General Order Number: 11-18	**Effective Date:** January 2010
Division: Personnel Management	
Chapter: Parental Leave and Family Medical Leave Act (FMLA)	
By Order of the Fire Chief: Marc S. Bashoor	**Revision Date:** May 23, 2012

POLICY

To advise employees of procedures regarding FMLA leave and to outline the process for authorization and compliance. The Department grants FMLA leave according to County Administrative Procedure and Federal regulations. The Director of the Office of Human Resource Management (OHRM) renders final approval of all requests based on compliance with the most recent policy. Employees, when requesting FMLA leave, must comply with the established requirements for consideration, and all supervisors' approval must be in accordance with these requirements.

DEFINITIONS

N/A

PROCEDURES / RESPONSIBILITIES

1. FMLA Leave

Eligibility

- FMLA leave for purposes not related to birth or adoption of a child (see below) will be granted to employees who are eligible to earn annual leave, who have been employed by the County for at least 12 months, and who have been in a pay status for at least 1,040 hours during the previous 12 months.
- FMLA leave will be granted for purposes of parental responsibilities associated with the birth, adoption, or foster care placement of a dependent child, to any employee eligible to earn annual leave, regardless of the employee's length of service with the County.

FMLA Request and Approval Guidelines

FMLA leave will not exceed 15 workweeks (600 hours) of any combination of paid leave and LWOP (leave without pay) during any 12-month period. Parental leave of 40 hours, granted by the County, is included in the maximum 15 workweeks (600 hours). With the exception of the birth of a child, leave will be granted for the time indicated on the Certification of Health Care Provider Form or Certification for Military Family Leave.

To be eligible to receive FMLA leave without pay, the employee must first exhaust all paid leave balances as part of his/her 15 workweeks (600 hours) of leave. Use of leave donations, in lieu of leave without pay, must be authorized by the Fire Chief or appointed designee; the intent to use donated leave should be noted on the request form. **Eligibility for leave donations is limited to sickness of employee only**.

Employees who request FMLA LWOP must contact OHRM prior to submitting their request to determine the effects upon their pension and health insurance benefits. Leave donation usage is further restricted in accordance with Personnel Law and Personnel Procedure 284. Also refer to applicable policies for correct processing of leave donations. For computing purposes, the employee's 12-month period of eligibility shall commence on the first day of approved FMLA leave. If so designated by the Department, FMLA leave will run concurrent with disability leave and workers' compensation.

FMLA leave will be granted to an employee for one or more of the following reasons:

- Birth of a child of the employee and in order to care for such child;
- The placement of a minor child with the employee for adoption or foster care;
- To care for the spouse, child, parent, or parent-in-law of the employee, if such family member has a serious health condition;
- To address issues arising out of Qualifying Exigency For Military Family Leave or
- A serious health condition that makes the employee unable to perform the function of the position of such employee. NOTE: "Serious Health Condition" (regardless of job or non-job related) means any illness, injury, impairment, or physical or mental condition that involves:
  - Any incapacity or treatment in connection with inpatient care;
  - An incapacity requiring absence of more than three (3) calendar days and continuing treatment by a health care provider; or
  - Continuing treatment by a health care provider of a chronic or long-term condition that is incurable or will likely result in incapacity of more than three (3) days if not treated.

The request for FMLA leave must be submitted on the appropriate FMLA leave request form **at least 30 days prior to expected use,** if the need for leave is foreseeable (see Attachment #1). The employee must indicate the specific dates desired on the request (estimated birth date for the birth of a child).

There must be a medical need for intermittent leave or leave on a reduced leave schedule. Intermittent leave or reduced leave schedule after a birth or placement of a child for adoption or foster care will be approved on a case-by-case basis.

For administrative purposes, employees on FMLA for any continuous block of time should record it as day work hours using the FMLA Code. The exception would be if they requested intermittent leave. The employee must indicate what type of leave is to be used to cover the period requested. Open-ended requests are not permitted.

