YOUTH SERVICES
POLICY

Title: Family and Medical Leave of Absence	**Type:** A. Administrative **Sub Type:** 2. Personnel **Number:** A.2.5
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References:
The Family and Medical Leave Act of 1993 (Public Law 103-3 as amended by the National Defense Authorization Act (NDAA) and the Airline Flight Crew Technical Corrections Act (AFCTCA) for FY 2008 Public Law 110-181) Section 585(a); FMLA 29 U.S.C. §2615;Title 29, Part 825 of the Code of Federal Regulations; United States Code, Title 10, Subpart A, Section 101(a) (13) (B); as amended for FY 2010 and the FMLA Final Rule of the U.S. Department of Labor, Wage and Hour Division (WHD) in 2013; Americans with Disabilities Act; U.S. Department of Labor, Wage and Hour Publication 1420 revised April 2016; Fair Labor Standards Act; Department of Defense (DOD) 7000.14-R Financial Management Regulation, Volume 9; La. Employment Discrimination law (La. R.S. 23:301et seq.); Civil Service Rules, Chapter 11; Civil Service General Circular #2013-006; 2-CO-1C-09-1 (Administration of Correctional Agencies); YS Policies A.2.1 "Employee Manual", A.2.3 “Outside Employment, Second Jobs”, A.2.13 "Americans with Disabilities Act – (Employees, Applicants, Candidates, Visitors”, A.2.28 “Return to Work”, A.2.49 “Worker’s Compensation” and A.2.55 “Time and Attendance”

STATUS: Approved	
Approved By: *Otha “Curtis” Nelson, Jr., Deputy Secretary*	**Date of Approval:** 03/03/2023

I. AUTHORITY:

Deputy Secretary of Youth Services (YS) as contained in La. R.S. 36:405. Deviation from this policy must be approved by the Deputy Secretary.

II. PURPOSE:

To outline the conditions under which an employee may request leave from work for a limited period of time with job protection, group health and life coverage, and no loss of accumulated service in accordance with requirements described in the federal “Family and Medical Leave Act” (FMLA) of 1993, as amended in 2008, 2010 and 2013 under Section 585 of the “National Defense Authorization Act”, the U.S. Department of Labor (DOL), Wage and Hour Division (WHD) and in Civil Service Rules. (YS Policy No. A.2.55 describes procedures regarding employee leave and attendance.)

For further clarification, the FMLA was amended in 2008 to provide employees with family members serving in the Armed Forces, National Guard and Reserves with FMLA leave for reasons related to their family members' military service.

In 2010, the FMLA was again amended, expanding the military related leave protections, as well as to include a special eligibility provision for airline flight crew employees.

In announcing the Final Rule of 2013, the U.S. DOL, WHD—provided expanded protections for military families and airline flight crew employees.

Final Rule updates are available on WHDs website: http://www.dol.gov/agencies/whd.

The FMLA optional-use forms and the poster have been removed from the regulations and are available on the above-mentioned website, as well as the local Wage and Hour district offices.

III. APPLICABILITY:

Deputy Secretary, Assistant Secretary, Undersecretary, Deputy Undersecretary, Chief of Operations, Probation and Parole Program Director, Youth Facilities Director - Statewide, Executive Management Advisor, General Counsel, Regional Directors, Facility Directors, Regional Managers, all other personnel who are authorized to approve leave for employees under their jurisdiction, and all employees eligible for leave under the Family Medical Leave Act, as amended.

It is the responsibility of each Unit Head to ensure that all necessary procedures are in place for proper management and administration of this policy.

IV. DEFINITIONS:

Child – For purposes of this policy, a biological, adopted or foster child, a stepchild, a legal ward or a child of a person standing *in loco parentis,* who is under age 18 or age 18 or older and is "incapable of self-care because of a mental or physical disability."

COBRA – (Consolidated Omnibus Budget Reconciliation) allows workers and their families who lose their health benefits the right to purchase group health coverage provided by the plan under certain circumstances.

Continuing Treatment – A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health conditions; a regimen of continuing treatment does not include the taking of over-the-counter

medications such as aspirin, antihistamines or salves; or bed-rest, drinking fluids, exercise, and similar activities that can be initiated without a visit to a health care provider.

Covered Active Duty – Duty under a call or order to active duty under Title 10, Section 101(a) (13) (B) of the United States Code and requires deployment to a foreign country.

Covered Veteran - An individual who was discharged or released other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran. (The period between enactment of FY 2010 NDAA in 2009 and the effective date of the 2013 Final Rule is excluded in the determination of the five-year period for covered veteran status.)

Essential Functions Form (EFF) - A form generated by YS' HR Liaisons that lists the fundamental job duties of a position. Before an applicant can be hired and before an employee can return to work after an illness or injury, they must have the EFF filled out completely and signed by their physician.

Equivalent Position – An equivalent position has the same pay, benefits and working conditions, including privileges, perquisites and status. Intangible, immeasurable aspects of the job (i.e., the perceived loss of potential for future promotional opportunities) are not guaranteed. Equivalent positions will be at the same or a geographically proximate work site as that to which the employee had previously been assigned.

Fair Labor Standards Act (FLSA) – The federal law that sets the minimum wage and requires the payment of overtime under certain conditions.

FMLA - Family and Medical Leave Act of 1993, as amended in 2008, 2010, and 2013.

GINA - "Genetic Information Non-Discrimination Act" – Prohibits genetic information discrimination in employment.

Health Care Provider -

- A doctor of medicine or osteopathy who is authorized to practice medicine or surgery by the State in which the doctor practices;

- Podiatrists, dentists, clinical psychologists, optometrists, and chiropractors (limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray to exist) authorized to practice in the State and performing within the scope of their practices as defined under State law;

- Nurse practitioners, nurse-midwives, and clinical social workers who are authorized to practice under state law and who are performing within the scope of their practices as defined under State law;

- Christian Science practitioners listed with the First Church of Christ Scientist in Boston, Massachusetts;

- Any health care provider from whom an employer or a group health plan's benefits manager will accept certification of the existence of a serious health condition to substantiate a claim for benefits;

- A health care provider as defined above who practices in a country other than the United States, who is licensed to practice in accordance with the laws and regulation of that country; or

- For a covered military member, the list of health care providers who are authorized to complete a certification for military caregiver leave has been expanded to include health care providers, as defined in Title 29, Part 825.125 of the Code of Federal Regulations, who are not affiliated with DOD, VA, or TRICARE.

Human Resource (HR) Liaison – The staff person designated by the Unit Head with the responsibility for collecting and retaining documents pertaining to employee's personnel records.

Incapable of Self-Care - The individual requires active assistance or supervision to provide daily self-care in several of the "activities of daily living" or "instrumental activities of daily living" (i.e., caring appropriately for one's grooming and hygiene, bathing, dressing, eating, cooking, cleaning, shopping, taking public transportation, paying bills, maintaining a residence, using telephones, using post office, etc.).

Incapacity - The inability to work, attend school, perform the duties of military office/grade, rank or rating, or perform other regular daily activities due to the treatment or recovery of a serious health condition.

Intermittent Leave - *L*eave taken in separate periods of time due to a single illness or injury, rather than for one continuous period of time, and may include leave of periods from a half-hour or more to several weeks [i.e., leave taken on an occasional basis for medical appointments or several days at a time spread over a period of six (6) months].

In Loco Parentis - Those individuals with day-to-day responsibilities to care for and financially support a child. A biological or legal relationship is not necessary; however, documentation of the responsibility shall be required, i.e., an affidavit signed by a notary and/or two (2) witnesses, income tax returns, etc.

***ITA/ITO* – (Invitational Travel Authorization/Invitational Travel Orders)** - Authorization for travel of a person, not a government employee, in connection with certain assignments directly related to activities and in the interests of the Department of Defense.

Military Member – Includes a member of the National Guard or Reserves, or the Regular Armed Forces, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, has a condition that was incurred in the line of duty while on active duty which prevents the performance of military duties, or is otherwise on the temporary disability retired list for a serious injury or illness. This also includes a covered veteran who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness. Serious injury or illness includes injuries or illnesses that existed before the beginning of the member's active duty in the Armed Forces.

Military Member Family Leave – An eligible employee who is the spouse, son, daughter, parent, or next of kin of a military member shall be entitled to a total of 26 workweeks of leave during a 12-month period to care for the service member. The leave shall only be available during a single 12-month period.

NDAA – "National Defense Authorization Act" for FY 2008 (Public Law 110-181), which permits a "spouse, son, daughter, parent, or next of kin" to take up to 26 workweeks of leave to care for a member of the Regular Armed Forces and provide employees with family members serving in the Armed Forces, National Guard and Reserves with FMLA leave for reasons related to their family members' military service, 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.

Next of Kin – The closest blood relative, as defined for this policy under the "National Defense Authorization Act" for FY 2008.

Outpatient Status – With respect to a covered service member, the status of a member of the Armed Forces assigned to a military medical treatment facility as an outpatient; or a unit established for the purpose of providing command control of members of the Armed Forces receiving medical care as outpatients.

Outside or Supplemental Employment – Full-time or part-time employment other than the employee's job with YS, whether or not that other employment has been previously disclosed and approved of in accordance with YS Policy No. A.2.3.

Parent - The biological parent of an employee or an individual who stands or stood *in loco parentis* to an employee when the employee was a child. The term does not include parents "in-law."

Physical or Mental Impairment - An impairment that substantially limits one or more of the major life activities of an individual as defined by the "Americans with Disabilities Act" (ADA).

Qualifying Exigency – A number of broad categories for which military employees can use FMLA leave are as follows:

(a) Short-notice deployment;
(b) Military events and related activities;
(c) Childcare and school activities;
(d) Financial and legal arrangements;
(e) Counseling;
(f) Rest and recuperation;
(g) Post-deployment activities;
(h) Parental Care; and
(i) Additional activities not encompassed in the other categories, but agreed to by the employer and employee.

