CITY OF GARDNER

Application for Family or Medical Leave

Employee's name: _____ Department: _____

Current Address: _____

Start Date of Anticipated Leave: _____

Expected Date of Return to Work: _____

Reason for Leave (Explain):_____

_____

_____

_____

_____

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

I hereby authorize The City of Gardner to contact my physician to verify the reason for my requested leave or for any other information concerning my requested family or medical leave.

I understand that a failure to return to work at the end of my leave period may be treated as a resignation unless an extension has been agreed upon and approved in writing by The City of Gardner.

Employee's signature: _____ Date: _____

Approved By:

Supervisor: _____ Date: _____

Human Resources Director:_____ Date: _____

CITY OF GARDNER

Physician Certification For Family or Medical Leave

Please Print

This form contains medical-related information and must be maintained in files separate from employee personnel files in locked cabinets with only designated persons having access.

To be Completed by Employee

Name _____ Title _____

Department _____ Employee Payroll # _____

Status ☐ Full-Time ☐ Part-Time ☐ Temporary Date ____/____/____

The Patient is: ☐ Self ☐ Spouse ☐ Parent ☐ Child

Patient's name (if different from employee): _____

o I am requesting leave from ____/____/____ until ____/____/____ or an intermittent or reduced schedule on the following dates: _____

_____

_____

o (If applicable) I will be providing the following care/services for a family member with a serious health condition on the following dates: _____

_____

_____

o (If applicable) The essential functions of my job are (or attach job description).

_____

_____

_____

Medical Release:

I authorize the release of any* medical information necessary to process the above request.

Patient's signature: _____ Date: _____

*** The information sought on this form relates only to the condition for which the employee is taking FMLA leave.**

The remainder of this form is to be completed by an authorized health car provider in order to verify the necessity of Family or Medical Leave as requested by the above employee. Under the Family and Medical Leave law, an authorized health care provider is:

- any health care provider recognized by the employer or the employer's group health plan
- a doctor of medicine or osteopathy authorized to practice medicine or surgery by the state in which he or she practices
- podiatrists, dentists, clinical psychologists, optometrists and chiropractors (limited to manual manipulation for the spine to correct a subluxation found by X-ray to exist) authorized to practice, and performing within the scope of their practice, under state law
- nurse practitioners, nurse-midwives and clinical social workers authorized to practice, and performing within the scope of their practice, as defined under state law, or
- Christian Science practitioners listed with the First Church of Christ, Scientist in Boston, MA.

The information sought on this form relates only to the condition for which the employee is taking FMLA leave.

Please read the six definitions on page four before completing this form.
After receiving this completed form, the employer is not permitted to contact the health care provider for additional information. A health care provider representing the employer may contact the health care provider for clarification of information contained on this form.

1. Page four describes what is meant by a "serious health condition" under the Family and Medical Leave Act. Does the patient's condition qualify under any of the categories described? If so, please check the applicable category.

☐ (1) ☐ (2) ☐ (3) ☐ (4) ☐ (5) ☐ (6) or ☐ None of the above

2. Describe the medical facts which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories:_____

3. a. State the approximate date the condition commenced and the probable duration of the condition (and also the probable duration of the patient's present incapacity, if different):_____

   b. Will it be necessary for the employee to take work only intermittently or to work on a less than full schedule as a result of the condition (including for treatment described in Item 4 below)? ☐ Yes ☐ No

   If yes, give probable duration:_____

   c. If the condition is a chronic condition (Category #4) or pregnancy, state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity (see page 4):_____

4. a. If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments._____

b. If any of these treatments will be provided by another provider of health services (e.g., physical therapist), please state the nature of the treatments: _____

_____

c. If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment):

_____

_____

5. a. If medical leave is required for the employee's absence from work because of the employee's own condition (including absence due to pregnancy or a chronic condition), is the employee unable to perform work of any kind?
☐ Yes ☐ No

b. If able to perform some work, is the employee unable to perform any one or more of the essential functions of the employee's job (the employee or the employer should supply you with information about the essential job functions)? ☐ Yes ☐ No

If yes, please list the essential functions the employee is unable to perform: _____

_____

_____

c. If neither a. nor b. applies is it necessary for the employee to be absent from work for treatment? ☐ Yes ☐ No

6. a. If leave is required to care for a family member of the employee with a serious health condition, does the patient require assistance for the basic medical, personal, safety, or transportation needs? ☐ Yes ☐ No

b. If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery? ☐ Yes ☐ No

c. If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need: _____

_____ / _____ / _____

Physician or Authorized Health Care Signature Date Type of Practice

_____

Physician or Authorized Health Care Provider Printed Name

Office Mailing Address _____

_____

_____ Phone # (_____) _____

A Serious Health Condition

A "Serious Health Condition" means an illness, injury, impairment, or physical or medical condition that involves one of the following:

1. **Hospital Care**

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

2. **Absence Plus Treatment**

   (a) A period of incapacity of more than three consecutive calendar days (including any subsequent treatment or period on incapacity relating to the same condition), that also involves:

   (1) Treatment two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider, *or*

   (2) Treatment by a health care provider on a least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider.

