

How the FMLA Can Affect Your Company's Bottom Line



TRAINING • CONNECTING
DEVELOPING ILLINOIS' WORKFORCE

Presented By:



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*This is intended to be an open discussion. Ask questions
or raise issues at any time. Don't hesitate to interrupt.*

Some basics of the FMLA (Slide 1/2)

- 29 USC 2601
- Enacted in 1993 & amended multiple times; most recently 2013
- The Act itself is about 17-pages long
- The Regulations explaining the Act, 29 CFR 825, are about 80-pages long
- Protects employee's job; employee has right to return to comparable job relative to duties, responsibilities, pay, location & benefits.

Some Basics of the FMLA Cont. (Slide 2/2)

- Has resulted in much confusion & litigation; hundreds or thousands of DOL complaints & court cases?
- Illinois follows the FMLA but other states or municipalities may have more stringent laws.
 - States or other units of local government are permitted more restrictive laws; they can't have less restrictive requirements than federal law.
- It might be our toughest law to understand & implement because of all of the regulations, amendments & litigation.
 - Relative to difficulty, the ACA will probably overtake the FMLA.

Points to Consider & Causes of Confusion (Slide 1/2)

- What is an eligible employer?
- Who is an eligible employee?
- What activities are protected?
- How is the time off for leave calculated?
- When does a leave start & end?
- Is leave continuous or intermittent?
- How does overtime factor into FMLA?

Points to Consider & Causes of Confusion (Slide 2/2)

- What's a serious health condition?
- How does FMLA interact with other laws?
- Can we change job duties or positions to accommodate a leave?
- What about record keeping?
- The rules are different for members of the military, airline flight crews, & the families of both. They're more restrictive for employers; more liberal for employees.
- Post the poster; i.e., laws; FMLA is included;
 - Consider using DOL's forms

Why the FMLA?

- A legislative & political solution to job loss for care of a newborn, newly adopted child or foster care child. Also for the need to take a leave of absence (LOA) for a **SERIOUS** health condition.
 - Provides UNPAID leave for these matters.
- Why Unpaid: Ostensibly to protect employers.
- Other stipulations were put in for employers: E.g., Only 12 weeks of protected leave permitted in any 12 months.

Communicate With Your Employees!

- The overall theme of the regulations is that employers should engage in open & sincere dialog with their employees.
 - This is also consistent with recent changes in the Americans With Disabilities Act, as well as guidance from the Equal Employment Opportunity Commission & National Labor Relations Board, on non-FMLA employment issues.
 - It's a continuing trend with government agencies.
- No one-way conversations. Listen, trust & verify.

The 12 Month Period Defined

- An employer may choose 1 of the following methods for determining the “12-month period” in which the 12 weeks of leave occurs:
 - The calendar year;
 - Any fixed 12-month leave year, like a fiscal year;
 - Starting from the date any employee's first FMLA leave begins; or
 - A rolling 12-month period measured backward from the date an employee uses any FMLA leave
 - This normally occurs with 2nd, 3rd, etc., LOA requests.

What's an Eligible Employer?

- Any public or private business employing 50 or more employees within 75 miles of the employee's worksite, during each of 20 or more calendar workweeks in the current or preceding calendar year.
- Per the FMLA, & for all practical purposes, every employer, whether private or public sector, is an eligible employer if they meet the above requirements.
- Employer must provide continuation of benefits, which includes *almost* any benefit granted by the employer. Doesn't include employee approved voluntary deduction like supplemental insurance coverage.

Can an FMLA Eligible Employer Lose Their Eligibility? **YES**

- Once an employer meets the 50 employees & 20 workweeks threshold, the employer remains subject to the FMLA until it no longer employs 50 or more employees for 20 workweeks during the the current or preceding calendar year.
 - In this scenario, nonconsecutive workweeks is okay.
 - E.g., employer who has 50 employees for 20 workweeks as of 9/1/13, but drops below 50 before 12/31/13, & continues to employ fewer than 50 employees during the entirety of 2014, is still subject to the FMLA in 2014 because it met the 20 workweeks of the prior year.

Who's an Eligible Employee?

