# Standard Operating Procedures

## Family and Medical Leave Act

**Poster Requirement**

As an employer of 50 or more, we are required to post an enlarged version of Attachment 1 (Notice to Employees of Rights Under FMLA) prominently where it can be readily seen by employees and applicants for employment. The poster and the text must be large enough to be easily read and contain fully legible text.

**Intake Process**

1. Any employee who is absent from work for any of the following reasons, must be referred to the Human Resources Dept. (HRD) or designated manager:

    a. employee's own health condition (i.e., a single overnight stay in the hospital, 3 or more consecutive days absent from work while under a doctor's care, any absence related to pregnancy, long-term health conditions like cancer, or chronic conditions like asthma, epilepsy, etc.)
    b. employee's family member's health condition (i.e., the same types of conditions described above in 1.a.)
    c. birth or adoption of a child or placement of a foster child in employee's home
    d. any "qualifying exigency" arising out of the fact that the employee's spouse, child, or parent is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces supporting a military action.
    e. if the employee is a spouse, child, parent, or next of kin of a covered Armed Services member who has an injury or illness he/she incurred in the line of duty. (Unlike the foregoing situations where the employee could have up to 12 workweeks of leave, the employee in this situation may be entitled to a total of 26 workweeks of leave.)

2. HRD will discuss the matter with the employee either in person or on the telephone. In either case, the conversation will be held in private. (Remember: All medical information must be kept confidential.)

**Initial Review by HRD**

1. HRD will analyze the situation to ensure that the employee is eligible for FMLA leave and notify him/her of that eligibility using Attachment 2 (Notice of Eligibility and Rights & Responsibilities).

    a. An employee is eligible for FMLA if he/she: 1) is employed at a worksite with 50 or more employees within a 75 mile radius; 2) has been employed by the Company for at least 12 months (including non-consecutive months); AND 3) has worked at least 1,250 hours in the 12 months immediately preceding the leave.

    b. Eligible employees are only entitled to FMLA leave for one of the five reasons described above in the "Intake Process". Beginning during this Initial Review, any leave an employee takes for one of these five reasons should be granted and counted against his/her 12-week or 26-week leave entitlement under the FMLA. If during the review process, it turns out that the employee's leave request must be denied, the leave taken may lose its FMLA protection. (PLEASE NOTE: Even if an employee is not eligible for FMLA, an absence for a condition more serious than a cold or minor headache will more then likely be considered a protected absence under the Americans with Disabilities Act or similar state law.)

2. Depending on how Attachment 2 is completed (i.e., if the leave is for the employee's or an immediate family member's serious health condition or a military-related leave), the employee may be required to provide a certification supporting his/her leave request. If a certification is required and completed properly, HRD will review it and notify the employee of whether or not his/her leave request is FMLA-qualifying within 5 business days of its receipt. Attachment 3

(Designation Notice) will be used for this purpose. (PLEASE NOTE: Even if no certification is required (e.g., for birth or placement of a child), use Attachment 3 to notify the employee of the FMLA designation or rejection.)

a. Have the employee complete and return Attachment 4 (Certification of Health Care Provider for Employee's Serious Health Condition) for his/her own condition or Attachment 5 (Certification of Health Care Provider for Family Member's Serious Health Condition) for an immediate family member's condition. Give the employee at least 15 calendar days to return it. Those certifications will be reviewed by HRD.

b. If the reason for the leave is military-related, the employee will be asked to submit a different kind of completed certification form appropriate for the leave (see Attachments 6 – Certification of Qualifying Exigency for Military Family Leave and 7 – Certification for Serious Injury or Illness of Covered Servicemember for Military Family Leave). Those certifications will be reviewed by HRD.