The qualifying exigency leave related to a military member's Rest and Recuperation (R&R) leave is a maximum of 15 calendar days. Information which is required includes a copy of the military member's R&R leave orders or other documentation issued by the military, setting forth the dates of the military member's leave.

Reduced Work Schedule - Leave that reduces the usual number of hours per workday or workweek of an employee.

Serious Health Condition - An illness, injury, impairment, or physical or mental condition that involves one of the following:

- Hospital Care - Inpatient care (i.e., an overnight stay) in a hospital, hospice or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

- Absence Plus Treatment - A period of incapacity of more than three (3) consecutive calendar days (including any subsequent treatment period of incapacity relating to the same condition), that also involves:

  a. Treatment two (2) or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of or on referral by a health care provider, or
  b. Treatment by a health care provider on at least one (1) occasion which results in a regiment of continuing treatment under the supervision of the health care provider.

- Pregnancy - Any period of incapacity due to pregnancy or for prenatal care. Ongoing pregnancy, severe morning sickness, prenatal care, childbirth and recovery from childbirth are considered serious health conditions.

- Chronic Condition Requiring Treatment - A chronic condition which:

  a. Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;
  b. Continues over an extended period of time (including episodes of a single underlying condition); and
  c. May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc).

- Permanent/Long-term Conditions Requiring Supervision - A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's disease, a severe stroke or the terminal stages of a disease.

- Multiple Treatment (Non-Chronic Conditions) - Any period of absence to receive multiple treatments (including any period of recovery) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity or more than three (3) consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).

- <u>Serious Health Conditions may include the following:</u>

  a. Appendicitis;
  b. Back conditions requiring extensive therapy or surgical procedures;
  c. Emphysema;
  d. Heart attacks, conditions requiring bypass surgery and valve operations;
  e. Injuries caused by accidents including restorative dental surgery after an accident;
  f. Most cancers and removal of cancerous growths;
  g. Ongoing pregnancy, severe morning sickness, prenatal care, childbirth and recovery;
  h. Pneumonia;
  i. Severe arthritis, nervous disorders and respiratory conditions;
  j. Severe illness but not receiving continuing active care from a doctor such as Alzheimer's disease and late-stage cancers;

k. Strokes;
l. Treatment for a serious, chronic health condition which, if left untreated, would likely result in an absence of more than three (3) days;
m. Treatment for substance use disorder if inpatient treatment is required; and
n. In the case of a member of the Armed Forces, National Guard or Reserves, an injury or illness incurred by the member in line of duty on activity duty in the Armed Forces that may render the member medically unfit to perform the duties of the member's office, grade, rank, or rating.

- Examples of Serious Health Conditions for Intermittent or Reduced Leave Schedule When Medically Necessary:

a. A course of medication or therapy to resolve a condition;
b. Treatment for early stage cancer (chemotherapy);
c. Physical therapy after a hospital stay or because of severe arthritis; and
d. Prenatal care.

Serious Injury or Illness for a Covered Veteran – An injury or illness that was incurred or aggravated by the member in the line of duty on active duty in the Armed Forces and manifested itself before or after the member became a veteran.

Spouse - A husband or wife as defined or recognized under State law for purposes of marriage.

Treatment - For the purpose of this policy, medical care that includes examination to determine if a health condition exists and evaluation of the condition, and does not include routine physical examinations, eye examinations, or dental examinations.

Unit Head – For purposes of this policy, the Deputy Secretary, Facility Directors and Regional Managers.

YS Central Office - Offices of the Deputy Secretary, Assistant Secretary, Undersecretary, Deputy Undersecretary, Chief of Operations, Probation and Parole Program Director, Youth Facilities Director - Statewide, Executive Management Advisor, General Counsel, Regional Directors, and their support staffs.

V. POLICY:

It is the Deputy Secretary's policy to grant family and medical leave to those employees whose family and/or individual medical needs require their absence from work and who are eligible for such leave. Due to the sensitive and personal nature of FMLA requests, all related information shall only be shared with those employees who have a business need to know, and shall be confidential at all levels. It is the policy of YS:

A. To provide up to 12 workweeks, or 26 workweeks in a case under the "National Defense Authority Act" for FY 2008, of job-protected, paid or unpaid leave during any 12-month period to eligible employees for certain specified family and medical reasons;

B. To maintain eligible employees' group health and life insurance coverage at the level and under the conditions coverage would have been provided if the employee had continued in employment continuously for the duration of such leave;

C. To restore eligible employees to their same or equivalent positions at the conclusion of their leave as provided by the "Family and Medical Leave Act" of 1993, as amended; and

D. That an employee on FMLA leave for self shall not participate in any form of outside or supplemental employment while on FMLA, regardless of whether or not that other employment has been previously disclosed and approved of pursuant to YS Policy No. A.2.3.

E. That an employee on FMLA leave for self shall not participate in any form of work related duties (i.e. answering emails, telephone calls, reviewing / signing paperwork, etc.) while on FMLA, regardless of the duration of the activity or from whom the request for such activity is being made. Work-related activity while in FMLA status is prohibited under U.S. DOL laws.

VI. PROCEDURES:

In order for YS to consistently administer the FMLA regulations, the following procedures have been developed for managers, supervisors, and all individuals charged with the responsibility of FMLA leave administration.

If the need for FMLA leave *is foreseeable*, an employee should provide their supervisor at least 30 days advance notice before FMLA leave is to begin based on the expected birth, placement of child with employee for adoption or foster care, or planned medical treatment for a serious health condition of the employee or a family member.

If the need for FMLA leave *is not foreseeable*, an employee should give notice of the need for FMLA leave as soon as practical under the facts and circumstances of the particular case. The employee is expected to give written notice within two (2) working days of learning of the need for leave.

A. Employees wishing to request FMLA shall consult with the unit's Human Resource (HR) Liaison, who shall provide the employee with the following:

1. A copy of YS Policy No. A.2.5;
2. The "FMLA Employee Request Form" [see Attachment (a)]; and
3. The appropriate medical certification form listed below, which is to be completed and returned to the Public Safety Services –Human Resources (PSS/HR) located at the Department of Public Safety (DPS) within 15 calendar days of receipt:

    a. "Certification of Health Care Provider for Employee's Serious Health Condition" (Form WH-380-E Expires June 30, 2023);
    b. "Certification of Health Care Provider for Family Member's Serious Health Condition" (Form WH-380-F June 30, 2023);
    c. "Certification of Qualifying Exigency for Military Family Leave" (Form WH-384 Expires June 30, 2023);
    d. "Certification for Serious Injury or Illness of a Current Service Member for Military Family Leave" (Form WH-385 Expires June 30, 2023); or
    e. "Certification for Serious Injury or Illness of a Veteran for Military Caregiver Leave" (Form WH-385-V Expires June 30, 2023).

    The completed form may be faxed to the PSS/HR at DPS at 225-925-3970, or mailed to the following address:

    PSS/HR at DPS Human Resources
    P.O. Box 66614
    Baton Rouge, LA 70896-6614

    Questions regarding the form should be directed to PSS/HR at DPS at 225-925-6067.

4. "FMLA Release to Return to Work" form [see Attachment A.2.5 (b)], to be completed by the employee's health care provider in order for the employee to return to work at the conclusion of FMLA.
5. Employee's "Position Description" (SF-3) and/or "Essential Functions Form" (EFF), to be reviewed by the health care provider when completing the "FMLA Release to Return to Work" form.

B. The employee must complete either the leave request screen in LEO or the hardcopy "SF-6 Application for Leave" (leave slip). This will provide the necessary basic information needed to determine the reason(s) for FMLA leave.

If the employee refuses to sign the "FMLA Employee Request Form", the "SF-6 Application for Leave" will serve as the FMLA request. The employee's supervisor shall make notation that the leave is FMLA in the remarks section of the SF-6 and initial the comments.

C. If the requested leave appears to meet the criteria of FMLA, the Unit's HR Liaison must complete the following within three (3) business days of the request, and forward a copy of all three (3) documents to PSS HR at the time of completion:

1. "FMLA Eligibility Checklist" [see Attachment A.2.5 (c)];
2. "Verification of FMLA Entitlement" form [see Attachment A.2.5 (d)];
3. "The "Memorandum of FMLA Status" form [see Attachment A.2.5 (e)] notifying the employee of their current status pending confirmation from the PSS/HR at DPS.

A copy of all three (3) documents noted shall be forwarded to the PSS/HR at DPS at the time of completion by the HR Liaison.

If an employee specifically requests leave under FMLA, and after completing Section VI.A of this policy, the leave request is determined as not qualifying or the employee is determined ineligible, the PSS/HR at DPS shall notify the employee in writing that the requested leave is not an FMLA Qualifying Event.

D. If the employee did not request FMLA prior to beginning FMLA leave, the Unit's HR Liaison shall tentatively designate the employee as being on FMLA leave after the employee has been out three (3) consecutive days, by mailing or providing the employee with the documents listed in VI.A above. The employee is required to provide the requested medical certification, included in the documents provided, within 15 calendar days of receipt to the PSS/HR at DPS.

E. Once the medical certification form is received from the health care provider, the PSS/HR at DPS shall review and determine whether the certification meets the FMLA criteria. If so, the PSS/HR at DPS shall immediately confirm to the employee that the leave shall be designated as FMLA.

If medical certification was requested but not received within 15 days of the request made by the unit's HR Liaison, the PSS/HR at DPS shall make a determination as to what action shall be taken.

F. Any aforementioned documents received by the unit's HR Liaison shall be immediately forwarded to the PSS/HR at DPS.

G. Upon exhaustion of any unpaid FMLA entitlement, the unit's HR Liaison shall issue the "FMLA Alert Form" [see Attachment A.2.5 (f)], notifying the employee of their placement in "Leave of Absence Without Pay" (LWOP) status, and their responsibility to reimburse the agency for their portion of premiums for health and life insurance coverage paid by the agency, upon their return to work, as well as the recoupment process through the PSS/HR at DPS.

