unit contract or pay ordinance.

With the approval of the Appointing Authority, the employee may receive an additional form of severance to be determined by the circumstances of the event.

If an employee does not return to work after FMLA leave, that employee is eligible for COBRA coverage on the first day following FMLA.

## **UNLAWFUL ACTS**

It is unlawful for any employer to interfere with, restrain, or deny the exercise of any right provided by the FMLA. It is also unlawful for an employer to discharge or discriminate against any individual for opposing any practice, or because of involvement in any proceeding, related to the FMLA.

## **ENFORCEMENT**

The Wage and Hour Division investigates complaints. If violations cannot be satisfactorily resolved, the U.S. Department of Labor may bring action in court to compel compliance. Individuals may also be able to bring a private civil action against an employer for violations.

Questions may be directed to:

Director of Human Resources & Safety  
206 Claremont Avenue  
Ashland, OH 44805  
(419) 289-3426

Sample FMLA forms:

- WH-380-E Certification of Health Care Provider for Employee's Serious Health Condition
- WH-380-F Certification of Health Care Provider for Family Member's Serious Health Condition
- WH-381 Notice of Eligibility and Rights & Responsibilities (used by Human Resources to initially notify employees regarding FMLA)
- WH-382 Designation Notice (used by Human Resources to notify employees of FMLA designation)
- WH-384 Certification of Qualifying Exigency for Military Family Leave
- WH-385 Certification for Serious Injury or Illness of Covered Servicemember for Military Family Leave

Forms for use are available at the Human Resources office or at [www.ashland-ohio.com](http://www.ashland-ohio.com)



OMB Control Number: 1215-0181 Expires: 12/31/2011

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.

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.

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.

Provider's name and business address: \_\_\_\_\_

Type of practice / Medical specialty: \_\_\_\_\_

Telephone: ( ) Fax: ( )

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

Blank lines for additional information.

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 on 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): \_\_\_\_\_

Blank lines for medical facts.

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.



SECTION I: For Completion by the EMPLOYER

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

Employer name and contact: \_\_\_\_\_

SECTION II: For Completion by the EMPLOYEE

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

Your name: \_\_\_\_\_ First Middle Last

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

Relationship of family member to you: \_\_\_\_\_

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

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

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

SECTION III: For Completion by the HEALTH CARE PROVIDER

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

Provider's name and business address: \_\_\_\_\_

Type of practice / Medical specialty: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

PART A: MEDICAL FACTS

1. Approximate date condition commenced: \_\_\_\_\_

Probable duration of condition: \_\_\_\_\_

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? \_\_\_ No \_\_\_ Yes. If so, dates of admission: \_\_\_\_\_

Date(s) you treated the patient for condition: \_\_\_\_\_

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

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

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? \_\_\_ No \_\_\_ Yes. If so, state the nature of such treatments and expected duration of treatment: \_\_\_\_\_

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

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

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

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

Estimate the beginning and ending dates for the period of incapacity: \_\_\_\_\_

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

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

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

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

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

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

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

\_\_\_\_\_ hour(s) per day; \_\_\_\_\_ days per week from \_\_\_\_\_ through \_\_\_\_\_

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

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

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

Frequency: \_\_\_\_\_ times per \_\_\_\_\_ week(s) \_\_\_\_\_ month(s)

Duration: \_\_\_\_\_ hours or \_\_\_\_\_ day(s) per episode

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

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

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER

Signature of Health Care Provider \_\_\_\_\_ Date \_\_\_\_\_

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20310. DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.

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

U.S. Department of Labor Wage and Hour Division



OMB Control Number: 1235-0003 Expires: 2/28/2015

In general, to be eligible an employee must have worked for an employer for at least 12 months, have worked at least 1,250 hours in the 12 months preceding the leave, and work at a site with at least 50 employees within 75 miles...