**Review of Certification Forms**

1. HRD will review the certification forms for completeness. If the certification is incomplete or unclear, HRD will return the form to the employee with instructions to have either his/her doctor or appropriate military official answer a list of specific questions. The specific questions will be any of the unanswered or vaguely answered questions which are applicable to the employee's situation. The employee must be given at least 15 days to return the amended form.

    a. If the amended certification is complete and clear, the HRD will grant the FMLA leave as described in the form.

    b. In the case of medical conditions, if the doctor fails to amend the certification or fails to complete or clarify it, or if the employee fails to return the amended certification, HRD will require the employee to obtain a second opinion at your Company's expense. The second opinion will be obtained from an independent doctor of your Company's choice (i.e., <u>not</u> a doctor with whom your Company has any type of business relationship).

        i. If the first and second opinions agree, HRD will grant the FMLA leave as described in the certificate.

        ii. If the first and second opinions conflict, your Company and the employee must agree on a doctor to provide a third opinion, at your Company's expense. The third opinion will control.

    c. If the employee never returns the certificate or otherwise refuses to cooperate to complete the certificate, the leave can be denied until he/she complies.

    d. Following the review, use Attachment 3 to notify the employee of the FMLA designation or rejection within 5 business days of receiving the properly completed certificate. (Remember: If the employee is determined to be entitled to an FMLA leave, count all the leave taken during the review process toward the employee 12-week or 26-week leave entitlement.)

**Managing Intermittent Leaves for Serious Health Conditions**

1. When an employee has been granted an intermittent leave under the FMLA, the HRD will provide a copy of the final completed medical certification and any related information to the employee's immediate supervisor. The immediate supervisor will meet with the employee prior to their first (or next) intermittent FMLA absence to set up a schedule that includes as many treatments or doctor's visits as possible during off-work hours (when applicable to the employee's situation).

2. When an employee calls in to take an intermittent FMLA leave day(s), the person taking the call should record the time at which the call was received. Remember, failure to adhere to call-in procedures may be grounds for discipline.

3. The person taking the call should notify the employee's immediate supervisor about the leave request and the time the call came in.

4. The employee's immediate supervisor will contact the employee to ask questions about the absence. The specific questions will vary depending on the circumstances. However, all the questions **must be job-related**. In other words the questions must be related to things such as:

    a. why the employee will be absent
    b. how long the employee will be absent
    c. where will the employee be going during the absence
    d. what the employee will be doing during the absence
    e. if applicable, ask why it (e.g., doctor visits, physical therapy) cannot be done before or after work. (Remember to ask these questions **in private**. All medical information must be kept confidential.)

5. If an employee approaches a supervisor requesting an intermittent FMLA leave day(s) in person, the supervisor should ask the same sort of job-related questions described above to the employee **in private**.

6. Whether the employee is questioned on the phone or in person, the manager who did the questioning must keep a written record of what was asked and said in the meeting.

**Notice to All Managers Aware of an Employee's FMLA Leave**

1. If you see a suspicious pattern to the employee's FMLA absences, **REPORT IT TO HRD** (Example – migraine headaches only on Mondays and Fridays, physical therapy appointments on holidays that employee is scheduled to work, etc.)

2. If you see the employee where he/she should not be on a day of FMLA leave, **REPORT IT TO HRD**. (Example – at a football game on the day of surgery)

3. If answers/reasons for the absence are suspicious, **REPORT IT TO HRD** (Examples - FMLA leave day taken after vacation is denied for that day; joking comments about "I feel an FMLA day coming up")

**Ongoing Medical Certifications and Misconduct Investigations**

1. All employees who are granted FMLA leave on an intermittent basis for their own serious health condition and/or the serious health condition of their immediate family members, should be required to provide new medical certifications every 30 days, unless the certification provides for a longer duration. For example, if the certification states that the employee's condition will last for eight months, the Company could not request certification every 30 days. In all cases, however, employees will be required to provide medical re-certifications every six months following that initial granting of FMLA leave.

2. If HRD receives a report indicating that an employee may be fraudulently using the FMLA leave, it will undertake a misconduct investigation of the employee. This may require obtaining evidence of the employee's use of the leave (e.g., doctor's notes to prove attendance at appointments, physical therapy, phone records etc.). Under these circumstances, medical re-certifications can be required more frequently than described above; even more frequently than every 30 days. Specifically, any time there is evidence that an employee's reason for taking FMLA leave has changed or ended, a medical re-certification can and will be requested.

**Once FMLA Leave is Exhausted**

1. Notify the employee that his/her FMLA leave has ended (Attachment 8) and inform him/her of the right to continue health benefits (if any) at his/her own expense with the appropriate COBRA notification forms.