Upon exhaustion of the 12-workweek FMLA entitlement or the 26-workweek entitlement under NDAA, the unit's HR Liaison shall issue the "FMLA Alert Form" notifying the employee that the FMLA entitlement has ended and that any additional leave must be applied for, and shall be evaluated pursuant to standard Civil Service rules and regulations, and YS policy and procedures.

It is critical that a copy of the completed "FMLA Alert Form" is forwarded to the PSS/HR at DPS immediately to ensure the appropriate entries are made in the LaGOV HCM System to maintain the employee's benefits.

The PSS/HR at DPS shall maintain the official FMLA medical files on all YS employees to comply with the record-keeping requirements established by the U.S. DOL.

VII. EMPLOYEE ELIGIBILITY:

To be eligible to request FMLA, an employee must meet the following criteria:

A. Have been employed by the State of Louisiana for at least 12 months. The 12 months of employment need not be consecutive months. If an employee is maintained on the payroll for any part of a week, that week counts as a week of employment; and

B. Have worked at least 1,250 in state hours during the 12-month period immediately preceding the commencement of the leave. "Fair Labor Standards Act" (FLSA) hours-worked principles shall be applied in determining whether an employee has worked 1,250 hours. Therefore, all hours, including overtime and on-call time, meet the FLSA hours-worked requirements.

VIII. LEAVE ENTITLEMENT:

Employees may request up to a total of 12 workweeks or 26 workweeks of FMLA under the NDAA, in accordance with the following.

A. An eligible employee shall be entitled to a total of 12 workweeks of leave during any 12-month period for one (1) or more of the following reasons:

1. The birth of a son or daughter, and to care for the newborn;
2. Placement with the employee of a child for adoption or foster care;
3. To care for the employee's spouse, child or parent with a serious health condition;
4. A serious health condition that makes the employee unable to perform the functions of the employee's position;
5. To deal with deployment or return of a family member on Active Duty under NDAA, under the term “qualifying exigency” in the NDAA, for non-medical demands or circumstances as defined and outlined in the amended FMLA of 1993; or
6. To care for a parent who is incapable of self-care as outlined in the Final Rule of 2013, necessitated by the covered active duty of a military member.

B. An eligible employee shall be entitled to a total of 26 workweeks of leave during any 12-month period to care for a spouse, son, daughter, parent or next of kin, who is a member of the National Guard or Reserves or the Regular Armed Forces and who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status or on the temporary disability retired list for a serious injury or illness.

C. The right to take FMLA leave applies equally to male and female state employees, as indicated in Section XI.A of this policy. A father, as well as a mother, can take leave for the birth, adoption or foster care placement of a child.

D. Employees working a reduced workweek shall be granted FMLA leave on a pro-rated basis when working less than 40 hours per week. (Example: 32 hrs/wk x 12 weeks = 384 hours; 32 hrs/wk x 26 weeks = 832 hours)

IX. GENERAL PROVISIONS:

A. The 12-month FMLA entitlement period is measured forward from the date of first use.

B. YS requires the use of accrued paid leave (annual, sick and, whenever applicable, hour-for-hour compensatory leave and time and a half compensatory leave) for FMLA leave purposes.

C. Accrued paid leave shall run concurrently with any FMLA leave granted to an eligible employee.

D. Rules under Title 29, Part 825.207 of the Code of Federal Regulations allow government employers to use time and a half compensatory leave (1.5K) for an FMLA absence, and count that absence against the employee's FMLA leave entitlement.

E. An employee who has exhausted all sick leave but is unable to return to work cannot be terminated for that reason if the employee has not used all of the employee's 12-workweek FMLA entitlement or the 26-workweek leave allowed under NDAA.

F. Leave in excess of the FMLA entitlement may be granted by the Appointing Authority pursuant to Civil Service Rules and YS Policy No. A.2.55.

G. The Appointing Authority or the PSS/HR at DPS may require an employee on FMLA leave to report every 30 days on the employee's status and intent to return to work. The employee may also be required to present a current medical certification. Failure to adhere to this process may result in disciplinary action.

H. When accrued paid leave balances are insufficient to meet the FMLA leave entitlement, unpaid leave shall be granted.

X. DESIGNATING FMLA LEAVE:

A. It is the PSS/HR at DPS' responsibility, in all circumstances, to designate leave, paid or unpaid, as FMLA-qualifying, and to give notice of the designation to the employee. The designation must be based on information received from the employee or the employee's spokesperson (spouse, adult child, parent, doctor). A copy of the designation shall be forwarded to the unit's HR Liaison by the PSS/HR at DPS.

B. If the employee has provided advance notice as required, the PSS/HR at DPS shall designate the leave prior to beginning FMLA if possible, but no later than five (5) business days after the employee begins FMLA leave, with written notification to the employee. The employee shall consult with their supervisor prior to scheduling of leave so as not to disrupt the operations of the unit.

C. An employee absent from work for a non-qualifying FMLA event shall be placed in the appropriate leave status.

D. The PSS/HR at DPS may not designate FMLA leave after an employee has returned to work except for the two (2) conditions listed below.

1. If an employee was absent for an FMLA reason and the PSS/HR at DPS did not learn the reason for the absence until the employee's return, the PSS/HR at DPS may designate [within two (2) business days of the employee's return to work] the leave retroactively with appropriate written notice to the employee. Similarly, an employee may request retroactive designation within two (2) business days; otherwise the employee may not assert FMLA protection for the absence.

2. If the PSS/HR at DPS knows the reason for the leave, but has not been able to confirm that the leave qualifies under FMLA, or the requested medical certification is delayed or a second or third medical opinion has been requested, the PSS/HR at DPS shall make a preliminary designation and so notify the employee. Upon receipt of the requisite information, the PSS/HR at DPS shall confirm in writing the preliminary designation as FMLA-qualifying. If the requisite information fails to confirm that the reason was FMLA-qualifying, the PSS/HR at DPS must withdraw the designation.

XI. SPECIAL PROVISIONS BY LEAVE ENTITLEMENT:

A. Birth of Child -

1. Ongoing pregnancy, severe morning sickness, prenatal care, childbirth and recovery from childbirth are considered serious health conditions, and leave taken for these conditions is counted toward the total 12 workweek entitlement.

   a. FMLA leave for the birth of a child expires at the end of the 12-month period beginning on the date of the birth; and
   b. FMLA leave taken in relation to pregnancy, severe morning sickness and prenatal care prior to the birth of the child is included in the 12-workweek entitlement.

2. Sick leave shall be granted for the conditions described in A.1.a and A.1.b Annual leave, hour-for-hour compensatory leave, time and a half compensatory, and/or leave without pay shall be granted for the care of a child after the recovery process to meet the 12-workweek FMLA entitlement.

   Accrued time and a half compensatory leave shall be taken prior to accrued compensatory leave earned at the hour-for-hour (straight time) rate, annual leave or leave without pay.

Time and a half compensatory leave and hour-for-hour compensatory leave may be taken in lieu of sick leave if requested by the employee and approved by the Appointing Authority.

3. A medical certification from a health care provider is required to substantiate the anticipated date of delivery and the duration of the recovery process.

4. Unless the employee's supervisor agrees, leave may not be utilized intermittently or on a reduced leave schedule for FMLA entitlement due to a birth of a healthy newborn child.

5. If both the father and the mother are state employees, the father and mother are limited to sharing a combined total of 12 workweeks for the birth of the child. The father shall be granted time and a half compensatory leave, hour-for-hour compensatory leave, annual leave, or leave without pay.

B. Placement of Child with the Employee for Adoption and Foster Care

An eligible employee shall be entitled to 12 workweeks for placement of a child for adoption or foster care.

1. FMLA leave for the placement of a child with an employee for adoption or foster care expires at the end of the 12-month period beginning on the date of the placement.

2. FMLA leave may begin before actual placement if an absence from work is required for placement to proceed. Leave taken to attend counseling sessions, appear in court, consult with an attorney or the doctor representing the birth parent, or submitting to a physical examination is counted toward the total 12-workweek entitlement.

3. Except for medical reasons involved in the placement of a child for adoption or foster care, annual leave, hour-for-hour compensatory leave, and leave without pay shall be granted to meet the 12-workweek entitlement. Accrued compensatory leave earned at time and a half and the straight-time rate shall be taken prior to the granting of leave without pay.

4. If both parents are employed by the state, the total entitlement for both parents combined is 12 workweeks, as noted in Section XI.A.5.

5. Unless the employee's supervisor agrees, leave shall not be utilized intermittently or on a reduced leave schedule after the placement of a child with the employee for adoption or foster care.

6. There is no age limit on a child being adopted or placed for foster care for determining leave eligibility.

7. The source of an adopted child is not a factor in determining leave eligibility.

8. Foster care must involve a state action in the removal of a child from parental custody rather than just an informal arrangement for care of another person's child.

C. Care for Spouse, Child or Parent, and "Next of Kin" under NDAA

1. Leave shall be granted under the FMLA to an eligible employee who is needed to care for a spouse, son, daughter or parent with a serious health condition and/or who qualifies as next of kin under "Military Member Family Leave" as defined herein under Section IV.

2. The term "needed to care for" encompasses both physical and psychological care, to include the following situations which are counted toward the total 12-workweek entitlement or 26-workweek under NDAA.

   a. The family member is incapable of self care;
   b. Providing psychological comfort and reassurance which are deemed beneficial to a seriously ill child, spouse or parent receiving inpatient care;
   c. The employee is needed to fill in for others who are caring for a family member or to make arrangements for changes in care, such as transfer to a nursing home;
   d. The employee is needed intermittently, such as instances where other care is normally available, or care responsibilities are shared with another member of the family or a third party; and/or
   e. A covered military member is otherwise on the temporary disability retired list.