The following documents are to be submitted to the employee's immediate supervisor:

- FAMILY MEDICAL LEAVE ACT (FMLA) REQUEST (Attachment #1)
- Leave Request, PGC Form #305 (Attachment 4)

- Letter of Intent to the Fire Chief stating the dates of intended use; and the justification for usage
- Appropriate Certification form (Attachment #2a,b,c,or d). The employee is required to submit certification by the appropriate primary health care provider to support his/her leave request. NOTE: "Health Care Provider" includes: licensed MDs and ODs, podiatrists, dentists, clinical psychologists, optometrists, and chiropractors authorized to practice in the State, nurse practitioners and nurse-midwives authorized under State law, and Christian Science practitioners. For HIPPA compliance, the Certification of Health Care Provider may be submitted in a sealed envelope only to be opened by the Fire Chief or designee.
- Parental Leave and FMLA Request Checklist (Attachment #3).

The supervisor will review/sign and forward the FMLA package to the Risk Management and Safety office (RMSO) within 48 hours of receipt.
Risk Management and Safety will examine each request and determine whether the employee's request meets eligibility requirements. Note: Risk Management and Safety may designate FMLA to run concurrently with Disability Leave. After Risk Management and Safety has obtained the approval signature of the Fire Chief or appointed designee, RMSO will then forward the FMLA package to the Fire/EMS Department Human Resources office. The Human Resources Division will then forward the completed package to OHRM for final approval.

If the need for leave is not foreseeable, the employee must submit the above paperwork as soon as reasonably practical. Requests for family and medical leave for parenting responsibilities must be used within 12 months of the birth of the child or placement of the child with the employee for adoption or foster care. OHRM will issue an approval form letter covering one (1) year; however, the actual dates utilized must be in accordance with those specified on the request. Any modifications must be processed through RMSO to obtain authorization from the Fire Chief for approval. A copy of any modifications will be maintained in Risk Management and Safety as well as forwarded to the Fire/EMS Department Human Resources office for payroll verification.

All timesheets coded with FMLA leave will be reviewed by RMSO for verification, authorization, and submission to Fiscal Affairs.

In cases where spouses are determined to be entitled to family and medical leave in the instance of the birth or adoption of a child, and both are employed by this Department, both employees will receive 40 hours of parental leave, but will have to split 14 workweeks (560 hours) within a 12 month period. In instances of the illness of a child, a total of 15 workweeks (600 hours) will have to be split between the two parents.

Where conditions exist that qualify an employee for FMLA leave, the Department may place the employee on FMLA leave status, requiring the employee to submit the appropriate forms and charge their leave under the FMLA leave status.

2. Parental Leave

Eligibility

Parental leave is granted by the County to employees who are eligible to earn annual leave for the responsibilities associated with the birth of his/her natural dependent child or the adoption of a child.

Request and Approval Process

An employee will be granted up to 40 hours of paid parental leave after submission of an approved FMLA package.

3. Responsibilities

Employees

Each employee of the Department should review this process. It is the individual employee's responsibility to understand and follow all procedures related to this General Order. Failure of the employee to comply with this General Order may result in disciplinary action up to and including separation. Employees are also responsible for accurately completing all forms associated with the FMLA package. Each employee must comply with all time frames and the submission process, as outlined in this General Order.

Supervisors

Supervisors will ensure that employees understand the FMLA procedure and process. Supervisors must comply with time frames and the submission process outlined in this General Order. Supervisors will monitor their employees leave usage and notify RMSO if the Department may need to place an employee on FMLA leave.

Risk Management and Safety

Risk Management and Safety will:

- Review all FMLA packages.
- Forward all approved FMLA packages to the Fire/EMS Department Human Resources office.
- Notify the appropriate Command of approved FMLA.
- Verify and approve all timesheets coded with FMLA.
- Maintain an adequate supply of FMLA forms available for Departmental use.

