CENTRAL CONNECTICUT REGIONAL PLANNING AGENCY
Family and Medical Leave Act (FLMA) Policy and Documentation
Date adopted/revised:

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POLICY

Employees who have worked for the Agency for at least twelve (12) months, and who have worked at least 1,250 actual work hours during the twelve (12) months immediately preceding the start of a leave, are eligible for unpaid leave under the Federal Family and Medical Leave Act ("FMLA"). Leaves under the FMLA may be taken for the following reasons:

a. the birth and/or care of the employee's newborn child;
b. the placement of a child with the employee by adoption or for foster care;
c. to care for the employee's spouse, child or parent who has a serious health condition;
d. to care for the employee's own serious health condition that renders the employee unable to perform the functions of his or her position;
e. to serve as an organ or bone marrow donor;
f. due to a "qualifying exigency" of an employee whose 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 in support of a contingency operation; or
g. to care for the employee's spouse, child, parent or next of kin who is a covered servicemember who has a serious injury or illness.

If a leave is designated for any of the reasons identified in Paragraphs (a) – (f) above, each eligible employee may take up to a total of twelve (12) weeks unpaid family or medical leave in any 12-month period measured from the initial date of the employee's first leave taken under this policy. If a leave is designated for the reason identified in Paragraph (g) above, each eligible employee may take up to a total of twenty-six (26) weeks unpaid family or medical leave in the 12-month entitlement period as measured from the initial date of the employee's first leave under this policy.

The maximum amounts of FMLA leave stated above do not afford eligible employees the ability to take more leave if they have multiple qualifying reasons than they otherwise would be entitled to take for a single qualifying reason during the applicable twelve-month period. Any absences that qualify as FMLA leave run concurrently with an absence under workers' compensation laws.

Any leave spent performing "light duty" work does not count against an employee's FMLA leave entitlement, whether such "light duty" work has been required by the Agency or requested by the employee. Therefore, any employee's right to restoration of his or her job is held in abeyance during the period of time (if any) the employee performs light duty (or until the end of the applicable FMLA leave period).

Since the purpose of any leave provided under this policy is to enable employees to maintain their ability to continue employment with the Agency, an employee may not work elsewhere while on FMLA leave, unless otherwise required by applicable law.

Full-time unpaid leave may be designated for any of the reasons permitted by the FMLA. Full-time leave excuses the employee from work for a continuous period of time. Intermittent leave means leave taken in separate periods of time rather than for one continuous period of time. Examples of intermittent leave include: leave taken one day per week over a period of a few months; or leave taken on an occasional/as-needed basis for medical appointments. Reduced schedule leave is leave that reduces the employee's usual number of work hours per day for some period of time. For example, an employee may be afforded half-time work leave for a number

of weeks so the employee can assist in the care of a seriously ill parent. An employee may be provided with full-time, intermittent or reduced schedule leave whenever it is medically necessary for a serious health condition of the eligible employee, his or her spouse, child or parent, or due to a qualifying exigency or the serious injury or illness of a covered servicemember. When planning medical treatment or seeking intermittent or reduced schedule leave, the employee must consult with the Executive Director (or a designee) and must make a reasonable effort to schedule the treatment or intermittent or reduced schedule leave to avoid unduly disruptive effects on the Agency's operations. Intermittent leave or reduced schedule leave for other reasons will be permitted only with the approval of the Executive Director (or a designee). If intermittent or reduced schedule leave is medically required, the Agency may, in its sole discretion, temporarily transfer the employee to another job that better accommodates such leave, so long as the temporary position has equivalent pay and benefits (but not necessarily equivalent duties).

If both spouses are employees of the Agency and request leave for the birth, placement of a child by adoption or for foster care, or to care for a parent with a serious health condition, they will be entitled only to a maximum combined total leave equal to twelve (12) weeks in the 12-month entitlement period as measured in the same manner as described above. If either spouse or both uses a portion of the total 12-week entitlement for one of the purposes identified in the preceding sentence, each is entitled to the difference between the amount he or she has taken individually and the 12 weeks for FMLA leave for their own or their spouse's serious health condition in the 12-month entitlement periods. For purposes of leave due to each spouse's own serious health condition, or to care for the serious health condition of his/her child or the other spouse, or due to a qualifying exigency, each spouse is eligible to receive the maximum leave time allowable to one individual eligible employee. Similarly, for leave taken due to the serious injury or illness of a covered servicemember (or for a combination of leave taken for this reason and any other qualifying reason), each spouse is eligible for the maximum leave allowable to one individual eligible employee.