3. Medical certification from a health care provider is required to substantiate the need for such care.

4. Annual leave, hour-for-hour compensatory leave, time and a half compensatory leave, and leave without pay shall be granted to care for a family member, with the exception that any accrued hour-for-hour compensatory leave shall be taken prior to the granting of annual leave or unpaid leave to meet the 12-workweek entitlement or 26-workweek under NDAA.

5. Leave shall be granted under the FMLA to an eligible employee to care for a spouse, child, parent or next of kin as follows:

    a. To care for a spouse, 12 workweeks (or 26 under NDAA) are allowed for each employee regardless of whether or not the spouse is employed by the state;
    b. To care for a child, 12 workweeks are allowed for each parent (FMLA entitlement does not cover the care of a son-in-law/daughter-in-law);
    c. Twelve (12) workweeks combined shall be allowed to care for a parent if both employees (siblings) work for the state (FMLA entitlement does not cover the care of a mother-in-law/father-in-law); and
    d. When two state employees utilize a portion of the total 12-workweek entitlement for the birth of a child, adoption, foster care or to care for a parent, each shall be entitled to the difference between the amount that either has taken individually for the above purposes, and the 12 workweeks FMLA leave allows for purposes of personal illness or to care for a spouse or sick child.

6. When medically necessary, leave may be taken intermittently or on a reduced work schedule. Employees must try to schedule their intermittent leave so as not to unduly disrupt the employer's business.

7. The employee's supervisor may require the employee to report every 30 calendar days on the status and intention of the employee to return to work. He may also request a current medical certification.

8. Unmarried domestic partners do not qualify for FMLA leave to care for their partners.

D. Employee Serious Health Condition -

1. FMLA entitlement shall be granted to an eligible employee for their own "serious health condition" as defined in Section IV of this policy.

2. Medical certification from a health care provider is required to substantiate the serious health condition.

3. A serious health condition does not cover short-term conditions for which treatment and recovery are for a short period of time Therefore, leave taken for a non-serious health condition is not counted toward the 12-workweek entitlement.

4. Sick leave shall be granted to an employee with a serious health condition. Also, accrued time and a half compensatory leave, accrued hour-for–hour compensatory leave, annual leave, and LWOP, shall be granted to meet the 12-workweek FMLA entitlement. Accrued time and a half compensatory leave shall be taken prior to the granting of hour-for-hour compensatory leave, annual leave or unpaid leave.

5. As stated in Section XI.C.6 of this policy, intermit and/or a reduced leave schedule may be used during an employee's serious health condition absence. Supervisors may change the employee's shift, reassignment or may require planned treatment around work schedule.

6. Spouses who are both employed by the state are both entitled to 12 workweeks of FMLA leave each for their own illnesses.

7. As stated in Section XI.C.7 of this policy, the employee's supervisor/PSSHR may require the employee to report every 30 days on the status and intention of the employee to return to work.

   For conditions certified as having a minimum duration of more than 30 days, YS must wait until the specified time period has past to request recertification.

   Leave code rolls in the ISIS system are as follows:

   FMLA Self = LB (sick) > 1.5 K > ST K (straight comp.) > Annual>LWOP

   FMLA Family = 1.5 K > ST K (straight comp.) > Annual>LWOP

   FMLA Workers Comp = LB (sick) > 1.5 K > ST K (straight comp.) > Annual>LWOP

XII. FITNESS-FOR-DUTY STATEMENT:

A. As a condition of restoring an employee whose FMLA leave was initiated by the employee's own serious health condition, YS requires an employee to obtain and present the completed "Release to Return to Work" form from the employee's health care provider that the employee is able to resume work.

   The fitness-for-duty certification shall contain only information regarding the particular condition that caused the employee's need for FMLA leave.

An “Essential Functions Form” furnished by YS must be completed by the health care provider at the same time the “Release to Return to Work” (a.k.a. “fitness-for-duty) form is obtained.

For those employees who qualify as disabled under the “Americans with Disabilities Act” (ADA) (refer to YS Policy No. A.2.13), fitness-for-duty examinations must be job-related and consistent with business necessity. The FMLA does not allow second or third fitness-for-duty certifications.

B. The DOL’s Final Rule amended the fitness-for-duty to allow an employer to require that the certification specifically address the employee’s ability to perform the essential functions of the employee’s job. Where reasonable job safety concerns exist, an employer may require a fitness-for-duty certification before an employee may return to work when the employee takes intermittent leave.

C. Information concerning an employee's return to work following an injury or illness is covered in YS Policy No. A.2.28.

XIII. REINSTATEMENT RIGHTS:

A. An employee is entitled to be returned to the same position the employee held when leave commenced, or to an equivalent position with equivalent benefits, pay and other terms and conditions of employment.

B. The right to reinstatement exists even if the employee's position has been restructured to accommodate the employee's absence or the employee was replaced. However, an employee is entitled to no greater right to reinstatement than he would be if he were not on leave. For example, if the employee's position is affected by a layoff, the employee is subject to the same layoff provisions as employees not on leave.

C. If an employee is unable to perform the essential functions of the position because of a physical or mental condition, including the continuation of a serious health condition, the employee has no rights to restoration to another position, subject to any overriding requirements of the ADA.

XIV. BENEFITS:

A. During FMLA leave, YS shall maintain the employee's group health plan coverage under the same conditions as coverage would have been provided if the employee had been continuously employed during the entire leave period.

B. If a new health plan, benefits or changes in health benefits or plans are provided while an employee is on FMLA leave, the employee is entitled to the new or changed plan/benefits to the same extent as if the employee was not on leave. It is the employee's responsibility to contact the PSS/HR at DPS to make changes to their plan or benefits should changes to either occur by the provider during their absence.

C. Except as required by the "Consolidated Omnibus Budget Reconciliation Act" (COBRA), YS' obligation to maintain health benefits during leave under FMLA ceases if the following occurs:

1. The employment relationship would have terminated if the employee had not taken FMLA leave;
2. The employee informs YS of their intent not to return from leave; or
3. The employee fails to return from leave or continues on leave after exhausting their FMLA leave entitlement in the 12 month period.

D. In cases where employees are on unpaid FMLA leave (LWOP), YS shall continue to pay the following insurance premiums:

1. Both the employer's and employee's share of health insurance premiums, including employee + child/children, employee + spouse or family; and
2. The employee's life insurance premium.

E. Prior to exhausting unpaid FMLA entitlement, the HR Liaison shall notify the employee of their responsibility to resume payment of such premiums, and that failure to comply could result in loss of health insurance coverage by issuing the "FMLA Alert Form". The FMLA requires that an employee on FMLA leave must reimburse their employer for any insurance premiums the employer paid while he was on FMLA leave.

XV. EMPLOYER NOTICES:

All YS statewide offices and facilities, are required to post, and keep posted on the premises, a notice explaining the FMLA provisions, and to provide information concerning the procedures for filing complaints of violations of the FMLA with the U.S. DOL "Wage and Hour Division". The notice must be posted prominently where it can be readily seen by employees and applicants for employment. (See attached WHD Publication 1420 – Revised April 2016.)

XVI. MEDICAL CERTIFICATION REQUIREMENTS:

A. An employer may require that-

1. Leave for a qualifying exigency be supported by a copy of the covered military member's active duty orders, a certification providing the appropriate facts related to the particular qualifying exigency for which leave is sought, including contact information if the leave involves meeting with a third party.

2. Leave to care for a covered military member with a serious injury or illness be supported by a certification completed by an authorized health care provider or by a copy of an “Invitational Travel Order” (ITO) or “Invitational Travel Authorization” (ITA) issued to any member of the covered service member’s family.

B. YS may require the employee to obtain a second opinion at YS' expense, if there is reason to doubt the validity of the original medical certification. The Appointing Authority or designee is permitted to designate the health care provider to furnish the second opinion, but the selected health care provider cannot be employed on a regular basis by the state.

If the second opinion differs from the first opinion, the Appointing Authority may require the employee to obtain certification from a third health care provider at YS' expense.

The third opinion shall be final and binding. The third health care provider must be agreed upon jointly by the Appointing Authority and the employee. If the Appointing Authority does not attempt in good faith to reach agreement on who to select for the third opinion, the Appointing Authority shall be bound by the first certification.

If the employee does not attempt in good faith to reach agreement on who to select for the third opinion, the employee shall be bound by the second certification.

C. If an employee fails to provide a requested medical certification in a timely manner to substantiate the need for FMLA due to a serious health condition, the employee’s supervisor shall consult with Legal Services.

If an employer deems a medical certification to be incomplete or insufficient, the employer must specify in writing what information is lacking, and give the employee 15 calendar days to cure the deficiency.

If an employer has not received the required certification on the 16th calendar day following the request, Legal Services shall request the required information from the health care provider in writing, with a copy to the PSS/HR at DPS.

The employee may be placed on LWOP until such time as the certification is produced. Failure to produce said certification may result in disciplinary action, up to and including termination.

XVII. RECORDS:

A. FMLA provides that the PSS/HR at DPS shall make, keep, and preserve records pertaining to their obligation under the Act pursuant to the record keeping requirements of Section 11 (c) of the “Fair Labor Standards Act” (FLSA). Records must be maintained no less than three (3) years and be available for inspection, copying and transcription by representatives of the U. S. DOL upon request.

B. Medical certifications, recertification, or medical histories of employees or employees' family members shall be maintained in separate files and be treated as confidential.

C. Federal regulations require employers to maintain records that disclose the following:

1. Basic payroll and identifying employee data, including name, address, occupation, rate or basis of pay and terms of compensation, daily and weekly hours worked per pay period, additions to or deductions from wages, and total compensation paid;

2. Dates FMLA leave is taken by employee;

3. The hours of leave, if FMLA leave is taken in increments of less than one (1) full day;

4. Copies of employee notices of leave (application for leave shall indicate FMLA in "Remarks" section);

5. Any documents describing employees' benefits or employer policies and practices regarding the taking of paid and unpaid leave;

6. Premium payments of employee benefits;

7. Records of any dispute between the employer and an employee regarding designation of leave as FMLA leave; and

8. Records showing compliance with the confidentiality requirements of the “Genetic Information Non-Discrimination Act” (GINA).