Fire/EMS Department Human Resources office

The Fire/EMS Department Human Resources office will:

- Forward all FMLA packages to the OHRM for final approval.
- Notify RMSO of FMLA approvals/disapprovals.
- Maintain an adequate supply of FMLA forms available for Departmental use.

REFERENCES

Personnel Law #16-225

Personnel Procedure #284

FORMS / ATTACHMENTS

Attachment #1 – FAMILY MEDICAL LEAVE ACT (FMLA) REQUEST

Attachment #2a - Certification of Health Care Provider for Employee's Serious Health Condition form

Attachment #2b – Certification of Health Care Provider for Family Member's Serious Health Condition

Attachment #2c – Certification for Serious Injury or Illness of Covered Service member –for Military Family Leave

Attachment #2d – Certification of Qualifying Exigency For Military Family Leave

Attachment #3 - Parental Leave and FMLA Leave Request Checklist

Attachment #4 - Leave Request, PGC Form #305

Prince George's County

Fire/EMS Department

PARENTAL LEAVE & FMLA LEAVE REQUEST CHECKLIST

☐ Request for Parental Leave and/or Family Medical Leave

☐ PGC Form 305 – Leave Request

☐ Certification of Health Care Provider

☐ Letter of Intent to Fire Chief

Supervisor _____

Battalion Chief _____

Assistant Chief _____

***Forward the above forms to the Risk Management and Safety office at least 30 days prior to the expected use.

***Refer to General Order 11-18

PRINCE GEORGE'S COUNTY GOVERNMENT

FAMILY MEDICAL LEAVE ACT (FMLA) REQUEST

A request for Family and Medical Leave must be made, if practical, at least 30 days before the date the requested leave is to begin. This form and appropriate documentation must be completed in its entirety in order to be processed.

TO BE COMPLETED BY THE EMPLOYEE

I understand that under the County's Family and Medical Leave provisions, I may be entitled to a total of 15 weeks (600 hours) of paid and unpaid leave. If the request is for the birth of child, adoption or foster care, the 15 week entitlement includes 5 days (maximum of 40 hours) paid Parental Leave

EMPLOYEE NAME: _____ EMPLOYEE IDENTIFICATION NUMBER (EIN): _____
DEPARTMENT/AGENCY: _____ DATE OF HIRE: _____
PATIENT'S NAME, if applicable _____
RELATIONSHIP TO EMPLOYEE: ☐SPOUSE ☐CHILD ☐PARENT ☐OTHER (specify) _____

REASON FOR REQUEST: (select one)

☐ Birth of the employee's child and to care for such child (Certification of Health Care Provider for Employee's Serious Health Condition OR Family Member's Serious Health Condition must be attached – Attachment L OR Attachment M) – Placement with the employee of a child for adoption or foster care and to care for such child (Legal documentation must be attached) – CHILD BIRTH, ADOPTION AND FOSTER CARE REQUESTS REQUIRE ONLY DEPARTMENTAL APPROVAL

☐ Employee's serious health condition that makes the employee unable to perform the functions of his/her job (Certification of Health Care Provider for Employee's Serious Health Condition must be attached – Attachment L)

☐ Family member's serious health condition and care for the family member (Certification of Health Care Provider for Family Member's Serious Health Condition must be attached – Attachment M)

☐ Military – Serious Injury or Illness for a covered member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness.
(Certification for Serious Injury or Illness of Covered Servicemember for Military Family Leave must be attached – Attachment N)

☐ Military – Qualifying exigency for reasons which arise when a covered military member is deployed
(Certification of Qualifying Exigency for Military Family Leave must be attached – Attachment O)

NOTE: A FMLA request based on an employee's serious health condition or the serious health condition of an employee's spouse, child or parent must be accompanied by a verifying medical certification from a physician.

State the beginning date of FMLA leave _____ Ending Date of FMLA leave _____

I understand that this is a request to determine my eligibility for FMLA coverage and I shall make time-off requests for leave as recognized by the respective department/agency's policy. I understand that a failure to return to work at the end of my leave period may be treated as a resignation unless an extension has been agreed upon and approved in writing by the Prince George's County Government. Further, I understand that at the discretion of the County, I may be subject to a fitness for duty examination before being returned to work.