2. If employee does not return within a reasonable time, send follow up letter (Attachment 9).

3. If it becomes clear that employee will not return to work, or employee continues to be out on "indefinite" leave, consult with an employment attorney about sending termination letter (Attachment 10).

**REMEMBER:** ALL MEDICAL DOCUMENTATION REFERRED TO UNDER THIS STANDARD OPERATING PROCEDURE IS CONFIDENTIAL. ONLY MANAGERS WITH A "NEED TO KNOW" FOR LEGITIMATE BUSINESS REASONS WILL BE GRANTED ACCESS TO IT. ALL SUCH CONFIDENTIAL DOCUMENTATION MUST BE KEPT IN LOCKED FILE CABINETS, SEPARATE FROM THE EMPLOYEES' PERSONNEL FOLDERS.

# Attachment 1

Appendix C to Part 825–Notice to Employees Of Rights Under FMLA (WH Publication 1420)

# EMPLOYEE RIGHTS AND RESPONSIBILITIES
## UNDER THE FAMILY AND MEDICAL LEAVE ACT

### Basic Leave Entitlement
FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:
- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

### Military Family Leave Entitlements
Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

### Benefits and Protections
During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

### Eligibility Requirements
Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

### Definition of Serious Health Condition
A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

### Use of Leave
An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

### Substitution of Paid Leave for Unpaid Leave
Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

### Employee Responsibilities
Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

### Employer Responsibilities
Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

### Unlawful Acts by Employers
FMLA makes it unlawful for any employer to:
- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

### Enforcement
An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

**FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.**

**For additional information:**
1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627
**WWW.WAGEHOUR.DOL.GOV**

U.S. Wage and Hour Division

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

WHD Publication 1420 (Rev. XX-XXX)

# Attachment 2

**Appendix D to Part 825—Notice of Eligibility and Rights & Responsibilities (Form WH-381)**

**Appendix D**

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

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

U.S. Wage and Hour Division

OMB Control Number: 1215-0181
Expires: XX/XX/XXX

In general, to be eligible an employee must have worked for an employer for at least 12 months, have worked at least 1,250 hours in the 12 months preceding the leave, and work at a site with at least 50 employees within 75 miles. While use of this form by employers is optional, a fully completed Form WH-381 provides employees with the information required by 29 C.F.R. § 825.300(b), which must be provided within five business days of the employee notifying the employer of the need for FMLA leave. Part B provides employees with information regarding their rights and responsibilities for taking FMLA leave, as required by 29 C.F.R. § 825.300(b), (c).

**[Part A – NOTICE OF ELIGIBILITY]**

TO: _____
Employee

FROM: _____
Employer Representative

DATE: _____

On _____, you informed us that you needed leave beginning on _____ for:

_____ The birth of a child, or placement of a child with you for adoption or foster care;

_____ Your own serious health condition;

_____ Because you are needed to care for your ____ spouse; _____child; _____ parent due to his/her serious health condition.

_____ Because of a qualifying exigency arising out of the fact that your ____ spouse; _____son or daughter; _____ parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves.

_____ Because you are the ____ spouse; _____son or daughter; _____ parent; _____ next of kin of a covered servicemember with a serious injury or illness.

This Notice is to inform you that you:

_____ Are eligible for FMLA leave (See Part B below for Rights and Responsibilities)

_____ Are **not** eligible for FMLA leave, because (only one reason need be checked, although you may not be eligible for other reasons):

_____ You have not met the FMLA's 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately ___ months towards this requirement.
_____ You have not met the FMLA's 1,250-hours-worked requirement.
_____ You do not work and/or report to a site with 50 or more employees within 75-miles.

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

**[PART B-RIGHTS AND RESPONSIBILITIES FOR TAKING FMLA LEAVE]**

As explained in Part A, you meet the eligibility requirements for taking FMLA leave and still have FMLA leave available in the applicable 12-month period. **However, in order for us to determine whether your absence qualifies as FMLA leave, you must return the following information to us by _____.** (If a certification is requested, employers must allow at least 15 calendar days from receipt of this notice; additional time may be required in some circumstances.) If sufficient information is not provided in a timely manner, your leave may be denied.