Part A - NOTICE OF ELIGIBILITY

TO: Employee

FROM: Employer Representative

DATE:

On \_\_\_\_\_, you informed us that you needed leave beginning on \_\_\_\_\_ for:
- The birth of a child, or placement of a child with you for adoption or foster care;
- Your own serious health condition;
- Because you are needed to care for your spouse, child, parent due to his/her serious health condition.

This Notice is to inform you that you:

- Are eligible for FMLA leave (See Part B below for Rights and Responsibilities)
Are not eligible for FMLA leave, because (only one reason need be checked, although you may not be eligible for other reasons):
- You have not met the FMLA's 12-month length of service requirement.
- You have not met the FMLA's 1,250-hours-worked requirement.
- You do not work and/or report to a site with 50 or more employees within 75-miles.

If you have any questions, contact \_\_\_\_\_ or view the FMLA poster located in \_\_\_\_\_.

Part B - RIGHTS AND RESPONSIBILITIES FOR TAKING FMLA LEAVE

As explained in Part A, you meet the eligibility requirements for taking FMLA leave and still have FMLA leave available in the applicable 12-month period. However, in order for us to determine whether your absence qualifies as FMLA leave, you must return the following information to us by \_\_\_\_\_.

- Sufficient certification to support your request for FMLA leave. A certification form that sets forth the information necessary to support your request is/ is not enclosed.
Sufficient documentation to establish the required relationship between you and your family member.
Other information needed:
No additional information requested

If your leave does qualify as FMLA leave you will have the following responsibilities while on FMLA leave (only checked blanks apply):

- Contact \_\_\_\_\_ at \_\_\_\_\_ to make arrangements to continue to make your share of the premium payments on your health insurance to maintain health benefits while you are on leave.
You will be required to use your available paid sick, vacation, and/or other leave during your FMLA absence.
Due to your status within the company, you are considered a "key employee" as defined in the FMLA.
While on leave you will be required to furnish us with periodic reports of your status and intent to return to work every \_\_\_\_\_.

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

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

- You have a right under the FMLA for up to 12 weeks of unpaid leave in a 12-month period calculated as:
- the calendar year (January - December);
- a fixed leave year based on \_\_\_\_\_;
- 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.
You have a right under the FMLA for up to 26 weeks of unpaid leave in a single 12-month period to care for a covered servicemember with a serious injury or illness.
Your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work.

Once we obtain the information from you as specified above, we will inform you, within 5 business days, whether your leave will be designated as FMLA leave and count towards your FMLA leave entitlement. If you have any questions, please do not hesitate to contact: \_\_\_\_\_

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT
It is mandatory for employers to provide employees with notices of their eligibility for FMLA protection and their rights and responsibilities.
Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

WH-381 Notice of Eligibility and Rights & Responsibilities

Designation Notice (Family and Medical Leave Act)

U.S. Department of Labor Wage and Hour Division



OMB Control Number: 1235-0003 Expires: 2/28/2015

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.

TO: \_\_\_\_\_
Date: \_\_\_\_\_

We have reviewed your request for leave under the FMLA and any supporting documentation that you have provided. We received your most recent information on \_\_\_\_\_ and decided:
Your FMLA leave request is approved. All leave taken for this reason will be designated as FMLA leave.

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

- Provided there is no deviation from your anticipated leave schedule, the following number of hours, days, or weeks will be counted against your leave entitlement:
Because the leave you will need will be unscheduled, it is not possible to provide the hours, days, or weeks that will be counted against your FMLA entitlement at this time.

Please be advised (check if applicable):

- You have requested to use paid leave during your FMLA leave. Any paid leave taken for this reason will count against your FMLA leave entitlement.
We are requiring you to substitute or use paid leave during your FMLA leave.
You will be required to present a fitness-for-duty certificate to be restored to employment. If such certification is not timely received, your return to work may be delayed until certification is provided.

Additional information is needed to determine if your FMLA leave request can be approved:
The certification you have provided is not complete and sufficient to determine whether the FMLA applies to your leave request. You must provide the following information no later than \_\_\_\_\_ unless it is not practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied.