Employees needing FMLA leave must, at a minimum, follow the Agency's usual and customary call-in procedures for reporting an absence, absent unusual circumstances.

Notice of and/or request for a family or medical leave must be submitted to the Executive Director) at least thirty (30) days before the leave is to commence whenever leave is foreseeable based upon an expected birth, placement for adoption or foster care, planned medical treatment, or to care for others. If thirty (30) day's notice is not possible, such as in the case of an unforeseen emergency or qualifying exigency, the employee must provide notice and/or submit a request as soon as practicable as the need for the leave is known (typically within one or two working days of learning of the need for the leave). Failure to comply with these notice rules is grounds for, and may result in, deferral or denial of the requested leave.

For leaves taken because of the serious health condition of the employee or the employee's child, parent or spouse, or due to the serious injury or illness of a covered servicemember, the employee must submit a completed health care provider certification form before the leave begins. This form may be obtained from the Executive Director. If providing such advance certification is impossible, the employee must submit the medical certification within fifteen (15) calendar days after the leave begins (or after otherwise being requested by the Agency), unless the employee can demonstrate that it is not practicable to do so despite his/her good faith

efforts. Subsequent medical re-certification will be required as necessary, but no more than once every thirty days after receipt of the initial medical certification.

In response to a request for leave necessitated by the serious health condition of the employee or others, the Agency may require the employee to obtain a second opinion from a health care provider selected and paid for by the Agency. All leaves due to a qualifying exigency must be accompanied by a certification as the United States Secretary of Labor has prescribed.

While on leave, employees are, at a minimum, required to report on the 1st day of each month to the Executive Director (or a designee) regarding the status of the family or medical condition(s) and their intent to return to work. Under Agency policy, employees are required to provide at least two weeks of advance notification of the date they intend to return to work from a leave of absence.

If an employee takes leave to care for his or her own serious health condition (other than an employee taking intermittent or reduced schedule leave), the employee must provide medical certification prior to returning to work that the health condition that created the need for the leave no longer renders the employee unable to perform the functions of the job. This certification must be submitted to the Executive Director. If there are any medical restrictions upon an employee's return to work, the health care provider should state these restrictions in the certificate provided. It is the employee's responsibility to notify the Executive Director prior to returning to work and make the Executive Director aware of any restrictions. Employees will not be eligible to return to work after a medical leave without being medically cleared to do so. In addition, the Agency reserves the right to have its own health care provider and/or the Executive Director (or a designee) contact the employee's health care provider for purposes of clarification of the employee's fitness to return to work certification. Other than the Executive Director, under no circumstances will an employee's direct supervisor make contact with the employee's health care provider for purposes of determining fitness of duty (or any other medical certification issue pertaining to FMLA). Failure to comply with any of the medical certification or re-certification rules identified above is grounds for, and may result in, termination of any leave entitlement or delay or denial of any return to work.

Accrued paid personal leave and accrued paid vacation will be substituted (in that order) for any unpaid portions of family or medical leave taken for any reason. However, where the leave is for the employee's own serious health condition, accrued paid sick leave shall be substituted for unpaid portions of family or medical leave prior to the substitution of accrued paid personal and accrued paid vacation leave. The amount of unpaid family or medical leave entitlement is reduced by the amount of paid leave that is substituted. While as stated above all accrued paid leave must be used in accordance with Agency policy before an employee is eligible to utilize any unpaid family or medical leave, an employee will not be required to utilize any such paid leave during an FMLA leave if she/he is simultaneously receiving payments under workers' compensation laws. The maximum amount of family and medical leave allowed, whether it includes paid and/or unpaid leave or whether it includes time off during which an employee is receiving payments under workers' compensation laws, will not exceed the maximum leave entitlement as described above.

