MIDWESTERN INTERMEDIATE UNIT #IV

SECTION: PROFESSIONAL EMPLOYEES

TITLE: FAMILY AND MEDICAL LEAVES

ADOPTED: October 24, 2001

REVISED: October 19, 2005
December 19, 2007

435. FAMILY AND MEDICAL LEAVES

1. Purpose
P.L. 103-3
of 1993

The purpose of this policy is to address specific leave of absence issues and to ensure the Intermediate Unit's compliance with the Family Medical Leave Act, hereinafter referred to as FMLA.

This policy shall not diminish the rights guaranteed to employees under FMLA. Furthermore, it is agreed that nothing in the Family and Medical Leave Act shall lessen or diminish any rights contained in the collective bargaining agreements or guaranteed by statute.

2. Definitions

Eligible Employee – all employees of Midwestern Intermediate Unit IV shall be eligible for leave under this policy.

Parent – the term means the biological parent of an employee or an individual who stood in loco parentis to an employee when the employee was a son or daughter.

Reduced Leave Schedule – the term means a leave schedule that reduces the usual number of hours per work week, or hours per work day, of an employee.

Serious Health Condition – the term means an illness, injury, impairment, or physical or mental condition that involves inpatient care in a hospital, hospice, or residential medical care facility; or continuing treatment by a health care provider.

Son or Daughter – the term means a biological, adopted, or foster child, a stepchild, a legal ward, or a child of a person standing in loco parentis, who is under eighteen (18) years of age or is eighteen (18) years of age or older and incapable of self-care because of a mental or physical disability.

Spouse – the term means a husband or wife, as the case may be.

3. Guidelines	Section 102. Leave Requirement (a) In General (1) Entitlement to leave – Subject to Section 103, an eligible employee shall be entitled to a minimum of twelve (12) work weeks of leave with all group health plan benefits provided at Board expense during the twelve-month period commencing with the first day of leave for one or more of the following: (A) Because of the birth of a son or daughter of the employee and in order to care for such son or daughter. (B) Because of the placement of a son or daughter with the employee for adoption or foster care. (C) In order to care for the spouse, or a son, daughter, or parent, of the employee, if such spouse, son, daughter, or parent has a serious health condition. (D) Because of a serious health condition that makes the employee unable to perform the functions of the position of such employee. (2) Expiration of Entitlement – The leave under Section 102, subsection (a)(1) subparagraphs (A) and (B) shall generally expire at the end of the twelve-month period beginning on the date of such birth or placement, except as provided for under Section 102, subsection (c)(1). (b) Leave taken intermittently or on a reduced leave schedule. (1) In General – Leave under Section 102, subsection (a)(1) subparagraph (A) or (B) shall not be taken by an employee intermittently or on a reduced leave schedule unless the employee and Midwestern Intermediate Unit IV agree otherwise. Subject to Section 102, subsection (e)(2) and Section 103, subsection (b)(5), leave under subparagraph (C) or (D) of Section 102, subsection (a)(1) may be taken intermittently or on a reduced leave schedule when medically necessary. The taking of leave intermittently or on a reduced leave schedule pursuant to this paragraph shall not result in a reduction in the total amount of leave to which the employee is entitled beyond the amount of leave actually taken.

(2) Alternative Position – If an employee requests intermittent leave or leave on a reduced leave schedule, under Section 102, subsection (a)(1) subparagraph (C) or (D), that is foreseeable based on planned medical treatment, Midwestern Intermediate Unit IV may require such employee to transfer temporarily to an available alternative position offered by Midwestern Intermediate Unit IV for which the employee is qualified and, where appropriate, properly certificated and that:

(A) Has equivalent pay and benefits; and

(B) Better accommodates recurring periods of leave than the regular employment position of the employee.

(3) Eligible employees employed principally in an instructional capacity have entitlement to intermittent leave or leave on a reduced leave schedule in accordance with Section 102, subsection (b)(1) and (2) above.

(c) Unpaid Leave Permitted -

(1) Leave granted under Section 102, subsection (a)(1) subparagraphs (A), (B), (C) shall be extended at the employee's request beyond the required twelve (12) work weeks generally to a maximum period of twelve (12) months, except that the employee shall be eligible for leave to expire at the beginning of the semester immediately following the end of such twelve-month period. Such leave shall be without compensation or benefits at Board expense.