XVIII. FMLA AND OTHER LAWS:

FMLA does not supersede any state or local law that provides greater family or medical leave rights than those provided by FMLA, nor does it modify or affect other federal or state laws such as the ADA and Workers' Compensation (refer to

YS Policy No. A.2.49). Leave taken under other federal or state laws which meets the criteria of FMLA shall run concurrently with FMLA leave.

The “Louisiana Employment Discrimination Law” (LA R.S.23:301 et seq.) requires employers with more than 25 employees to allow a female employee affected by pregnancy, childbirth or related medical conditions to take leave on account of pregnancy for a "reasonable period of time" not to exceed four (4) months. "Reasonable period of time" means that period during which the employee is disabled on account of pregnancy, childbirth or related medical conditions.

The U.S. DOL is not responsible for enforcing state laws, nor may a state enforce the federal FMLA.

The employee who believes that YS has violated the FMLA may either file a complaint pursuant to YS Policy No. A.2.1, or file a private lawsuit in federal court.

The PSS/HR at DPS should be consulted when encountering these situations.

Previous Regulation/Policy Number: A.2.5
Previous Effective Date: 02/03/2022
Attachments/References:
A.2.5 (a) FMLA Employee Request Form June2018
A.2.5 (b) FMLA Return to Work June2018
A.2.5 (c) FMLA Eligibility Checklist June2018
A.2.5 (d) Verification of FMLA Entitlement June2018
A.2.5 (e) Memo of FMLA Status June2018
A.2.5 (f) FMLA Alert Form June2018
WH-380-E Certification of Health Care Provider - Employee's Serious Health Condition
WH-380-F Certification of Health Care Provider - Family Member's Serious Health Condition
WH-384 Certification of Qualifying Exigency
WH-385 Certification for Serious Injury or Illness of a Current Service Member
WH-385-V Certification for Serious Injury or Illness of a Veteran
WHD Publication 1420 Revised Apr 2016

YOUTH SERVICES
FAMILY AND MEDICAL LEAVE ACT
EMPLOYEE REQUEST FORM

Date of Request: _____

Employee Name: _____

Position Number: _____

Home Address: _____
Street

_____ ____ _____
City State Zip Code

Home / Cell Telephone Number: _____

Agency: _____

Unit: _____

FMLA request is for: ☐ Self

☐ To care for a family member
Name of family member: _____
Relationship: _____

If married, is your spouse a state employee? ☐ Yes ☐ No

Briefly explain reason for FMLA request: _____

_____

_____

_____

Start date of anticipated leave: _____

Expected date of return: _____Employee Signature: _____

Date: _____

c: PSS/HR Employee FMLA File

YOUTH SERVICES
FMLA RELEASE TO RETURN TO WORK

Employee: _____

Job Title: _____

Position Number: _____

TO: HEALTH CARE PROVIDER

Please review the above noted employee's Position Description and/or Essential Functions Form indicating the required physical conditions required in order to perform his/her job, and certify that he/she is or is not medically fit to return to work with / without restrictions.

(Check One)

☐ _____ may return to work on _____ (date) with no restrictions.

☐ _____ may return to work on _____ (date) with the following restrictions.

Restrictions:

_____

_____

_____

☐ _____ may not return to work at this time.

Anticipated date employee should be medically fit to return to work: _____.

Employee may not return to work until health care provider certifies that he/she is medically fit to return to work. If the health care provider indicates the employee may only return to work with restrictions, the Agency will consider the restrictions and determine whether reasonable accommodations can be afforded to the employee.

_____ _____

Signature of Health Care Provider Date

_____

Print Name of Health Care Provider

c: PSS/HR Employee FMLA File

YOUTH SERVICES
FMLA ELIGIBILITY CHECKLIST

EMPLOYEE NAME: _____

JOB TITLE: _____ **POSITION#:**_____

Instructions: To determine employee eligibility, the unit's HR Liaison shall complete the following checklist. If the answer is "Yes", go to the next question. If the answer is "No", the employee does not qualify for FMLA leave.

1. ☐ The employee works for the State of Louisiana.
2. ☐ The employee has worked for the State of Louisiana for at least 12 months prior to leave request (need not be consecutive). The 12 months is defined as 52 weeks, and any part of a week is counted as a full week.
3. ☐ The employee has worked at least 1,250 hours over the 12 months preceding the date of commencement of FMLA leave. Annual leave, sick leave and compensatory leave <u>are not</u> counted as hours worked.
4. ☐ The employee is requesting FMLA for one (1) or more of the following reasons (circle all applicable):
    a. For the birth of a child of the employee and to care for such son or daughter.
    b. Placement of a son or daughter with the employee for adoption or foster care.
    c. To care for the employee's spouse, son, daughter or parent with a serious health condition.
    d. Because of a serious health condition that makes the employee unable to perform the functions of the job.
5. ☐ The employee does have leave available from the 12-week entitlement. The 12-month period is measured from the date of first use.

If all answers are yes, the employee is entitled to FMLA.

_____ _____

HR Liaison Signature HR Liaison Name (Printed)

_____

Date

c: PSS/HR Employee FMLA File

YOUTH SERVICES
VERIFICATION OF FMLA ENTITLEMENT
(To Be Completed by Unit's HR Liaison)

DATE: _____

EMPLOYEE: _____

POSITION NUMBER: _____

PERSON COMPLETING FORM: _____

To determine the 12-month employment period:

The HR Liaison should review the employee's personnel record to determine if the employee has been employed by the State of Louisiana (not just YS) for at least 12 months prior to the leave request. (Employment does not need to be consecutive.)

_____ to _____

To determine if the employee has physically worked at least 1,250 hours:

The HR Liaison should review the payroll leave registers in ISIS for the 12 months immediately preceding the date of the FMLA leave request to determine that the following hours were not worked:

Annual	_____
Sick	_____
Holidays	_____
LWOP	_____
Special Closure	_____
Other	_____
TOTAL	_____

During the pay periods reviewed, the employee has worked the following hours in excess of regularly scheduled work hours:

Compensatory	_____
Paid Overtime	_____
TOTAL	_____

FMLA Formula: *2080 hours (80 hours x 26 pay periods)*

Leave Taken	-	_____
Compensatory/ Paid Overtime Hours worked	+	_____
Total Hours Worked		_____

c: PSS/HR Employee FMLA File

YOUTH SERVICES
MEMORANDUM OF FAMILY AND MEDICAL LEAVE STATUS

Date: _____

TO: _____ _____
Employee Name Classification

_____
Street Address

_____
City, State & Zip Code

This memorandum is to confirm that you have notified the unit's HR Liaison of your need for FMLA. Your request is currently being reviewed by the OSHCM at the Department of Public Safety, who will notify you directly to confirm whether or not you qualify for FMLA.

Until such time as you are notified by the OSHCM at the Department of Public Safety, your current FMLA status is as noted below:

1. ☐ Our records suggest that you are ineligible for FMLA.

2. ☐ Our records suggest that you are eligible for FMLA.

3. ☐ Review of your FMLA request by the OSHCM at the Department of Public Safety is pending their receipt of the appropriate medical certification form provided to you on _____, the date of your request to the unit's HR Liaison, for the following reason:

   - ☐ Birth of a child
   - ☐ Placement of a child for adoption or foster care
   - ☐ Your own serious health condition
   - ☐ Serious health condition affecting your:
     - ☐ spouse
     - ☐ child
     - ☐ parent which is incapable of self care.

The form must be returned within 15 days of the date of receipt. You may fax the form to: 225-925-3970 or mail it to:

OSHCM
Department of Public Safety
P.O. Box 66614
Baton Rouge, LA 70896-6614

If you have questions concerning the form, please call 225-925-6067.

4. ☐ You are tentatively being placed on FMLA pending approval by the OSHCM at the Department of Public Safety.

5. ☐ This leave ☐ may ☐ will be counted against your FMLA entitlement and will begin, or began on, _____. You have indicated that you expect this need for leave to continue until, on, or about _____.

Provided you comply with the conditions listed below, you have a right under the FMLA for up to 12 workweeks of leave in a 12-month period for the reason indicated above. 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 leave.

6. ☐ You must first use your available paid leave balances for FMLA leave. Leave Without Pay (LWOP) will only be granted after you have exhausted your paid leave (annual, sick or straight compensatory balances). If LWOP is used, YS shall continue to pay the employer and employee's share of the insurance premiums, but the employee will be required to pay back to the agency the employee's share of those premiums upon returning to work. Please circle your choice of a. or b. below.

   a. Upon my return to work, I agree to repay the employee share of my insurance premiums that YS paid while I was on FMLA/LWOP.

      _____
      (Employee signature)

   b. I will send payments to YS for the employee share of my monthly insurance premiums while I am on FMLA/LWOP. (Checks must be made payable to Youth Services.)

      NOTE: If payment is not received, the recoupment process will start upon my returning to work through the OSHCM at the Department of Public Safety.

      _____
      (Employee signature)

7. ☐ For leave due to your own serious health condition, pregnancy complications or a chronic condition, you are required to furnish the "FMLA Request to Return to Work" form completed by your health care provider upon your return to work. This form was provided to you on the date of your FMLA request to the unit's HR Liaison.8. ☐ While on leave, you are required to furnish the unit's HR Liaison with periodic reports every 30 calendar days of your status and intent to return to work.

9. ☐ Please note that in accordance with U.S. DOL FMLA laws, work-related duties must not occur while you are in FMLA status (i.e. answering emails, telephone calls, reviewing / signing paperwork, etc.). Should such activity take place while on FMLA status, you are required to contact your immediate supervisor and the unit's HR Liaison to report such activity and document your time appropriately. Work activity during FMLA status is required to be coded as "annual" leave in the LaGOV OSHCM system, therefore annual leave must be applied for through LEO or a hard-copy SF-6 "Application for Leave" form. Your FMLA status will be adjusted accordingly following these events. However, it is highly recommended that these activities do not occur during FMLA status.