During approved family or medical leaves of absence, the Agency will continue to pay its portion of medical insurance premiums for the period of unpaid family or medical leave. The employee

must continue to pay his/her share of the premium, and failure to do so may result in loss of coverage. While on paid leave, the Agency will continue to make payroll deductions to collect the employee's share of the medical insurance premiums. While on unpaid leave, the employee must continue to pay his/her share of the medical insurance premiums, either in person or by mail. The payment must be received by the 1st day of each month. Failure of the employee to pay the premium may result in loss of coverage.

Employees have a 30-day grace period in which to make required premium payments while on unpaid leave. If payment is not timely made, health insurance coverage may be cancelled, if the employee has been notified in writing at least 15 days before the date that coverage would lapse. At the Agency's option, the Agency may pay the employee's share of the premiums during FMLA leave if the coverage were to lapse due to failure of the employee to make timely payments, and then recover such payments from the employee upon return to work. Should an employee's health insurance lapse due to non-payment while on FMLA leave, the Agency will again provide health insurance benefits according to the applicable plans when and if the employee returns from the leave of absence. If the employee does not return to work after expiration of the leave, the employee will be required to reimburse the Agency for payment of medical insurance premiums during the family or medical leave, unless the employee does not return because of: (a) the continuation, recurrence or onset of a serious health condition (or serious injury or illness in the case of a covered servicemember) which would otherwise render the employee eligible for FMLA leave; or (b) other circumstances beyond the employee's control.

An employee will not be credited for any service time accrued during FMLA leave until they return to work. Furthermore, any unused employment benefits accrued by the employee up to the day on which the leave begins will not be lost upon return to work. During any portion of FMLA leave that is unpaid, an employee shall not continue to accrue sick, vacation or personal leave. However, during any portion of FMLA leave in which the employee continues to be paid, an employee shall continue to accrue sick, vacation or personal leave but cannot use any such leave until after they return to work following FMLA leave. If the employee does not return to work following FMLA (whether paid or not), any accrued time earned but unused during the FMLA leave will be paid out in accordance with any applicable Agency policies.

If an employee is considered a "key employee" as defined in the FMLA, restoration to employment may be denied following FMLA if restoration will cause substantial and grievous economic injury to the Agency. If an employee is not a "key employee" as defined in the FMLA, upon the conclusion of an employee's FMLA leave (or the expiration of the maximum family or medical leave provided by law, whichever occurs first), an employee may be reinstated to the position held prior to such leave. If the job previously held is unavailable, an equivalent position with equivalent pay, benefits, and other terms and conditions of employment will be provided. If an employee is medically unable to perform his/her prior job, s/he will be offered work suitable to his or her physical condition, if such work is available, at the pay rate appropriate to that job.

If an employee cannot return to work at the expiration of the maximum FMLA leave allowed, the Agency has no obligation under the FMLA to restore an employee to any position. An employee on leave or returning from leave has no greater right to reinstatement or to other benefits and conditions of employment than if the employee had been continuously employed during the leave period.

EMPLOYEE RIGHTS AND RESPONSIBILITIES

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 Armed Forces (including a member of 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 service member during a single 12-month period. A covered service member is either: (1) 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 (or existing before the beginning of the member's active duty and aggravated by service in line of duty on active duty in the Armed Forces) that may render the service member medically unfit to perform his or her duties for which the service member is under medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list; or (2) a veteran who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness (incurred in line of duty on active duty in the Armed Forces, or existing before the beginning of the member's active duty and aggravated by service in line of duty on active duty in the Armed Forces, that manifested itself before or after the member became a veteran) and who was a member of the Armed Forces (including a member of the National Guard or Reserves) at any time during the five year period before the date on which the veteran undergoes such medical treatment, recuperation or therapy.

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 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.