(2) Leave granted under Section 102, subsection (a)(1) subparagraph (D) shall be extended at employee request, subject to Section 103, beyond the required twelve (12) work weeks without compensation. Such leave shall be with all group health benefits provided at Board expense for a total of twenty-four (24) months for each serious health condition.

(3) An employee with a recurring serious health condition shall be required to wait twelve (12) months after return to work before again becoming eligible for the full amount of extended leave under Section 102, subsection (c)(2). Prior to the expiration of the twelve-month period, such employee shall only be eligible for the remainder of unused extended leave entitlement under Section 102, subsection (c)(2) or for the required twelve (12) work weeks under Section 102, subsection (a)(1) subparagraph (D).

(4) Employees on extended leave under Section 102, subsection (c)(1) shall be entitled to purchase at their own expense all group health benefits.

(d) Substitution of Paid Leave

(1) Employees shall not be required to substitute any accrued paid leave for leave provided under Section 102, subsection (a)(1).

(2) Accrued paid leave shall not be considered as part of the employee's entitlement under Section 102, subsection (a)(1).

(e) Foreseeable Leave

(1) Requirement of Notice – In any case in which the necessity for leave under Section 102, subsection (a)(1) subparagraph (A) or (B) is foreseeable based on an expected birth or placement, the employee shall provide Midwestern Intermediate Unit IV with not less than thirty (30) days' notice, before the date the leave is to begin, of the employee's intention to take leave under such subparagraph, except that if the date of the birth or placement requires leave to begin in less than thirty (30) days, the employee shall provide such notice as is practicable.

(2) Duties of Employee – In any case in which the necessity for leave under Section 102, subsection (a)(1) subparagraph (C) or (D) is foreseeable based on planned medical treatment, the employee:

(A) Shall make a reasonable effort to schedule the treatment so as not to disrupt unduly the operations of Midwestern Intermediate Unit IV, subject to the approval of the health care provider of the employee or the health care provider of the son, daughter, spouse, or parent of the employee, as appropriate; and

(B) Shall provide Midwestern Intermediate Unit IV with not less than thirty (30) days' notice, before the date the leave is to begin, of the employee's intention to take leave under such subparagraph, except that if the date of the treatment requires leave to begin in less than thirty (30) days, the employee shall provide such notice as is practicable.

(f) Spouses Employed by the Same Employer – Spouses who are both employed by Midwestern Intermediate Unit IV shall be individually entitled to all leave rights for reasons under Section 102, subsection (a)(1).

Section 103. Certification

(a) In General – The Midwestern Intermediate Unit IV may require that a request for leave under subparagraph (C) or (D) of Section 102, subsection (a)(1) be supported by a certification issued by the health care provider of the eligible employee or the son, daughter, spouse, or parent of the employee, as appropriate. The employee shall provide, in a timely manner, a copy of such certification to Midwestern Intermediate Unit IV.

(b) Sufficient Certification – Certification provided under Section 103, subsection (a) shall be sufficient if it states:

(1) The date on which the serious health condition commenced.

(2) The probable duration of the condition.

(3) The appropriate medical facts within the knowledge of the health care provider regarding the condition;

(4) (A) For purposes of leave under Section 102, subsection (a)(1) subparagraph (C), a statement that the eligible employee is needed to care for the son, daughter, spouse, or parent and an estimate of the amount of time that such employee is needed to care for the son, daughter, spouse, or parent.

(B) For purposes of leave under Section 102, subsection (a)(1) subparagraph (D), a statement that the employee is unable to perform the functions of the position of the employee.

(5) In the case of the certification for intermittent leave or leave on a reduced leave schedule for planned medical treatment, the dates on which such treatment is expected to be given and the duration of such treatment;

(6) In the case of certification for intermittent leave, or leave on a reduced leave schedule, under Section 102, subsection (a)(1) subparagraph (D). A statement of the medical necessity for the intermittent leave or leave on a reduced leave schedule, and the expected duration of the intermittent leave or reduced leave schedule; and

(7) In the case of certification for intermittent leave, or leave on a reduced leave schedule, under Section 102, subsection (a)(1) subparagraph (C), a statement that the employee's intermittent leave or leave on a reduced leave schedule is necessary for the care of the son, daughter, parent, or spouse who has a serious health condition or will assist in their recovery, and the expected duration and schedule of the intermittent leave or reduced leave schedule.