- We are exercising our right to have you obtain a second or third opinion medical certification at our expense, and we will provide further details at a later time.
Your FMLA Leave request is Not Approved.
The FMLA does not apply to your leave request.
You have exhausted your FMLA leave entitlement in the applicable 12-month period.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT
It is mandatory for employers to inform employees in writing whether leave requested under the FMLA has been determined to be covered under the FMLA.
Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

WH-382 Designation Notice

Certification of Qualifying Exigency  
For Military Family Leave  
(Family and Medical Leave Act)

U.S. Department of Labor  
Wage and Hour Division



OMB Control Number: 1235-0003  
Form WH-384 January 2009

**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 leave due to a qualifying exigency to submit a certification. Please complete Section I before giving this form to your employee. Your response is voluntary, and 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. § 825.309.

Employer name: \_\_\_\_\_

Contact Information: \_\_\_\_\_

**SECTION II: For Completion by the EMPLOYEE**

**INSTRUCTIONS to the EMPLOYEE:** Please complete Section II fully and completely. The FMLA permits 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. Several questions in this section seek a response as to the frequency or duration of the qualifying exigency. Be as specific as you can; terms such as "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Your response is required to obtain a benefit. 29 C.F.R. § 825.310. While you are not required to provide this information, failure to do so may result in a denial of your request for FMLA leave. Your employer must give you at least 15 calendar days to return this form to your employer.

Your Name: \_\_\_\_\_  
                     First                    Middle                    Last

Name of covered military member on active duty or call to active duty status in support of a contingency operation:

\_\_\_\_\_  
                     First                    Middle                    Last

Relationship of covered military member to you: \_\_\_\_\_

Period of covered military member's active duty: \_\_\_\_\_

A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes written documentation confirming a covered military member's active duty or call to active duty status in support of a contingency operation. Please check one of the following:

- A copy of the covered military member's active duty orders is attached.
- Other documentation from the military certifying that the covered military member is on active duty (or has been notified of an impending call to active duty) in support of a contingency operation is attached.
- I have previously provided my employer with sufficient written documentation confirming the covered military member's active duty or call to active duty status in support of a contingency operation.

**PART A: QUALIFYING REASON FOR LEAVE**

- Describe the reason you are requesting FMLA leave due to a qualifying exigency (including the specific reason you are requesting leave):  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
- A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes any available written documentation which supports the need for leave; such documentation may include a copy of a meeting announcement for informational briefings sponsored by the military, a document confirming an appointment with a counselor or school official, or a copy of a bill for services for the handling of legal or financial affairs. Available written documentation supporting this request for leave is attached.  Yes  No  None Available

**PART B: AMOUNT OF LEAVE NEEDED**

- Approximate date exigency commenced: \_\_\_\_\_  
 Probable duration of exigency: \_\_\_\_\_
- Will you need to be absent from work for a single continuous period of time due to the qualifying exigency?  No  Yes.  
 If so, estimate the beginning and ending dates for the period of absence:  
 \_\_\_\_\_
- Will you need to be absent from work periodically to address this qualifying exigency?  No  Yes.  
 Estimate schedule of leave, including the dates of any scheduled meetings or appointments:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Estimate the frequency and duration of each appointment, meeting, or leave event, including any travel time (i.e., 1 deployment-related meeting every month lasting 4 hours):  
 Frequency: \_\_\_\_\_ times per \_\_\_\_\_ week(s) \_\_\_\_\_ month(s)  
 Duration: \_\_\_\_\_ hours \_\_\_\_\_ day(s) per event.

**PART C:**

If leave is requested to meet with a third party (such as to arrange for childcare, to attend counseling, to attend meetings with school or childcare providers, to make financial or legal arrangements, to act as the covered 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), a complete and sufficient certification includes the name, address, and appropriate contact information of the individual or entity with whom you are meeting (i.e., either the telephone or fax number or email address of the individual or entity). This information may be used by your employer to verify that the information contained on this form is accurate.

Name of Individual: \_\_\_\_\_ Title: \_\_\_\_\_

Organization: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: (\_\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

Describe nature of meeting: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**PART D:**

I certify that the information I provided above is true and correct.