3. **Pregnancy**

   Any period of incapacity due to pregnancy, or for prenatal care.

4. **Chronic Conditions Requiring Treatments**

   A chronic condition which:

   (1) Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;

   (2) Continues over an extended period of time (including recurring episodes of a single underlying condition); and

   (3) May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

5. **Permanent/Long-term Conditions Requiring Supervision**

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

6. **Multiple Treatments (Non-Chronic Conditions)**

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

CITY OF GARDNER

Notice of Intention to Return From Leave

Employee's name: _____

Supervisor: _____

Date leave commenced: _____

Date of planned return: _____

I understand that my restoration to employment is subject to the following conditions:

1. As a condition of restoration, each employee must provide a written certification from his or her health care provider that the employee is able to resume working.

2. Every attempt will be made to restore the employee returning from leave to his or her original position. If the employee's original position is unavailable, the employee will be placed in an equivalent position with equivalent pay and benefits.

Employee's signature: _____ Date: _____

I have examined [employee] and can certify that she/he is fully able to resume working.

Health care provider's signature: _____ Date: _____

Health care provider's name (please print) _____

Health care provider's office phone: _____

Your Rights
under the
Family and Medical Leave Act of 1993

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to "eligible" employees for certain family and medical reasons. Employees are eligible if they have worked for their employer for at least one year, and for 1,250 hours over the previous 12 months, and if there are at least 50 employees within 75 miles. The FMLA permits employees to take leave on an intermittent basis or to work a reduced schedule under certain circumstances.

Reasons for Taking Leave:

Unpaid leave must be granted for *any* of the following reasons:

- 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.

At the employee's or employer's option, certain kinds of *paid* leave may be substituted for unpaid leave.

Advance Notice and Medical Certification:

The employee may be required to provide advance leave notice and medical certification. Taking of leave may be denied if requirements are not met.

- The employee ordinarily must provide 30 days advance notice when the leave is "foreseeable."
- An employer may require medical certification to support a request for leave because of a serious health condition, and may require second or third opinions (at the employer's expense) and a fitness for duty report to return to work.

Job Benefits and Protection:

- For the duration of FMLA leave, the employer must maintain the employee's health coverage under any "group health plan."
- Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.
- The use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

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:

- The U.S. Department of Labor is authorized to investigate and resolve complaints of violations.
- An eligible employee may bring a civil action against an employer for violations.

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.

For Additional Information:

If you have access to the Internet visit our FMLA website: **http://www.dol.gov/esa/whd/fmla.** To locate your nearest Wage-Hour Office, telephone our Wage-Hour toll-free information and help line at 1-866-4USWAGE (1-866-487-9243): a customer service representative is available to assist you with referral information from 8am to 5pm **in your time zone;** or log onto our Home Page at **http://www.wagehour.dol.gov**.

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Employment Standards Administration
Wage and Hour Division
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NOTICE

Military Family Leave

On January 28, President Bush signed into law the National Defense Authorization Act for FY 2008 (NDAA), Public Law 110-181. Section 585(a) of the NDAA amended the FMLA to provide eligible employees working for covered employers two important new leave rights related to military service:

(1) **New Qualifying Reason for Leave.** Eligible employees are entitled to up to 12 weeks of leave because of "any qualifying exigency" arising out of the fact that the spouse, son, daughter, or parent of the employee is on active duty, or has been notified of an impending call to active duty status, in support of a contingency operation. By the terms of the statute, this provision requires the Secretary of Labor to issue regulations defining "any qualifying exigency." In the interim, employers are encouraged to provide this type of leave to qualifying employees.

(2) **New Leave Entitlement.** An eligible employee who is the spouse, son, daughter, parent, or next of kin of a covered servicemember who is recovering from a serious illness or injury sustained in the line of duty on active duty is entitled to up to 26 weeks of leave in a single 12-month period to care for the servicemember. This provision became effective immediately upon enactment. This military caregiver leave is available during "a single 12-month period" during which an eligible employee is entitled to a combined total of 26 weeks of all types of FMLA leave.

Additional information on the amendments and a version of Title I of the FMLA with the new statutory language incorporated are available on the FMLA amendments Web site at http://www.dol.gov/esa/whd/fmla/NDAA_fmla.htm.

WHD

U.S. Wage and Hour Division