(c) Second Opinion

(1) In General – In any case in which Midwestern Intermediate Unit IV has reason to doubt the validity of the certification provided under Section 102, subsection (a)(1) subparagraph (D), Midwestern Intermediate Unit IV may require, at the expense of the Midwestern Intermediate Unit IV, that the eligible employee obtain the opinion of a second health care provider designated by Midwestern Intermediate Unit IV concerning any information certified under Section 103, subsection (b) for such leave.

(2) Limitation – A health care provider designated under subparagraph (1) shall not be an employee of Midwestern Intermediate Unit IV.

(3) Second Opinion for Family Members – Midwestern Intermediate Unit IV shall not require second opinions for family members of employees utilizing leave under Section 102, subsection (a)(1) subparagraph (C).

(d) Resolution of Conflicting Opinions

(1) In General – In any case in which the second opinion described in Section 103, subsection (c) differs from the opinion in the original certification provided under Section 103, subsection (a), Midwestern Intermediate Unit IV may require, at the expense of Midwestern Intermediate Unit IV, that the employee obtain the opinion of a third health care provider designated and approved jointly by Midwestern Intermediate Unit IV and the employee concerning the information certified under Section 103, subsection (b).

(2) Finality – The opinion of the third health care provider concerning the information certified under Section 103, subsection (b) shall be considered to be final and shall be binding on Midwestern Intermediate Unit IV and the employee.

(e) Subsequent Recertification – Midwestern Intermediate Unit IV may require that the eligible employee obtain subsequent recertifications on a reasonable basis.

Section 104. Employment and Benefits Protection

(a) Restoration to Position

(1) Any eligible employee who takes leave under Section 102 for the intended purpose of the leave shall be entitled, on return from such leave:

(A) To be restored by Midwestern Intermediate Unit IV to the position of employment held by the employee when the leave commenced; or

(B) To be restored to an equivalent position with equivalent employment benefits, pay, and other terms and conditions of employment.

(2) Loss of Benefits – The taking of leave under Section 102 shall not result in the loss of any employment benefit accrued prior to the date on which the leave commenced.

(3) Limitations – Nothing in this section shall be construed to entitle any restored employee to:

(A) The accrual of any seniority or employment benefits during any period of leave except as provided for by the School Code and/or collective bargaining agreements; or

(B) Any right, benefit, or position of employment other than any right, benefit, or position to which the employee would have been entitled had the employee not taken the leave.

(4) Certification – As a condition of restoration under paragraph (1) for an employee who has taken leave under Section 102, subsection (a)(1) subparagraph (D), Midwestern Intermediate Unit IV may require each such employee to receive certification from the health care provider of the employee that the employee is able to resume work, except that nothing in this paragraph shall supersede a valid state or local law or collective bargaining agreement that governs the return to work of such employees.

(5) Construction – Nothing in this subsection shall be construed to prohibit an employer from requiring an employee on leave under Section 102 to report periodically to Midwestern Intermediate Unit IV on the status and intention of the employee to return to work. Such report of intention shall not be binding upon the employee.

(b) Maintenance of Health Benefits

(1) Coverage – During the twelve (12) work weeks that an eligible employee takes leave under Section 102 and the extended leave as defined in Section 102, subsection (c)(2), Midwestern Intermediate Unit IV shall maintain coverage under any group health plan and the collective bargaining agreements for the duration of such leave at the level and under the conditions coverage would have been provided if the employee had continued in employment continuously for the duration of such leave.

(2) Midwestern Intermediate Unit IV shall not demand recovery of the premiums that Midwestern Intermediate Unit IV paid for maintaining coverage for the employee under such group health plan should the employee choose not to return to work at the end of the leave period.

Section 105. Local Educational Agencies

(1) Eligible employees employed principally in an instructional capacity requesting intermittent or reduced schedule leave for the reasons set forth under Section 102, subsection (a)(1), subparagraphs (C) and (D) shall be provided such leave in accordance with Section 102, subsection (b).

(2) Midwestern Intermediate Unit IV shall not require instructional employees to remain out on an involuntary basis if the employee's leave under Section 102, subsection (a)(1) would fall within three (3) weeks of the end of the academic term.

(3) Restoration to Equivalent Employment Position – For purposes of determination under Section 104, subsection (a)(1) subparagraph (B) (relating to restoration of an eligible employee to an equivalent position), such determination shall be made on the basis of established Board policies and practices, and collective bargaining agreements.