10. ☐ Comments or questions regarding FMLA request, or issues concerning the request, should be directed to the OSHCM at the Department of Public Safety at 225-925-3970.

_____	_____
HR Liaison Signature	Unit Head's Signature
_____	_____
HR Liaison Name (Print or Type)	Unit Head's Name (Print or Type)

c: PSS/HR Employee FMLA File

YOUTH SERVICES
FMLA ALERT FORM

This form is being provided to you by the unit's HR Liaison to advise you of the issue noted below regarding your FMLA status.

EMPLOYEE: _____ Position #: _____

HR LIAISON NAME: _____

PHONE #: _____ FAX #: _____

Check and complete one of the following:

☐ 1. You have completely exhausted the FMLA quota of 480 hours of leave and are hereby required to return to work or apply for additional leave, effective: _____.

☐ 2. Although you have not reached the FMLA quota of 480 hours of leave, you have exhausted your leave balance and have been placed on "Leave Without Pay" (LWOP) status; you are now responsible for your portion of health and insurance premiums, effective: _____.

☐ 3. You have completely exhausted the FMLA quota and your leave balance, and have been placed on "Leave Without Pay" (LWOP) status; you are now responsible for the full premium of your health / insurance coverage, effective: _____

Recoupment of your premiums will be set up through the OSHCM at the Department of Public Safety, who will be in contact with you to discuss your options, or you may contact their offices at 225-925-6067.

Employee Signature: _____ Date: _____

Print Employee Name: _____

UNIT HR LIAISON USE ONLY

Date FMLA Quota Entered: _____

Signature of Person Entering Quota: _____

c: PSS/HR Employee FMLA File

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

U.S. Department of Labor
Wage and Hour Division

WAGE AND HOUR DIVISION

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

OMB Control Number: 1235-0003
Expires: 6/30/2023

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. 29 U.S.C. §§ 2613, 2614(c)(3); 29 C.F.R. § 825.305. The employer must give the employee **at least 15 calendar days** to provide the certification. If the employee fails to provide complete and sufficient medical certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

SECTION I – EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, this form asks the health care provider for the information necessary for a complete and sufficient medical certification, which is set out at 29 C.F.R. § 825.306. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308.** Additionally, you **may not** request a certification for FMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care.

Employers must generally maintain records and documents relating to medical information, medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

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

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

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

(4) Employee's job title: _____ Job description (☐ is / ☐ is not) attached.
Employee's regular work schedule: _____
Statement of the employee's essential job functions: _____
_____
(*The essential functions of the employee's position are determined with reference to the position the employee held at the time the employee notified the employer of the need for leave or the leave started, whichever is earlier.)*

SECTION II - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form. Your patient has requested leave under the FMLA. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of the employee. For FMLA purposes, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves *inpatient care* or *continuing treatment by a health care provider*. For more information about the definitions of a serious health condition under the FMLA, see the chart on page 4.

You may, but are **not required** to, provide other appropriate medical facts including symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment. Please note that some state or local laws may not allow disclosure of private medical information about the patient's serious health condition, such as providing the diagnosis and/or course of treatment.

Employee Name: _____

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

Health Care Provider's business address: _____

Type of practice / Medical specialty: _____

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

PART A: Medical Information

Limit your response to the medical condition(s) for which the employee is seeking FMLA leave. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. **After completing Part A, complete Part B to provide information about the amount of leave needed.** Note: For FMLA purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

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

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

(3) Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

☐ **Inpatient Care**: The patient (☐ has been / ☐ is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): _____

☐ **Incapacity plus Treatment**: *(e.g. outpatient surgery, strep throat)*
Due to the condition, the patient (☐ has been / ☐ is expected to be) incapacitated for *more than* three consecutive, full calendar days from _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*.

The patient (☐ was / ☐ will be) seen on the following date(s): _____
_____

The condition (☐ has / ☐ has not) also resulted in a course of continuing treatment under the supervision of a health care provider *(e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment)*

☐ **Pregnancy**: The condition is pregnancy. List the expected delivery date: _____ *(mm/dd/yyyy)*.

☐ **Chronic Conditions**: *(e.g. asthma, migraine headaches)* Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

☐ **Permanent or Long Term Conditions**: *(e.g. Alzheimer's, terminal stages of cancer)* Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

☐ **Conditions requiring Multiple Treatments**: (*e.g. chemotherapy treatments, restorative surgery)* Due to the condition, it is medically necessary for the patient to receive multiple treatments.

☐ **None of the above**: If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed. Go to page 4 to sign and date the form.

Employee Name: _____

(4) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. *(e.g., use of nebulizer, dialysis*) _____

_____

PART B: Amount of Leave Needed

For the medical condition(s) checked in Part A, complete all that apply. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage.

(5) Due to the condition, the patient (☐ had / ☐ will have) **planned medical treatment(s)** (scheduled medical visits) *(e.g. psychotherapy, prenatal appointments)* on the following date(s): _____

_____

(6) Due to the condition, the patient (☐ was / ☐ will be) **referred to other health care provider(s)** for evaluation or treatment(s).

State the nature of such treatments: *(e.g. cardiologist, physical therapy)* _____

Provide your **best estimate** of the beginning date _____ *(mm/dd/yyyy)* and end date _____ *(mm/dd/yyyy)* for the treatment(s).

Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery *(e.g. 3 days/week)*

_____

(7) Due to the condition, it is medically necessary for the employee to work a **reduced schedule**.

Provide your **best estimate** of the reduced schedule the employee is able to work. From _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)* the employee is able to work: *(e.g., 5 hours/day, up to 25 hours a week)*

_____

(8) Due to the condition, the patient (☐ was / ☐ will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.

Provide your **best estimate** of the beginning date _____ *(mm/dd/yyyy)* and end date _____ *(mm/dd/yyyy)* for the period of incapacity.

(9) Due to the condition, it (☐ was / ☐ is / ☐ will be) medically necessary for the employee to be absent from work on an **intermittent basis** (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, episodes of incapacity are estimated to occur _____ times per (☐ day / ☐ week / ☐ month) and are likely to last approximately _____ (☐ hours / ☐ days) per episode.

Employee Name: _____

PART C: Essential Job Functions

If provided, the information in Section I question #4 may be used to answer this question. If the employer fails to provide a statement of the employee's essential functions or a job description, answer these questions based upon the employee's own description of the essential job functions. An employee who must be absent from work to receive medical treatment(s), such as scheduled medical visits, for a serious health condition is considered to be *not able* to perform the essential job functions of the position during the absence for treatment(s).

(10) Due to the condition, the employee (☐ was not able / ☐ is not able / ☐ will not be able) to perform *one or more* of the essential job function(s). Identify at least one essential job function the employee is not able to perform:

_____

_____

Signature of Health Care Provider _____ **Date** _____ *(mm/dd/yyyy)*

Definitions of a Serious Health Condition *(See 29 C.F.R. §§ 825.113-.115)*
Inpatient Care
• An overnight stay in a hospital, hospice, or residential medical care facility. • Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.
Continuing Treatment by a Health Care Provider (any one or more of the following)
Incapacity Plus Treatment: A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either: o Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or, o At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.
Pregnancy: Any period of incapacity due to pregnancy or for prenatal care.
Chronic Conditions: Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.
Permanent or Long-term Conditions: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.
Conditions Requiring Multiple Treatments: Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.

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 under the Family and Medical Leave Act

U.S. Department of Labor
Wage Hour Division

WAGE AND HOUR DIVISION

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

OMB Control Number: 1235-0003
Expires: 6/30/2023

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave to care for a family member with a serious health condition to submit a medical certification issued by the family member's health care provider. 29 U.S.C. §§ 2613, 2614(c)(3); 29 C.F.R. § 825.305. The employer must give the employee **at least 15 calendar days** to provide the certification. If the employee fails to provide complete and sufficient medical certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

SECTION I - EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, this form asks the health care provider for the information necessary for a complete and sufficient medical certification, which is set out at 29 C.F.R. § 825.306. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308**. Additionally, you **may not** request a certification for FMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care.

Employers must generally maintain records and documents relating to medical information, medical certifications, recertifications, or medical histories of employees or employees' family members created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

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

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

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

SECTION II - EMPLOYEE

Please complete and sign Section II before providing this form to your family member or your family member's health care provider. The FMLA allows an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of your family member. If requested by your employer, your response is required to obtain or retain the benefit of the FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). **You are responsible for making sure the medical certification is provided to your employer within the time frame requested, which must be at least 15 calendar days.** 29 C.F.R. §§ 825.305-825.306. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA leave request. 29 C.F.R. § 825.313.

(1) Name of the family member for whom you will provide care: _____

(2) Select the relationship of the family member to you. The family member is your:

☐ Spouse ☐ Parent ☐ Child, under age 18
☐ Child, age 18 or older and incapable of self-care because of a mental or physical disability

Spouse means a husband or wife as defined or recognized in the state where the individual was married, including in a common law marriage or same-sex marriage. The terms "child" and "parent" include *in loco parentis* relationships in which a person assumes the obligations of a parent to a child. An employee may take FMLA leave to care for an individual who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave to care for a child for whom the employee has assumed the obligations of a parent. No legal or biological relationship is necessary.

Employee Name: _____

(3) Briefly describe the care you will provide to your family member: (*Check all that apply)*

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

☐ Physical Care ☐ Psychological Comfort ☐ Other: _____

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

_____

(5) If a **reduced work schedule** is necessary to provide the care described, give your **best estimate** of the reduced schedule you are able to work. From _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy),* I am able to work _____ (*hours per day*) _____ (*days per week).*

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

SECTION III - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form below. A family member of your patient has requested leave under the FMLA to care for your patient. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a family member with a serious health condition. For FMLA purposes, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that *involves inpatient care* or *continuing treatment by a health care provider*. For more information about the definitions of a serious health condition under the FMLA, see the chart at the end of the form.