MILITARY FAMILY LEAVE - CERTIFICATION OF SERIOUS INJURY OR ILLNESS OF COVERED SERVICE MEMBER

SECTION I

For Completion by the EMPLOYEE and/or the COVERED SERVICE MEMBER 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: EMPLOYER INFORMATION

Name and Address of Employer (of the employee requesting leave to care for covered service member):

_____

Name of Employee Requesting Leave to Care for Covered Service Member:

_____

First Middle Last

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

_____

First Middle Last

Relationship of Employee to Covered Service Member Requesting Leave to Care:

† Spouse † Parent † Son † Daughter † Next of Kin

Part B: COVERED SERVICE MEMBER INFORMATION

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

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

_____

Is the covered service member 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 Service Member on the Temporary Disability Retired List (TDRL)?__Yes __No

(3) Is the Covered Service Member a Veteran who was a member of the Armed Forces (including a member of the National Guard or Reserves) at any time during the five year period before the date on which this individual has requested medical leave? __Yes __ No

If yes, please provide the Veteran's last known military branch, rank and assigned unit:

_____

Part C: CARE TO BE PROVIDED TO THE COVERED SERVICE MEMBER

Describe the Care to Be Provided to the Covered Service Member 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 Service Member'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 that 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: (1) may render the service member medically unfit to perform the duties of the member's office, grade, rank, or rating (if a current member of the Armed Forces); or that (2) manifested itself before or after the member became a veteran (if a veteran).
- † 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 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 (or existing before the beginning of the member's active duty and aggravated by service 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 service member undergoing medical treatment, recuperation, or therapy? _____ Yes _____ No.

If yes, please describe medical treatment, recuperation or therapy:

_____

_____

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

(1) Will the covered service member 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 service member require periodic follow-up treatment appointments? _____ Yes _____ No. If yes, estimate the treatment schedule: _____

(3) Is there a medical necessity for the covered service member to have periodic care for these follow-up treatment appointments? _____Yes _____ No

(4) Is there a medical necessity for the covered service member 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

MILITARY FAMILY LEAVE - CERTIFICATION OF QUALIFYING EXIGENCY

Employee 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.

FAMILY MEMBER'S SERIOUS HEALTH CONDITION - CERTIFICATION OF HEALTH CARE PROVIDER

INSTRUCTIONS to the EMPLOYEE: You must complete the following information before providing this form to your family member or his/her health care provider.

Employee 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 family member and estimate leave needed to provide care:

_____

_____

_____

_____

_____ _____
Employee Signature Date

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 care. Space is provided 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. PLEASE NOTE: Pursuant to The Genetic Information Nondiscrimination Act of 2008 (GINA), employers are prohibited from requesting or requiring genetic information of an employee (or family member of an employee), except as specifically allowed by this law. Accordingly, to comply with this law, do not provide any genetic information when responding to any question here and elsewhere on the form. "Genetic information" as defined by GINA, includes "an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services"):

_____

_____

_____

_____

PART B: AMOUNT OF CARE NEEDED

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

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

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? _____No _____Yes
Estimate the hours the patient needs care on an intermittent basis, if any:
_____ hour(s) per day; _____ days per week from _____ through _____
Explain the care needed by the patient, and why such care is medically necessary:

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? _____No _____Yes
Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):
Frequency: _____ times per ____ week(s) _____ month(s)
Duration: _____ hours or _____ day(s) per episode
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

NOTICE OF ELIGIBILITY AND RIGHTS & RESPONSIBILITIES

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; or

_____ Your own serious health condition; or

_____ The serious health condition of your _____ spouse; _____; child; parent for which you are needed to provide care; or

_____ 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 armed forces (including the National Guard or Reserves; or

_____ A serious injury or illness affecting a covered service member for whom you are the spouse; son or daughter; parent; next of kin.

You further informed us that you expect leave to continue until on or about _____.

This Notice is to inform you that you:

_____ Are not eligible for FMLA leave because:

_____ 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.

_____You have no FMLA leave available to take within the applicable 12-month period.

_____ Are eligible for FMLA leave -see Rights and Responsibilities, below.

RIGHTS AND RESPONSIBILITIES

Although you meet the minimum eligibility requirements for taking FMLA leave as stated above, in order for us to determine whether your absence does, in fact, qualify as FMLA leave, you must return the following information to us within 15 calendar days from receipt of this notice:

_____ 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.

NOTE: If additional information above is not provided in a timely manner, your leave may be denied.

If following our timely receipt of the requested information above we determine that your leave does qualify as FMLA leave, you will have the following responsibilities while on FMLA leave:

- You must 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 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 _____ will not 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.