(4) No employee on leave shall be gainfully employed during the period of such leave during the employee's regular work hours.

Separability

If any provision of this policy or any application of this policy to any employee is held to be contrary to law, then such provision or application shall not be deemed valid and subsisting, except as permitted by law, but all other provisions and applications shall continue in full force and effect.

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

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

U.S. Wage and Hour Division

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

SECTION I: For Completion by the EMPLOYER

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

Employer name and contact: _____

_____

SECTION II: For Completion by the EMPLOYEE

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

Your name: _____
First Middle Last

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

Relationship of family member to you: _____

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

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

_____

_____

_____

_____ _____
Employee Signature Date

CONTINUED ON NEXT PAGE

SECTION III: For Completion by the HEALTH CARE PROVIDER

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

Provider's name and business address: _____

Type of practice / Medical specialty: _____

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

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

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

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

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

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

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

   _____

   _____

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

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

_____

_____

_____

_____

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**

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

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

Certification 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: 12/31/2011

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

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

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

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

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

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

U.S. Wage and Hour Division

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

Part A: EMPLOYEE INFORMATION

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

_____

Name of Employee Requesting Leave to Care for Covered Servicemember:

_____
First Middle Last

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

_____
First Middle Last

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

Part B: COVERED SERVICEMEMBER INFORMATION

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

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

_____

Is the covered servicemember assigned to a military medical treatment facility as an outpatient or to a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients (such as a medical hold or warrior transition unit)? ☐ Yes ☐ No If yes, please provide the name of the medical treatment facility or unit:

_____

(2) Is the Covered Servicemember on the Temporary Disability Retired List (TDRL)? ☐ Yes ☐ No

Part C: CARE TO BE PROVIDED TO THE COVERED SERVICEMEMBER

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

_____

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

Part A: HEALTH CARE PROVIDER INFORMATION
Health Care Provider's Name and Business Address:

_____

Type of Practice/Medical Specialty: _____

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

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

PART B: MEDICAL STATUS

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

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

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

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

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

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

(3) Approximate date condition commenced: _____

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

(5) Is the covered servicemember undergoing medical treatment, recuperation, or therapy? ☐ Yes ☐ No. If yes, please describe medical treatment, recuperation or therapy:

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

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

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

(3) Is there a medical necessity for the covered servicemember to have periodic care for these follow-up treatment appointments? ☐ Yes ☐ No

(4) Is there a medical necessity for the covered servicemember to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)? ☐ Yes ☐ No If yes, please estimate the frequency and duration of the periodic care:

_____

_____

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

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

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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: 12/31/2011

SECTION I: For Completion by the EMPLOYER

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

Employer name: _____

Contact Information: _____

SECTION II: For Completion by the EMPLOYEE

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

Your Name: _____
First Middle Last

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

_____
First Middle Last

Relationship of covered military member to you: _____

Period of covered military member's active duty: _____

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

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

CONTINUED ON NEXT PAGE

PART A: QUALIFYING REASON FOR LEAVE

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

_____

_____

_____

_____

_____

_____

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

PART B: AMOUNT OF LEAVE NEEDED

1. Approximate date exigency commenced: _____

   Probable duration of exigency: _____

2. Will you need to be absent from work for a single continuous period of time due to the qualifying exigency? ☐ No ☐ Yes.

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

   _____.

3. Will you need to be absent from work periodically to address this qualifying exigency? ☐ No ☐ Yes.

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

   _____

   _____

   _____

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

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

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

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PART C:

If leave is requested to meet with a third party (such as to arrange for childcare, to attend counseling, to attend meetings with school or childcare providers, to make financial or legal arrangements, to act as the covered military member's representative before a federal, state, or local agency for purposes of obtaining, arranging or appealing military service benefits, or to attend any event sponsored by the military or military service organizations), a complete and sufficient certification includes the name, address, and appropriate contact information of the individual or entity with whom you are meeting (i.e., either the telephone or fax number or email address of the individual or entity). This information may be used by your employer to verify that the information contained on this form is accurate.

Name of Individual: _____ Title: _____

Organization: _____

Address: _____

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

Email: _____

Describe nature of meeting: _____

_____

_____

_____

_____

_____

_____

_____

_____

PART D:

I certify that the information I provided above is true and correct.

_____ _____

Signature of Employee Date

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

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