____ Sufficient certification to support your request for FMLA leave. A certification form that sets forth the information necessary to support your request ____**is**/____**is not** enclosed.

____ Sufficient documentation to establish the required relationship between you and your family member.

____ Other information needed: _____

_____

_____

____ No additional information requested


CONTINUED ON NEXT PAGE

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

____ Contact _____ at _____ to make arrangements to continue to make your share of the premium payments on your health insurance to maintain health benefits while you are on leave. You have a minimum 30-day (or, indicate longer period, if applicable) grace period in which to make premium payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse, or, at our option, we may pay your share of the premiums during FMLA leave, and recover these payments from you upon your return to work.

____ You will be required to use your available paid _____ **sick**, _____ **vacation**, and/or _____**other leave** during your FMLA absence. This means that you will receive your paid leave and the leave will also be considered protected FMLA leave and counted against your FMLA leave entitlement.

____ Due to your status within the company, you are considered a "key employee" as defined in the FMLA. As a "key employee," restoration to employment may be denied following FMLA leave on the grounds that such restoration will cause substantial and grievous economic injury to us. We ___**have**/____ **have not** determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic harm to us.

____ While on leave you will be required to furnish us with periodic reports of your status and intent to return to work every _____. (Indicate interval of periodic reports, as appropriate for the particular leave situation).

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

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

- You have a right under the FMLA for up to 12 weeks of unpaid leave in a 12-month period calculated as:

  _____ the calendar year (January – December).

  _____ a fixed leave year based on _____.

  _____ the 12-month period measured forward from the date of your first FMLA leave usage.

  _____ a "rolling" 12-month period measured backward from the date of any FMLA leave usage.

- You have a right under the FMLA for up to 26 weeks of unpaid leave in a single 12-month period to care for a covered servicemember with a serious injury or illness. This single 12-month period commenced on _____.
- Your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work.
- You must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA-protected leave. (If your leave extends beyond the end of your FMLA entitlement, you do not have return rights under FMLA.)
- If you do not return to work following FMLA leave for a reason other than: 1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; 2) the continuation, recurrence, or onset of a covered servicemember's serious injury or illness which would entitle you to FMLA leave; or 3) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave.
- If we have not informed you above that you must use accrued paid leave while taking your unpaid FMLA leave entitlement, you have the right to have ____ **sick,** ____**vacation,** and/or ___ **other leave** run concurrently with your unpaid leave entitlement, provided you meet any applicable requirements of the leave policy. Applicable conditions related to the substitution of paid leave are referenced or set forth below. If you do not meet the requirements for taking paid leave, you remain entitled to take unpaid FMLA leave.

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

  ____Applicable conditions for use of paid leave:_____

  _____

  _____

  _____

  _____

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

_____at _____.

**PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT**

It is mandatory for employers to provide employees with notice of their eligibility for FMLA protection and their rights and responsibilities. 29 U.S.C. § 2617; 29 C.F.R. § 825.300(b), (c). It is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 10 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.**

# Attachment 3

**Appendix E to Part 825—Designation Notice to Employee of FMLA Leave (Form WH-382)**

**Appendix E**

## Designation Notice (Family and Medical Leave Act)

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

U.S. Wage and Hour Division

OMB Control Number: 1215-0181
Expires: XX/XX/XXX

**Leave covered under the Family and Medical Leave Act (FMLA) must be designated as FMLA-protected and the employer must inform the employee of the amount of leave that will be counted against the employee's FMLA leave entitlement. In order to determine whether leave is covered under the FMLA, the employer may request that the leave be supported by a certification. If the certification is incomplete or insufficient, the employer must state in writing what additional information is necessary to make the certification complete and sufficient. While use of this form by employers is optional, a fully completed Form WH-382 provides an easy method of providing employees with the written information required by 29 C.F.R. §§ 825.300(c), 825.301, and 825.305(c).**

To: _____

Date: _____

We have reviewed your request for leave under the FMLA and any supporting documentation that you have provided. We received your most recent information on _____ and decided:

_____ **Your FMLA leave request is approved. All leave taken for this reason will be designated as FMLA leave.**

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

_____ Provided there is no deviation from your anticipated leave schedule, the following number of hours, days, or weeks will be counted against your leave entitlement: _____

_____ Because the leave you will need will be unscheduled, it is not possible to provide the hours, days, or weeks that will be counted against your FMLA entitlement at this time. You have the right to request this information once in a 30-day period (if leave was taken in the 30-day period).