You also may, but are **not required** to, provide other appropriate medical facts including symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment. Please note that some state or local laws may not allow disclosure of private medical information about the patient's serious health condition, such as providing the diagnosis and/or course of treatment.

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

Health Care Provider's business address: _____

Type of practice / Medical specialty: _____

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

PART A: Medical Information

Limit your response to the medical condition for which the employee is seeking FMLA leave. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. **After completing Part A, complete Part B to provide information about the amount of leave needed.** Note: For FMLA purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

(1) Patient's Name: _____

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

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

(4) For FMLA to apply, care of the patient must be medically necessary. Briefly describe the type of care needed by the patient (*e.g., assistance with basic medical, hygienic, nutritional, safety, transportation needs, physical care, or psychological comfort).*

_____

_____

Employee Name: _____

(5) Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

☐ **Inpatient Care**: The patient (☐ has been / ☐ is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): _____

☐ **Incapacity plus Treatment**: *(e.g. outpatient surgery, strep throat)*
Due to the condition, the patient (☐ has been / ☐ is expected to be) incapacitated for *more than* three consecutive, full calendar days from _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*.

The patient (☐ was / ☐ will be) seen on the following date(s): _____

_____

The condition (☐ has / ☐ has not) also resulted in a course of continuing treatment under the supervision of a health care provider *(e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment)*

☐ **Pregnancy**: The condition is pregnancy. List the expected delivery date: _____ *(mm/dd/yyyy)*.

☐ **Chronic Conditions**: *(e.g. asthma, migraine headaches)* Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

☐ **Permanent or Long Term Conditions**: *(e.g. Alzheimer's, terminal stages of cancer)* Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

☐ **Conditions requiring Multiple Treatments**: (*e.g. chemotherapy treatments, restorative surgery)* Due to the condition, it is medically necessary for the patient to receive multiple treatments.

☐ **None of the above**: If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed. Go to page 4 to sign and date the form.

(6) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. *(e.g., use of nebulizer, dialysis)* _____

_____

PART B: Amount of Leave Needed

For the medical condition(s) checked in Part A, complete all that apply. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine if the benefits and protections of the FMLA apply.

(7) Due to the condition, the patient (☐ had / ☐ will have) **planned medical treatment(s)** (scheduled medical visits) *(e.g. psychotherapy, prenatal appointments)* on the following date(s): _____

_____

(8) Due to the condition, the patient (☐ was / ☐ will be) **referred to other health care provider(s)** for evaluation or treatment(s).

State the nature of such treatments: *(e.g. cardiologist, physical therapy)* _____

Provide your **best estimate** of the beginning date _____ *(mm/dd/yyyy)* and end date _____ *(mm/dd/yyyy)* for the treatment(s).

Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery

_____ *(e.g. 3 days/week)*

Employee Name: _____

(9) Due to the condition, the patient (☐ was / ☐ will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.

Provide your **best estimate** of the beginning date: _____ *(mm/dd/yyyy)* and end date _____ *(mm/dd/yyyy)* for the period of incapacity.

(10) Due to the condition it, (☐ was / ☐ is / ☐ will be) medically necessary for the employee to be absent from work to provide care for the patient on an **intermittent basis** (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, episodes of incapacity are estimated to occur _____ times per (☐ day / ☐ week / ☐ month) and are likely to last approximately _____ (☐ hours / ☐ days) per episode.

Signature of
Health Care Provider _____ **Date** _____ *(mm/dd/yyyy)*

Definitions of a Serious Health Condition *(See 29 C.F.R. §§ 825.113-.115)*
Inpatient Care
• An overnight stay in a hospital, hospice, or residential medical care facility. • Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.
Continuing Treatment by a Health Care Provider (any one or more of the following)
Incapacity Plus Treatment: A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either: o Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or, o At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.
Pregnancy: Any period of incapacity due to pregnancy or for prenatal care.
Chronic Conditions: Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.
Permanent or Long-term Conditions: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.
Conditions Requiring Multiple Treatments: Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 15 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

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

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

U.S. Department of Labor
Wage and Hour Division

WAGE AND HOUR DIVISION

DO NOT SEND FORM TO THE DEPARTMENT OF LABOR.
RETURN THE COMPLETED FORM TO THE EMPLOYER.

OMB Control Number: 1235-0003
Expires: 6/30/2023

The Family and Medical Leave Act (FMLA) provides that eligible employees may take FMLA leave for a qualifying exigency while the employee's spouse, child, or parent (the military member) is on covered active duty or has been notified of an impending call or order to covered active duty. The FMLA allows an employer to require an employee seeking FMLA leave due to a qualifying exigency to submit a certification. 29 U.S.C. §§ 2613, 2614(c)(3). The employer must give the employee **at least 15 calendar days** to provide the certification. 29 C.F.R. § 825.305(b). If the employee fails to provide complete and sufficient certification, the employee's FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at http://www.dol.gov/agencies/whd/fmla.

SECTION I - EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, it asks the employee for the information necessary for a complete and sufficient qualifying exigency certification, which is set out at 29 C.F.R. § 825.309. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. § 825.309.**

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

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

(3) This certification must be returned by_____ *(mm/dd/yyyy).*
(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee's diligent, good faith efforts.)

SECTION II - EMPLOYEE

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

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

_____
First *Middle* *Last*

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

☐ Spouse ☐ Parent ☐ Child, of any age

Spouse means a husband or wife as defined or recognized in the state where the individual was married, including a common law marriage or same-sex marriage. The terms "child" and "parent" include *in loco parentis* relationships in which a person assumes the obligations of a parent to a child. An employee may take FMLA leave for a qualifying exigency related a military member who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave for a qualifying exigency related a military member for whom the employee has assumed the obligations of a parent. No legal or biological relationship is necessary.

Employee Name: _____

PART A: COVERED ACTIVE DUTY STATUS

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

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

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

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

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

PART B: APPROPRIATE FACTS

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

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

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

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

  _____

Employee Name: _____

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

  _____

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

  _____

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

  _____

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

PART C: AMOUNT OF LEAVE NEEDED

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

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

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

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

(9) Due to a qualifying exigency, I need to work a **reduced schedule**. Provide your **best estimate** of the reduced schedule you are able to work:

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

I am able to work _____
(e.g., 5 hours/day, up to 25 hours a week)

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

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

Employee Name: _____

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

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

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

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

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

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

PART D: THIRD PARTY INFORMATION

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

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

Address: _____

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

Describe purpose of meeting: _____

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

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 15 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THE DEPARTMENT OF DEPARTMENT OF LABOR. RETURN FORM TO THE EMPLOYER.

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

U.S. Department of Labor
Wage Hour Division

WAGE AND HOUR DIVISION

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

OMB Control Number: 1235-0003
Expires: 6/30/2023

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

SECTION I - EMPLOYER

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

Employers must generally maintain records and documents relating to medical information, medical certifications, recertifications, or medical histories of employees or employees' family members created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

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

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

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

SECTION II - EMPLOYEE and/or CURRENT SERVICEMEMBER

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

PART A: EMPLOYEE INFORMATION

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

Employee Name: _____

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

☐ Spouse ☐ Parent ☐ Child ☐ Next of Kin

Spouse means a husband or wife as defined or recognized in the state where the individual was married, including a common law marriage or same-sex marriage. The terms "child" and "parent" include *in loco parentis* relationships in which a person assumes the obligations of a parent to a child. An employee may take FMLA leave to care for a covered servicemember who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave to care for a covered servicemember for whom the employee has assumed the obligations of a parent. No biological or legal relationship is necessary. "Next of kin" is the servicemember's nearest blood relative, other than the spouse, parent, son, or daughter, in the following order of priority: (1) a blood relative as designated in writing by the servicemember for purposes of FMLA leave, (2) blood relatives granted legal custody of the servicemember, (3) brothers and sisters, (4) grandparents, (5) aunts and uncles, and (6) first cousins.

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

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

_____

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

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

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

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

☐ Psychological Comfort ☐ Physical Care

☐ Transportation ☐ Other: _____

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

_____

(8) If a reduced work schedule is necessary to provide the care described, give your **best estimate** of the reduced work schedule you are able to work. From _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy),* I am able to work: _____ *(hours per day)* _____ (*days per week).*

SECTION III - HEALTH CARE PROVIDER

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

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

PART A: HEALTH CARE PROVIDER INFORMATION

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

Health Care Provider's business address: _____

Type of practice/Medical specialty: _____

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

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

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

PART B: MEDICAL INFORMATION

Please provide appropriate medical information of the patient as requested below. Limit your responses to the servicemember's condition for which the employee is seeking leave. If you are unable to make some of the military-related determinations contained below, you are permitted to rely upon determinations from an authorized DOD representative, such as a DOD recovery care coordinator. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. §1635.3(e).

(1) Patient's Name: _____

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

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

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

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

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

Employee Name: _____

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

☐ **(VSI) Very Seriously Ill/Injured** Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately. *Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.*

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

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

☐ **NONE OF THE ABOVE.** *Note to Employee: If this box is checked, you may still be eligible to take leave to care for a covered family member with a "serious health condition" under 29 C.F.R. § 825.113 of the FMLA. If such leave is requested, you may be required to complete DOL FORM WH-380-F or an employer-provided form seeking the same information.*

PART C: AMOUNT OF LEAVE NEEDED

For the medical condition checked in Part B, complete all that apply. Some questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage.

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

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

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

Over the next 6 months, intermittent care is estimated to occur _____ times per (☐ day / ☐ week / ☐ month) and are likely to last approximately _____ (☐ hours / ☐ days) per episode.