_____
Employee's Signature Date

_____ _____
Appointing Authority Date Director of Human Resources Management Date

Original & Copy: OHRM

Copies: Employee and Department/Agency File

PRINCE GEORGE'S COUNTY, MARYLAND

LEAVE REQUEST

NAME: _____ SOC. SEC. # _____ DATE: _____

TYPE OF LEAVE		TIME & DATE LEAVE IS TO BEGIN	TIME & DATE LEAVE IS TO END	NO. OF HOURS
☐ ADMIN.	☐ LWOP*			
☐ ANNUAL	☐ PERSONAL			
☐ COMP.	☐ SICK			
☐ OTHER _____ *specify*				

REMARKS: _____

EMPLOYEE'S SIGNATURE: _____

APPROVED BY: _____ DATE: _____
NAME/TITLE

APPROVED BY: _____ DATE: _____
NAME/TITLE

*LWOP IS APPROVED LEAVE WITHOUT PAY.

P.G.C. FORM #305 (Rev. 5/84)

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

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division

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 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.

 CONTINUED ON NEXT PAGE

PART A: QUALIFYING REASON FOR LEAVE

1. Describe the reason you are requesting FMLA leave due to a qualifying exigency (including the specific reason you are requesting leave):

_____

_____

_____

_____

_____

_____

2. 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

1. Approximate date exigency commenced: _____

   Probable duration of exigency: _____

2. 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:

   _____.

3. 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.

CONTINUED ON NEXT PAGE

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.**

Certification for Serious Injury or Illness of Covered Servicemember - - for Military Family Leave (Family and Medical Leave Act)

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division

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

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. 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. § 825.310. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees or employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

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. The FMLA permits an employer to require that an employee submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a serious injury or illness of a covered servicemember. If requested by the employer, your response is required to obtain or retain the benefit of FMLA-protected leave. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to do so may result in a denial of an employee's FMLA request. 29 C.F.R. § 825.310(f). The employer must give an employee at least 15 calendar days to return this form to the employer.

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 INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed on Page 2 has requested leave under the FMLA to care for a family member who is a member of the Regular Armed Forces, the National Guard, or the Reserves who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list for a serious injury or illness. For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty that may render the servicemember medically unfit to perform the duties of his or her office, grade, rank, or rating.

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. 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.

Certification for Serious Injury or Illness of Covered Servicemember - - for Military Family Leave (Family and Medical Leave Act)

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division

U.S. Wage and Hour Division

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 If yes, please provide the name of the medical treatment facility or unit:

_____

(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. If you are unable to make certain of the military-related determinations contained below in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator). (Please ensure that Section I above has been completed before completing this section.) Please be sure to sign the form on the last page.

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. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

☐ **(SI) Seriously Ill/Injured** – Illness/injury is of such severity that there is cause for immediate concern, but there is no imminent danger to life. Family members are requested at bedside. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

☐ **OTHER Ill/Injured** – a serious injury or illness that may render the servicemember medically unfit to perform the duties of the member's office, grade, rank, or rating.

☐ **NONE OF THE ABOVE** (Note to Employee: If this box is checked, you may still be eligible to take leave to care for a covered family member with a "serious health condition" under § 825.113 of the FMLA. If such leave is requested, you may be required to complete DOL FORM WH-380 or an employer-provided form seeking the same information.)

(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 If yes, please estimate the frequency and duration of the periodic care:

_____

_____

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. 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 PATIENT.**

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

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division

U.S. Wage and Hour Division

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. 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:(_____) _____

CONTINUED ON NEXT PAGE

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.

_____

_____

_____

_____

_____

_____

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.**

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

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division

U.S. Wage and Hour Division

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 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

CONTINUED ON NEXT PAGE

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**

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