**Please be advised (check if applicable):**

_____ You have requested to use paid leave during your FMLA leave. Any paid leave taken for this reason will count against your FMLA leave entitlement.

_____ We are requiring you to substitute or use paid leave during your FMLA leave.

_____ You will be required to present a fitness-for-duty certificate to be restored to employment. If such certification is not timely received, your return to work may be delayed until certification is provided. A list of the essential functions of your position ___ **is** ___ **is not** attached. If attached, the fitness-for-duty certification must address your ability to perform these functions.

_____ **Additional information is needed to determine if your FMLA leave request can be approved:**

_____ The certification you have provided is not complete and sufficient to determine whether the FMLA applies to your leave request. You must provide the following information no later than _____, unless it is not
(Provide at least seven calendar days)
practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied.

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

_____

_____ We are exercising our right to have you obtain a second or third opinion medical certification at our expense, and we will provide further details at a later time.

_____ Your FMLA Leave request is Not Approved.
_____ The FMLA does not apply to your leave request.
_____ You have exhausted your FMLA leave entitlement in the applicable 12-month period.

**PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT**

It is mandatory for employers to inform employees in writing whether leave requested under the FMLA has been determined to be covered under the FMLA. 29 U.S.C. § 2617; 29 C.F.R. §§ 825.300(d), (e). It is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 10 – 30 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.**

Form WH-382 November 2008

# Attachment 4

**Appendix B**

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

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

U.S. Wage and Hour Division

OMB Control Number: 1215-0181
Expires: XX/XX/XXX

**SECTION I: For Completion by the EMPLOYER**

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

Employer name and contact: _____

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions: _____

_____

Check if job description is attached: _____

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

**INSTRUCTIONS to the EMPLOYEE:** Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: _____
First Middle Last

**SECTION III: For Completion by the HEALTH CARE PROVIDER**

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

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____) _____ Fax:(_____) _____


CONTINUED ON NEXT PAGE

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

Probable duration of condition: _____

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

_____

Date(s) you treated the patient for condition:

_____

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

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

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

_____

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

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

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

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

_____

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

_____

_____

_____

_____

_____

_____

_____


CONTINUED ON NEXT PAGE

PART B: AMOUNT OF LEAVE NEEDED

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

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

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

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

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

   _____

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

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

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

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

   _____

   _____

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

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

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

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____


CONTINUED ON NEXT PAGE

**Signature of Health Care Provider** **Date**

**PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT**

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

# Attachment 5

**Appendix B**

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

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

U.S. Wage and Hour Division

OMB Control Number: 1215-0181
Expires: XX/XX/XXX

**SECTION I: For Completion by the EMPLOYER**

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

Employer name and contact: _____

_____

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

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

Your name: _____
First Middle Last

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

Relationship of family member to you: _____

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

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

_____

_____

_____

_____ _____
Employee Signature Date



CONTINUED ON NEXT PAGE

**SECTION III: For Completion by the HEALTH CARE PROVIDER**

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

Provider's name and business address:_____

Type of practice / Medical specialty: _____

Telephone: (_____) _____ Fax:(_____) _____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

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

   Date(s) you treated the patient for condition: _____

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

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

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

   _____

   _____

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

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

_____

_____

_____

_____

 CONTINUED ON NEXT PAGE 

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

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ___No ___Yes.

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

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

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

   _____

   _____

   _____

   _____

   _____

5. Will the patient require follow-up treatments, including any time for recovery? ___No ___Yes.

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

   _____

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

   _____

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

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

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

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

   _____

   _____

   _____

   _____


CONTINUED ON NEXT PAGE

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ____No ____Yes.