- Employee has to have been employed for a total of at least 12 months, & 1,250 hours, prior to the START of the LOA (*not when LOA requested*).
- An employee, for purposes of the 50 or more requirement, can be practically anyone who's not a true independent contractor (be careful of misclassification; FMLA uses the same definition of employee as the Fair Labor Standards Act).
- Military, airline flight personnel & some schools have different rules. Also, a collective bargaining agreement (i.e., union agreement) might change LOA entitlement.
- The 12 months of employment need not be consecutive. Separate periods of employment will be counted provided that the break in service does not exceed 7 years.
 - Separate periods of employment will be counted if the break in service exceeds 7 years due to National Guard or Reserve military service obligations, or when there is a written agreement stating the company's intention to rehire the employee after the service break.

Note About the FLSA:

- In defining an employee, the FMLA uses the same definition of employer as the Fair Labor Standards Act, 29 U.S.C. 203(g).
- This is a broad definition of employee *intended* to include as many people as possible.
- It includes any person acting directly or indirectly in the interest of an employer.
- Managers and officers may be individually liable for any violations of the requirements of FMLA.
 - In all likelihood individual liability only attaches to intentional & outrageous or wanton conduct.
- Context, circumstances, control, & the other usual factors are considered.

What Triggers a LOA & What's a Serious Health Condition? (Slide 1/2)

- Birth, death, adoption or foster custody of a child or loved one.
- Serious health condition is something that prevents employee from performing essential job functions.
- More specifically: Illnesses of a serious & long-term nature, resulting in lengthy absences.
 - Like a chronic or long-term health condition resulting in 3 consecutive days of incapacitation.
 - Includes 1st visit to a health care provider within 7 days of onset, & a 2nd visit within 30 days of incapacitation.
 - For chronic conditions requiring periodic health care visits, such visits must take place at least twice a year.

What Triggers a LOA & What's a Serious Health Condition? (Slide 2/2)

- Illness, injury, impairment or physical or mental condition involving:
 - Inpatient care
 - Continuing treatment by a health care provider
 - An overnight stay in a hospital, hospice or residential medical facility
 - Includes any related incapacity or subsequent treatment

What About Substance Abuse?

- Can be a serious health condition if receiving continuing treatment by a “health care provider” or by referral from a “health care provider.”
- If employer has an “established policy” against substance abuse, then employer can follow it regardless of FMLA.
 - Better make sure policy is relevant to your business & not an arbitrary consideration.

Physical or Mental Disability Defined

- 29 CFR 825.102
- Impairment that substantially limits 1 or more of the major life activities;
- Same as the ADA regs, 29 CFR 1630
 - “Any mental or psychological disorder, such as an intellectual disability (formerly termed ‘mental retardation’), organic brain syndrome, emotional or mental illness, and specific learning disabilities.”

What's a Health Care Provider?

- 29 CFR 825.102—a lot of people can be a HCP, but all have to be:
 - Licensed by their state;
 - A doctor of medicine or osteopathy who's licensed by their state to practice;
 - Anyone designated by the DOL;
 - Podiatrists, dentists, psychologist, & optometrists;
 - Chiropractors, licensed by their state, *but* limited for treatment of spinal injuries discovered via X-ray;
 - Nurses, midwives, social workers & physician assistants; &
 - Practically any practitioner accepted by the employer's group health plan (warning to employers: know your history & plans).

Continuing Treatment Defined

- Continuing Treatment by a Health Care Provider
 - Incapacity Plus Treatment
 - Pregnancy
 - Chronic Conditions
 - Permanent/Long-Term Conditions
 - Absence to Receive Multiple Treatments
- Permanent/Long-Term Conditions
 - A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective.
- Absence to Receive Multiple Treatments
 - For restorative surgery after an accident or other injury, or
 - For conditions that, if left untreated, will likely result in incapacity of more than 3 consecutive & full calendar days.

Military Families Get Up to 26 Weeks

- To care for an immediate family member in military service with a serious illness or injury incurred in the line of duty when on active duty.
- This type of FMLA leave is also known as military caregiver leave or covered servicemember leave.

Intermittent Leave & Reduced Schedule (Slide 1/2)

- Leave may be taken intermittently or on a reduced work schedule except:
 - When leave is taken after a child's birth, adoption or placement in foster care, leave may be taken intermittently or on a reduced leave schedule only if the employer agrees.
- Entitled to take intermittent or reduced schedule leave for:
 - Employee or qualifying family member's serious health condition when the leave is medically necessary
 - Covered servicemember's serious injury or illness when the leave is medically necessary
 - A qualifying exigency arising out of a military member's covered active duty status

Intermittent/Reduced Leave (Slide 2/2)

- Leave to bond with a child after the birth, adoption or foster placement must be taken as a continuous block of leave, unless the employer agrees to allow intermittent or reduced schedule leave.
- In calculating the amount of leave, employer must use the shortest increment the employer uses to account for other types of leave, provided it is not greater than 1 hour.
- Shortest increment may vary based on different times of day or shift (what the employer customarily does).
- Required overtime not worked may count against an employee's FMLA entitlement; i.e., 1250 hours.