- You will be required while on an FMLA leave, at a minimum, to furnish us with periodic reports on the 1st day of each month of your status and intent to return to work.

- You will be required while on an FMLA leave, at a minimum, to furnish us with medical recertification every 30 days after receipt of the initial medical certification (unless a minimum duration of incapacity longer than 30 days has been specified in the certification, in which case recertification will generally be required once the duration specified has passed; or unless you have an ongoing condition, in which case recertification will generally be required every six months in conjunction with an absence; or unless you have requested an extension of leave, or circumstances described by the prior certification have changed significantly, or unless we receive information that casts doubt on the continuing validity of the leave, in which case you will be required to provide us with recertification in less than 30 days).

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

If following our timely receipt of the requested information above we determine that your leave does qualify as FMLA leave you will have the following rights while on FMLA leave:

- You have a right under the FMLA to receive up to 12 weeks of unpaid leave due to: (1) your serious health condition or the serious health condition of your child, parent or spouse; (2) birth, adoption or foster care placement of your child; or (3) a qualifying exigency, in the one-year period measured by:

_____ 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 the right under the FMLA for up to 26 weeks of unpaid leave due to the serious injury or illness of a covered service member in the one-year period measured from the first day you take FMLA leave.
- 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 are considered a "key employee" as defined in the FMLA, 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.
- 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 service member'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 our policies 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 _____

DESIGNATION NOTICE

TO: _____
Employee
FROM: _____
Employer Representative
DATE: _____

We have reviewed your request for leave under the FMLA and any supporting documentation that you have provided and respond as follows (as applicable):

DENIAL OF LEAVE REQUEST

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

ADDITIONAL INFORMATION NEEDED

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 to make the certification complete and sufficient:

_____

_____

NOTE: You must provide the information above no later than seven calendar days from receipt of this Notice, unless it is not practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied.

_____ We are exercising our right to have you obtain a second or third opinion medical certification at our expense as follows:

_____

APPROVAL OF LEAVE REQUEST

Based on the information we have received from you, we hereby designate your absence as an FMLA leave for the following qualifying reason:

_____ The birth of a child, or placement of a child with you for adoption or foster care; or
_____ Your own serious health condition; or
_____ The serious health condition of your _____ spouse; _____; child; parent for which you are needed to provide care; or
_____ 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 armed forces (including the National Guard or Reserves; or

_____ A serious injury or illness affecting a covered service member for whom you are the ___ spouse; _____ son or daughter; ____ parent; _____next of kin.

All leave taken for the reason identified above will be designated as FMLA leave.
Your FMLA leave [begins/began] on _____ and is expected to continue until on or about _____.

As more fully described in our company policies and applicable law, under the FMLA, you are eligible to receive up to 12 weeks of unpaid leave due to: (1) your serious health condition or the serious health condition of your child, parent or spouse; (2) birth, adoption or foster care placement of your child; or (3) a qualifying exigency, in the one-year period measured by:
_____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 are also eligible to receive up to 26 weeks of unpaid leave due to the serious injury or illness of a covered service member in the one-year period measured from the first day you take FMLA leave.

The maximum amounts of FMLA leave stated herein do not afford you the ability to take more leave if you have multiple qualifying reasons than you otherwise would be entitled to take for a single qualifying reason during the applicable time period. In addition, special rules apply for employees who are married to each other.

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:

- We <u>are</u> <u>are not</u> requiring you to substitute or use accrued paid leave during your FMLA leave. The only exception is if you are simultaneously receiving payments under the Company's Short Term Disability Plan or Workers' Compensation laws (in which case your accrued paid leave time will not be charged to you). Any paid leave taken is counted as part of your total FMLA leave entitlement. Accordingly, the maximum amount of FMLA leave allowed, whether it includes paid and/or unpaid leave or whether it includes time off during which you are receiving payments under either the Company's Short Term Disability Plan or the Workers' Compensation law, will not exceed the maximum leave entitlement described above.