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

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

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

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

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

_____

_____

_____

_____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

_____ _____

**Signature of Health Care Provider** **Date**

**PUBLIC BURDEN STATEMENT**

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

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

# Attachment 6

**Appendix F to Part 825—[Reserved]**

**Appendix G to Part 825—Certification of Qualifying Exigency for Military Family Leave (Form WH-384)**

**Appendix G**

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

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

U.S. Wage and Hour Division

OMB Control Number: 1215-0181
Expires: XX/XX/XXX

**SECTION I: For Completion by the EMPLOYER**

**INSTRUCTIONS to the EMPLOYER:** The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a qualifying exigency to submit a certification. Please complete Section I before giving this form to your employee. Your response is voluntary, and while you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. § 825.309.

Employer name: _____

Contact Information: _____

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

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

Your Name: _____
First Middle Last

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

_____
First Middle Last

Relationship of covered military member to you: _____

Period of covered military member's active duty: _____

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

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


CONTINUED ON NEXT PAGE

PART A: QUALIFYING REASON FOR LEAVE

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

_____

_____

_____

_____

_____

_____

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

PART B: AMOUNT OF LEAVE NEEDED

1. Approximate date exigency commenced: _____

Probable duration of exigency: _____

2. Will you need to be absent from work for a single continuous period of time due to the qualifying exigency? ___No ___Yes.

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

_____.

3. Will you need to be absent from work periodically to address this qualifying exigency? ___No ___Yes.

Estimate schedule of leave, including the dates of any scheduled meetings or appointments:_____

_____

_____

_____

Estimate the frequency and duration of each appointment, meeting, or leave event, including any travel time (i.e., 1 deployment-related meeting every month lasting 4 hours):

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

Duration: _____ hours ___ day(s) per event.


CONTINUED ON NEXT PAGE

# Attachment 7

**Appendix H to Part 825—Certification for Serious Injury or Illness of Covered Servicemenber for Military Family Leave (Form WH-385)**

**Appendix H**

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

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

U.S. Wage and Hour Division

OMB Control Number: 1215-0181
Expires: XX/XX/XXX

**Notice to the EMPLOYER** **INSTRUCTIONS to the EMPLOYER:** The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a serious injury or illness of a covered servicemember to submit a certification providing sufficient facts to support the request for leave. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. § 825.310. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees or employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

**SECTION I: For Completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the Employee Is Requesting Leave** **INSTRUCTIONS to the EMPLOYEE or COVERED SERVICEMEMBER:** Please complete Section I before having Section II completed. The FMLA permits an employer to require that an employee submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a serious injury or illness of a covered servicemember. If requested by the employer, your response is required to obtain or retain the benefit of FMLA-protected leave. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to do so may result in a denial of an employee's FMLA request. 29 C.F.R. § 825.310(f). The employer must give an employee at least 15 calendar days to return this form to the employer.

**SECTION II: For Completion by a UNITED STATES DEPARTMENT OF DEFENSE ("DOD") HEALTH CARE PROVIDER or a HEALTH CARE PROVIDER who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider** **INSTRUCTIONS to the HEALTH CARE PROVIDER:** The employee listed on Page 2 has requested leave under the FMLA to care for a family member who is a member of the Regular Armed Forces, the National Guard, or the Reserves who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list for a serious injury or illness. For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty that may render the servicemember medically unfit to perform the duties of his or her office, grade, rank, or rating.

A complete and sufficient certification to support a request for FMLA leave due to a covered servicemember's serious injury or illness includes written documentation confirming that the covered servicemember's injury or illness was incurred in the line of duty on active duty and that the covered servicemember is undergoing treatment for such injury or illness by a health care provider listed above. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave.

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

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

U.S. Wage and Hour Division

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

## Part A: EMPLOYEE INFORMATION

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

_____

Name of Employee Requesting Leave to Care for Covered Servicemember:

_____
First Middle Last

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

_____
First Middle Last

Relationship of Employee to Covered Servicemember Requesting Leave to Care:
☐ Spouse ☐ Parent ☐ Son ☐ Daughter ☐ Next of Kin

## Part B: COVERED SERVICEMEMBER INFORMATION

(1) Is the Covered Servicemember a Current Member of the Regular Armed Forces, the National Guard or Reserves? ___Yes ____No

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

_____

Is the covered servicemember assigned to a military medical treatment facility as an outpatient or to a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients (such as a medical hold or warrior transition unit)? ___Yes ___No If yes, please provide the name of the medical treatment facility or unit:

_____

(2) Is the Covered Servicemember on the Temporary Disability Retired List (TDRL)? ____Yes ____No

## Part C: CARE TO BE PROVIDED TO THE COVERED SERVICEMEMBER

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

_____

**SECTION II: For Completion by a United States Department of Defense ("DOD") Health Care Provider or a Health Care Provider who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider. If you are unable to make certain of the military-related determinations contained below in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator).** (Please ensure that Section I above has been completed before completing this section.) Please be sure to sign the form on the last page.