The Use of Paid Time Off (PTO; Slide 1/2)

- Employers may require employees to use any PTO that they may have as part of their FMLA leave.
 - I.e., FMLA leave, as a matter of employer policy, can run concurrently with sick and vacation leave, workers' compensation & disability insurance.
 - Workers' comp is a serious health condition.
- Employee's lack of having PTO doesn't affect their FMLA eligibility. Remember it's unpaid to begin with.

The Use of Paid Time Off (PTO; Slide 2/2)

- Workers' compensation leave
 - may count against FMLA entitlement
 - “topping off” allowed if state law permits; i.e., workers comp + PTO; i.e., 66% + 34%=100%
 - employer & employee have to agree to this
- Disability leave
 - may count against FMLA entitlement
 - “topping off” allowed if state law permits
- Compensatory time off (public sector only)
 - may count against FMLA entitlement
 - subject to FLSA requirements

Employee Notice of Leave

- When the need *is not* foreseeable, the employee must comply with employer's policy for requesting leave, absent unusual circumstances. There's a lot of "grey" area here.
- When foreseeable, employees requesting FMLA leave must provide at least 30 days verbal or written notice.
- When the employee becomes aware of the need for FMLA leave less than 30 days in advance, the employee must provide notice of the need for the leave either the same day or the next business day.
- Form of notice should be consistent with employer's rules.
- Employee must follow all of employer's usual absence notification procedures, unless circumstances prevent it.
 - This is the area where a lot of legally fired employees seem to screw up.

Employer Obligations

- If employee doesn't specifically request FMLA LOA, then employer should inform employee that FMLA may apply to that LOA, & what employee's subsequent obligations are.
 - Employer should ask employee questions ("Catch 22")
- If employer can, then inform employee of how much LOA time employee has in terms of hours, days or weeks.
 - Provide this to employee if employee requests (30 days to provide).
- If employer fails to designate LOA as FMLA, then employer can retroactively do so, with notice to or agreement of employee.
 - Unless employee can show hardship
- 1 obscure point: Employer's failure to inform employees, in writing, of FMLA rights is fined \$110.

Employer's Obligation to Respond to LOA Request

- Within 5 business days after the employee has provided notice, the company must provide the employee with oral or written notice of eligibility & rights.
- Or, within 5 days after learning that LOA request *MAY* qualify as FMLA
- Exception: Extenuating circumstances.
- Employer's obliged to designate LOA as FMLA eligible or not; must state why; must be in writing. 3rd party can do this for employer.

Employer's Request for Proof, I.E., Certification

- Employers can require employees to submit certification of the need for FMLA leave. Certification may come from a licensed health care professional; i.e., not a “voodoo doctor,” if that’s what the employer wants.
- Certification may be required for the:
 - Employee’s serious health condition;
 - Family member’s serious health condition;
 - Qualifying exigency for military family leave; or
 - Serious injury or illness of covered servicemember for military family leave.
- Employees get 15 days to respond to employer.
- Employers can’t require that employee sign a release or waiver, or do anything that violates HIPAA.

Illegal Activities Per the FMLA

- Don't:
 - Make pre-hire inquiries regarding the need for FMLA leave, or any other LOA for that matter.
 - Include FMLA leave when considering to award/incentivize employees for attendance & other non-performance related perks, unless the perk is based on goals such as hours worked, products sold or perfect attendance, & the employee has not met that goal because of the FMLA absences, so long as other employees on an equivalent leave status are treated the same.
 - Ask for doctor's note, or recertification, each time intermittent FMLA leave is used.
 - Can ask for new note or recert for an entirely new FMLA leave
 - Interfere with an employee's FMLA rights or retaliate against employees who file FMLA complaints.

FMLA Record Retention

- The statute of limitations for an FMLA complaint is 2 years for most actions (good faith violations), unless the complaint is for a willful (deliberate & knowing) violation of the FMLA, then it's 3 years.
- Be conservative & keep records for at least 3 years.

Enforcement

- Employee can either file a DOL complaint or a private lawsuit. It's their choice.
- 2 years statute of limitations for good faith violation; or
- 3 years for willful violation.
- Employee can get lost pay, benefits, bonuses, health care reimbursements (restricted to 12 weeks; or 26 weeks for military);
- Interest @ the prevailing rate;
- “Liquidated damages” equal to the cost of the above!
- Attorneys fees & other legal expenses!