- Your health insurance benefits will be maintained during any period of FMLA leave under the same conditions as if you continued to work, as long as you continue to make timely payments of your portion of any health insurance premiums during your FMLA leave period. When paid leave is substituted for unpaid FMLA leave, the Company will continue to deduct your portion of health insurance premiums as a regular payroll

deduction. When FMLA leave is unpaid, you must pay your portion of these premiums on _____ by submitting a check to _____. You have a 30-day grace period in which to make premium payments. If payment is not timely made, your health insurance may be canceled, provided we notify you in writing at least 15 days before the date that your health coverage would lapse. Alternatively, 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. Should your health insurance lapse due to non-payment while on FMLA leave, the Company will again provide health insurance benefits according to the applicable plans when you return from the leave of absence.

- While on an FMLA leave, you will be required, at a minimum, to furnish the Company with periodic reports on the 1st day of each month of your status and intent to return to work.

- While on an FMLA leave, you will be required, at a minimum, to furnish the Company with medical recertification every 30 days after receipt of the initial medical certification (unless a minimum duration of incapacity longer than 30 days has been specified in the certification, in which case recertification will generally be required once the duration specified has passed; or unless you have an ongoing condition, in which case recertification will generally be required every six months in conjunction with an absence; or unless you have requested an extension of leave, or circumstances described by the prior certification have changed significantly, or unless we receive information that casts doubt on the continuing validity of the leave, in which case you will be required to provide us with recertification in less than 30 days).
- There will be no accruals of seniority, retirement or fringe benefits (including paid time off) during an FMLA leave of absence. However, you will be reinstated to the same or equivalent job with the same or equivalent benefits you had on your return from the expiration of your FMLA leave.

- If you cannot return to work at the expiration of your entitlement to FMLA leave, the Company has no obligation under the FMLA to restore you to any position. In addition, 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 (or serious injury or illness in the case of a covered service member) which would otherwise render you eligible for FMLA leave; or (2) other circumstances beyond your control, you may be required to reimburse the Company for its share of health insurance premiums paid on your behalf during your FMLA leave.

- If you qualify as a "key employee" as described under federal regulations and we have determined that restoring you to employment at the conclusion of your FMLA leave would cause substantial and grievous economic harm to the Company, we may deny you reinstatement following your leave.

- Prior to returning to work, you will be required to present a fitness-for-duty certificate if the reason for your FMLA leave was due to your own serious health condition (unless you had been taking intermittent leave or leave on a reduced schedule). 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. If there are any medical restrictions upon your return to work, your health care provider should state these restrictions in the certificate provided. In addition, the Company reserves the right to have its own health care provider contact your health care provider for purposes of clarification of your fitness to return to work certification. Your return to work may be delayed until the fitness-for-duty certification is provided.

- 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 our Employee Handbook.

EMPLOYEE'S SERIOUS HEALTH CONDITION - CERTIFICATION OF HEALTH CARE PROVIDER

Employer name and contact: _____

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

Employee's essential job functions: _____

_____

Check if job description is attached: _____

INSTRUCTIONS TO THE HEALTH CARE PROVIDER

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

Provider's name and business address: _____

Type of practice / Medical specialty: _____

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

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____
   Probable duration of condition: _____
   Mark below as applicable:
   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? _____No _____Yes. If so, dates of admission:

   _____

   Date(s) you treated the patient for condition:

   _____

   Will the patient need to have treatment visits at least twice per year due to the condition?
   _____No _____Yes
   Was medication prescribed for the patient (other than over-the-counter medication?)
   _____No _____Yes
   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? _____No _____Yes.
   If so, indicate 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. PLEASE NOTE: Pursuant to The Genetic Information Nondiscrimination Act of 2008 (GINA), employers are prohibited from requesting or requiring genetic information of an employee (or family member of an employee), except as specifically allowed by this law. Accordingly, to comply with this law, do not provide any genetic information when responding to any question here and elsewhere on the form. "Genetic information" as defined by GINA, includes "an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services."):

_____

_____

_____

_____

_____

_____

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
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
7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? _____No _____Yes
Is it medically necessary for the employee to be absent from work during the flare-ups?
_____No _____Yes. If so, explain:

_____

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

Frequency: _____ times per ____ week(s) _____ month(s)
Duration: _____ hours or _____ day(s) per episode

ADDITIONAL INFORMATION:
IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER:

Signature of Health Care Provider

Date