Signature of Employee \_\_\_\_\_ 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 AV, NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE EMPLOYER.**



OMB Control Number: 1235-0003 Expires: 2/28/2015

Notice to the EMPLOYER INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a serious injury or illness of a covered servicemember to submit a certification providing sufficient facts to support the request for leave.

SECTION I: For Completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the Employee Is Requesting Leave INSTRUCTIONS to the EMPLOYEE or COVERED SERVICEMEMBER: Please complete Section I before having Section II completed.

SECTION II: For Completion by a UNITED STATES DEPARTMENT OF DEFENSE ("DOD") HEALTH CARE PROVIDER or a HEALTH CARE PROVIDER who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider.

A complete and sufficient certification to support a request for FMLA leave due to a covered servicemember's serious injury or illness includes written documentation confirming that the covered servicemember's injury or illness was incurred in the line of duty on active duty and that the covered servicemember is undergoing treatment for such injury or illness by a health care provider listed above.

SECTION I: For Completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the Employee Is Requesting Leave: (This section must be completed first before any of the below sections can be completed by a health care provider.)

Part A: EMPLOYEE INFORMATION

Name and Address of Employer (this is the employer of the employee requesting leave to care for covered servicemember):

Name of Employee Requesting Leave to Care for Covered Servicemember:

First Middle Last

Name of Covered Servicemember (for whom employee is requesting leave to care):

First Middle Last

Relationship of Employee to Covered Servicemember Requesting Leave to Care:

Spouse Parent Son Daughter Next of Kin

Part B: COVERED SERVICEMEMBER INFORMATION

(1) Is the Covered Servicemember a Current Member of the Regular Armed Forces, the National Guard or Reserves? Yes No

If yes, please provide the covered servicemember's military branch, rank and unit currently assigned to:

Is the covered servicemember 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)? Yes No

(2) Is the Covered Servicemember on the Temporary Disability Retired List (TDRL)? Yes No

Part C: CARE TO BE PROVIDED TO THE COVERED SERVICEMEMBER

Describe the Care to Be Provided to the Covered Servicemember and an Estimate of the Leave Needed to Provide the Care:

SECTION II: For Completion by a United States Department of Defense ("DOD") Health Care Provider or a Health Care Provider who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider.

Part A: HEALTH CARE PROVIDER INFORMATION

Health Care Provider's Name and Business Address:

Type of Practice/Medical Specialty:

Please state whether you are either: (1) a DOD health care provider; (2) a VA health care provider; (3) a DOD TRICARE network authorized private health care provider; or (4) a DOD non-network TRICARE authorized private health care provider:

Telephone: ( ) Fax: ( ) Email:

Part B: MEDICAL STATUS

(1) Covered Servicemember's medical condition is classified as (Check One of the Appropriate Boxes):

(VSI) Very Seriously Ill/Injured - Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately.

(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.

(O) 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.

(N) 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 § 825.113 of the FMLA.

(2) Was the condition for which the Covered Service member is being treated incurred in line of duty on active duty in the armed forces? Yes No

(3) Approximate date condition commenced:

(4) Probable duration of condition and/or need for care:

(5) Is the covered servicemember undergoing medical treatment, recuperation, or therapy? Yes No. If yes, please describe medical treatment, recuperation or therapy:

Part C: COVERED SERVICEMEMBER'S NEED FOR CARE BY FAMILY MEMBER

(1) Will the covered servicemember need care for a single continuous period of time, including any time for treatment and recovery? Yes No

If yes, estimate the beginning and ending dates for this period of time:

(2) Will the covered servicemember require periodic follow-up treatment appointments? Yes No

If yes, estimate the treatment schedule:

(3) Is there a medical necessity for the covered servicemember to have periodic care for these follow-up treatment appointments? Yes No

(4) Is there a medical necessity for the covered servicemember to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)? Yes No

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, in accordance with 29 U.S.C. § 2616; 29 C.F.R. § 825.500.