DOL's Forms

- Notice of Eligibility & Rights & Responsibilities for FMLA
 - <http://www.dol.gov/whd/forms/WH-381.pdf>
- Designation Notice of FMLA (or not)
 - <http://www.dol.gov/whd/forms/WH-382.pdf>
- Certification of Serious Health Condition by Healthcare Provider
 - <http://www.dol.gov/whd/forms/WH-380-E.pdf>
 - Employee's own condition
 - <http://www.dol.gov/whd/forms/WH-380-F.pdf>
 - Employee's family member
- There's also forms for military related LOAs

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, meet the hours of service requirement in the 12 months preceding the leave, and work at a site with at least 50 employees within 75 miles. While use of this form by employers is optional, a fully completed Form WH-381 provides employees with the information required by 29 C.F.R. § 825.300(b), which must be provided within five business days of the employee notifying the employer of the need for FMLA leave. Part B provides employees with information regarding their rights and responsibilities for taking FMLA leave, as required by 29 C.F.R. § 825.300(b), (c).

[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.
- _____ Because of a qualifying exigency arising out of the fact that your _____ spouse; _____ son or daughter; _____ parent is on covered active duty or call to covered active duty status with the Armed Forces.
- _____ Because you are the _____ spouse; _____ son or daughter; _____ parent; _____ next of kin of a covered servicemember with a serious injury or illness.

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. As of the first date of requested leave, you will have worked approximately _____ months towards this requirement.
- _____ You have not met the FMLA’s hours of service 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 _____.** (If a certification is requested, employers must allow at least 15 calendar days from receipt of this notice; additional time may be required in some circumstances.) If sufficient information is not provided in a timely manner, your leave may be denied.

- _____ 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 (such as documentation for military family leave): _____

_____ 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 have a minimum 30-day (or, indicate longer period, if applicable) grace period 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 will be required to use your available paid _____ sick, _____ vacation, and/or _____ other leave during your FMLA absence. This means that you will receive your paid leave and the leave will also be considered protected FMLA leave and counted against your FMLA leave entitlement.

Due to your status within the company, you are considered a "key employee" as defined in the FMLA. As a "key employee," restoration to employment may be denied following FMLA leave on the grounds that 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.

While on leave you will 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 particular leave situation).

If the circumstances of your leave change, and you are able to return to work earlier than the date indicated on the 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. This single 12-month period commenced on _____.
- Your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work.
- You must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA-protected leave. (If your leave extends beyond the end of your FMLA entitlement, you do not have return rights under FMLA.)
- If you do not return to work following FMLA leave for a reason other than: 1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; 2) the continuation, recurrence, or onset of a covered servicemember's serious injury or illness which would entitle you to FMLA leave; or 3) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave.
- If we have not informed you above that you must use accrued paid leave while taking your unpaid FMLA leave entitlement, you have the right to have _____ sick, _____ vacation, and/or _____ other leave run concurrently with your unpaid leave entitlement, provided you meet any applicable requirements of the leave policy. Applicable conditions related to the substitution of paid leave are referenced or set forth below. If you do not meet the requirements for taking paid leave, you remain entitled to take unpaid FMLA leave.

_____ For a copy of conditions applicable to sick/vacation/other leave usage please refer to _____ available at: _____.

_____ Applicable conditions for use of paid leave: _____

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:

_____ at _____.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

It is mandatory for employers to provide employees with notice of their eligibility for FMLA protection and their rights and responsibilities. 29 U.S.C. § 2617; 29 C.F.R. § 825.300(b), (c). 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 10 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 THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.**

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. In order to determine whether leave is covered under the FMLA, the employer 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. While use of this form by employers is optional, a fully completed Form WH-382 provides an easy method of providing employees with the written information required by 29 C.F.R. §§ 825.300(c), 825.301, and 825.305(c).

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. 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 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. A list of the essential functions of your position is is not attached. If attached, the fitness-for-duty certification must address your ability to perform these functions.

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.

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

We are exercising our right to have you obtain a second or third opinion medical certification at our expense, and 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. 29 U.S.C. § 2617; 29 C.F.R. §§ 825.300(d), (e). 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 10 – 30 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 THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.**

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



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

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.

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. 20 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. 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):

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.

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 as medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

Signature of Health Care Provider

Date

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

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