Signature of Health Care Provider _____ **Date** _____ *(mm/dd/yyyy)*

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 15 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

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

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

U.S. Department of Labor
Wage and Hour Division

WAGE AND HOUR DIVISION

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

OMB Control Number: 1235-0003
Expires: 6/30/2023

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

SECTION I – EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, it asks the health care provider for the information necessary for a complete and sufficient medical certification. **Recertifications are not allowed for FMLA leave to care for a covered servicemember. Where medical certification is requested by an employer, an employee may not be held liable for administrative delays in the issuance of military documents, despite the employee's diligent, good-faith efforts to obtain such documents.** In lieu of this form or your own certification form, you **must** accept as sufficient certification of the veteran's serious injury or illness documentation indicating the veteran's enrollment in the Department of Veterans Affairs Program of Comprehensive Assistance for Family Caregivers. **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 information, medical certifications, recertifications, or medical histories of employees or employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

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

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

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

SECTION II - EMPLOYEE and/or VETERAN

Please complete all Parts in Section II before having the veteran's health care provider complete Section III. The FMLA allows an employer to require that an employee submit a timely, complete, and sufficient certification to support a request for military caregiver leave under the FMLA due to a serious injury or illness of a covered veteran. If requested by the employer, your response is required to obtain or retain the benefit of FMLA-protected leave. The employer must give an employee **at least 15 calendar days** to return this form to the employer. 29 U.S.C. §§ 2613, 2614(c)(3).

PART A: EMPLOYEE INFORMATION

(1) Name of veteran for whom employee is requesting leave: _____
First *Middle* *Last*

Employee Name: _____

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

☐ Spouse ☐ Parent ☐ Child ☐ Next of Kin

Spouse means a husband or wife as defined or recognized in the state where the individual was married, including a common law marriage or same-sex marriage. The terms "child" and "parent" include *in loco parentis* in which a person assumes the obligations of a parent to a child. An employee may take FMLA leave to care for a covered servicemember who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave to care for a covered servicemember for whom the employee has assumed the obligations of a parent. No biological or legal relationship is necessary. "Next of kin" is the veteran's nearest blood relative, other than the spouse, parent, son, or daughter, in the following order of priority: (1) a blood relative as designated in writing by the veteran for purposes of FMLA leave, (2) blood relatives granted legal custody of the veteran, (3) brothers and sisters, (4) grandparents, (5) aunts and uncles, and (6) first cousins.

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

(3) The veteran was (☐ honorably / ☐ dishonorably) discharged or released from the Armed Forces, including the National Guard or Reserves. List the date of the veteran's discharge: _____ *(mm/dd/yyyy)*

(4) Please provide the veteran's military branch, rank and unit at the time of discharge: _____

_____

(5) The veteran (☐ is / ☐ is not) receiving medical treatment, recuperation, or therapy for an injury or illness.

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

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

☐ Psychological Comfort ☐ Physical Care ☐ Other: _____

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

_____

(8) If a **reduced work schedule** is necessary to provide the care described, give your **best estimate** of the reduced work schedule you are able to work. From _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)* I am able to work: _____ *(hours per day)* _____ *(days per week).*

SECTION III - HEALTH CARE PROVIDER

Please provide your contact information, complete all Parts of this Section fully and completely, and sign the form below. The employee named in Section I has requested leave under the military caregiver leave provision of the FMLA to care for a family member who is a veteran.

Note: For purposes of FMLA military caregiver leave, a serious injury or illness means an injury or illness incurred by the servicemember in the line of duty on active duty in the Armed Forces (or that existed before the beginning of the servicemember's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces) and manifested itself before or after the servicemember became a veteran, and is: a continuation of a serious injury or illness that was incurred or aggravated when the covered veteran was a member of the Armed Forces and rendered the servicemember unable to perform the duties of the servicemember's office, grade, rank, or rating; or a physical or mental condition for which the covered veteran has received a U.S. Department of Veterans Affairs Service Related Disability Rating (VASRD) of 50 percent or greater, and such VASRD rating is based, in whole or in part, on the condition precipitating the need for military caregiver leave; or a physical or mental condition that substantially impairs the covered veteran's ability to secure or follow a substantially gainful occupation by reason of a disability or disabilities related to military service, or would do so absent treatment; or an injury, including a psychological injury, on the basis of which the covered veteran has been enrolled in the Department of Veterans' Affairs Program of Comprehensive Assistance for Family Caregivers.

Employee Name: _____

"Need for care" includes both physical and psychological care. It includes situations where, for example, due to his or her serious injury or illness, the veteran is not able to care for his or her own basic medical, hygienic, or nutritional needs or safety, or needs transportation to the doctor. It also includes providing psychological comfort and reassurance which would be beneficial to the veteran who is receiving inpatient or home care.

A complete and sufficient certification to support a request for FMLA military caregiver leave due to a covered veteran's serious injury or illness includes written documentation confirming that the veteran's injury or illness was incurred in the line of duty on active duty or existed before the beginning of the veteran's active duty and was aggravated by service in the line of duty on active duty, and that the veteran is undergoing treatment, recuperation, or therapy for such injury or illness by a health care provider listed above. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

PART A: HEALTH CARE PROVIDER INFORMATION

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

Health Care Provider's business address: _____

Type of Practice/Medical Specialty: _____

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

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

- ☐ DOD health care provider
- ☐ VA health care provider
- ☐ DOD TRICARE network authorized private health care provider
- ☐ DOD non-network TRICARE authorized private health care provider
- ☐ Health care provider as defined in 29 CFR 825.125

PART B: MEDICAL INFORMATION

Please provide appropriate medical information of the patient as requested below. Limit your responses to the veteran's condition for which the employee is seeking leave. If you are unable to make certain military-related determinations contained below, you are permitted to rely upon determinations from an authorized DOD representative, such as a DOD Recovery Care Coordinator, or an authorized VA representative. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e).

(1) Patient's Name: _____

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

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

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

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

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

_____

Employee Name: _____

(5) The veteran's medical condition is: *(Select as appropriate)*

☐ A continuation of a serious injury or illness that was incurred or aggravated when the covered veteran was a member of the Armed Forces and rendered the servicemember not able to perform the duties of the servicemember's office, grade, rank, or rating.

☐ A physical or mental condition for which the covered veteran has received a U.S. Department of Veterans Affairs Service Related Disability Rating (VASRD) of 50% or higher, and such VASRD rating is based, in whole or in part, on the condition precipitating the need for military caregiver leave.

☐ A physical or mental condition that substantially impairs the covered veteran's ability to secure or follow a substantially gainful occupation by reason of a disability or disabilities related to military service, or would do so absent treatment.

☐ An injury, including a psychological injury, on the basis of which the covered veteran is enrolled in the Department of Veterans' Affairs Program of Comprehensive Assistance for Family Caregivers.

☐ None of the above. *Note to Employee: If this box is checked, you may still be eligible to take leave to care for a covered family member with a "serious health condition" under 29 C.F.R. § 825.113 of the FMLA. If such leave is requested, you may be required to complete DOL FORM WH-380-F or an employer-provided form seeking the same information.*

Part C: Amount of Leave Needed

For the medical condition checked in Part B, complete all that apply. Some questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA military caregiver leave coverage.

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

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

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

Over the next 6 months, intermittent care is estimated to occur _____ times per (☐ day / ☐ week / ☐ month) and are likely to last approximately _____ (☐ hours / ☐ days) per episode.

Signature of Health Care Provider_____ **Date** _____ *(mm/dd/yyyy)*

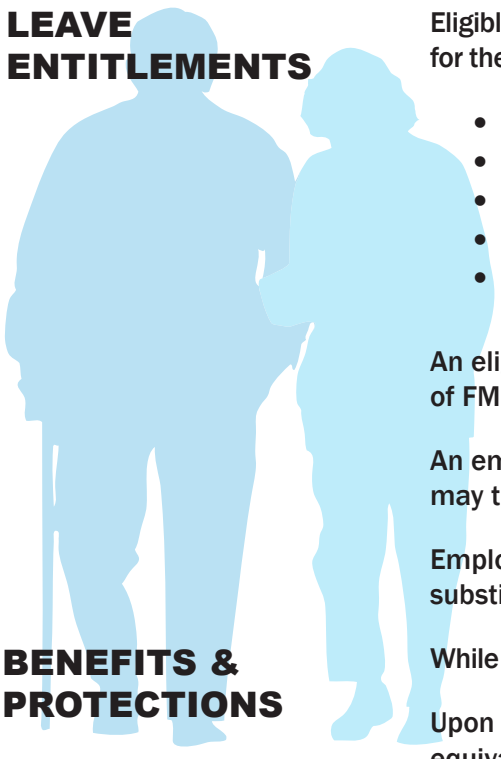
PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

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 15 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Avenue, NW, Washington, DC 20210.

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

EMPLOYEE RIGHTS
UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION



LEAVE ENTITLEMENTS

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within one year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

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

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

BENEFITS & PROTECTIONS

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

ELIGIBILITY REQUIREMENTS

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

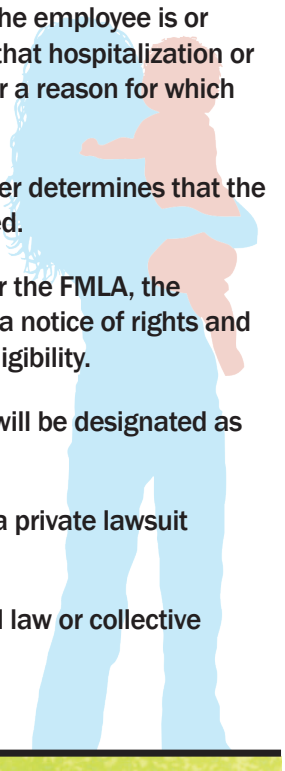
*Special "hours of service" requirements apply to airline flight crew employees.

REQUESTING LEAVE

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.



EMPLOYER RESPONSIBILITIES

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

ENFORCEMENT

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

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