Part A: HEALTH CARE PROVIDER INFORMATION

Health Care Provider's Name and Business Address:

_____

Type of Practice/Medical Specialty: _____

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

Telephone: (  ) _____ Fax: (  ) _____ Email: _____

PART B: MEDICAL STATUS

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

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

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

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

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

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

(3) Approximate date condition commenced: _____

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

(5) Is the covered servicemember undergoing medical treatment, recuperation, or therapy? ____Yes ___No. If yes, please describe medical treatment, recuperation or therapy:


CONTINUED ON NEXT PAGE

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

(1) Will the covered servicemember need care for a single continuous period of time, including any time for treatment and recovery? ___ Yes ___ No
If yes, estimate the beginning and ending dates for this period of time: _____

(2) Will the covered servicemember require periodic follow-up treatment appointments?
___ Yes ___ No If yes, estimate the treatment schedule: _____

(3) Is there a medical necessity for the covered servicemember to have periodic care for these follow-up treatment appointments? ____Yes _____No

(4) Is there a medical necessity for the covered servicemember to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)? ____Yes ____No If yes, please estimate the frequency and duration of the periodic care:

_____

_____

**Signature of Health Care Provider:** _____ **Date:** _____

**PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT**

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



[FR Doc. E8–26577 Filed 11–14–08; 8:45 am]
BILLING CODE 4510–27–C

**CERTIFIED MAIL**
**RETURN RECEIPT REQUESTED**

**RE: Leave of Absence**

Dear _____:

I am writing to inform you that your 12 weeks of leave under the provisions of the Family and Medical Leave Act (FMLA) expired on _____. I understand that you are not able to return to work at this time. We are willing to extend your leave as an accommodation.

**[Please be advised that your employment-related benefits will terminate effective _____. If COBRA is applicable -- we will provide you with additional information shortly regarding any rights you and your dependents may have to continuation of certain benefits at your own expense.]**

You should be aware, however, that we will not be able to continue your leave indefinitely. Your continued absence has placed a strain on our operations. Further extensions of your leave may present an undue hardship to our Company.

Please keep me informed of your progress, including any updated doctor's notes.

Please call me if you have any questions.

Yours truly,

**CERTIFIED MAIL**
**RETURN RECEIPT REQUESTED**

**RE: Employment Status**

Dear _____:

Your inability to return to work due to your ongoing medical problem is putting increased strains on our organization. It is becoming increasingly difficult for us to get by without a full time [position] . As you know, we have a limited-staff and cannot readily "cover" for employees who are absent for long periods of time.

While we have endeavored to keep a position open for you at our Company, unfortunately, the prolonged nature of your absence is making it virtually impossible for us to do so. We can no longer guarantee a position for you when you are ready and able to return to work.

Please advise us by [approx, two weeks] of the status of your medical situation to the extent it affects your ability to work here. If we do not hear from you by this date, your employment will be automatically terminated.

Should you have any questions regarding this letter, please do not hesitate to contact me.

Sincerely,

**CERTIFIED MAIL**
**RETURN RECEIPT REQUESTED**

**RE: Employment Status**

Dear _____:

As you know, you have been out of work since _____. Your FMLA leave was exhausted on _____. We then attempted to accommodate you by allowing you to continue on a leave of absence until now.

Based on the information you have provided to date, there does not appear to be a timeframe within which you might be able to return to work and perform the essential functions of your job. Given the continued indefiniteness of your absence, your inability to perform the essential functions of your job (or any open job we might have here) and the increased strains placed on the Company by your absence, we have found it is necessary to replace you. We regret that our business necessities require this action.

If you are able to return to work at a later time, we strongly encourage you to reapply. As always, we do hope things work out for the best. Please call me with any questions.