Hazelwood School District
"A Culture of High Expectations and Excellence!"

Family Medical Leave Act, FMLA
Employee Checklist

- ✓ Please review your Articles of Agreement and Board policy regarding leaves.
- ✓ Immediately notify your supervisor of your FMLA intentions.
- ✓ All completed FMLA forms must be received by Human Resources 30 days prior to the scheduled leave. In case of an emergency, we allow 48 hours.
- ✓ Return forms to **benefits@hazelwoodschools.org** **or fax 314-218-9079**
- ✓ Complete the Leave of Absence request form and submit to HR.
- ✓ Complete Section I of the Certification for Health Care Provider form.
- ✓ Give the certification form and a copy of your job description to the health care provider. If the leave is for a family member, a job description is not required.
- ✓ The health care provider returns the completed certification form via email or fax.
- ✓ Coordinator with your principal to complete a Long-Term Substitute form. Kelly Educational Services Long Term Substitute Link
- ✓ If FMLA is approved, HR will notify the employee, supervisor, and administrator.
- ✓ If intermittent FMLA is approved, employee must submit an intermittent (IFMLA) form to HR for each absence by 5 PM on your next regularly scheduled workday. Be sure to copy your supervisor.
- ✓ While on leave, employee must use all available compensable days for time missed.
- ✓ Prior to returning to work, employee must submit a Fitness for Duty form to HR. If you are released with restrictions, you may not be able to return to work if there is no work available within the restrictions.

YOUR HEALTH AND SAFETY IS IMPORTANT TO US. IF YOU HAVE QUESTIONS, CONTACT HR AT:
BENEFITS@HAZELWOODSCHOOLS.ORG

04/26

EMPLOYEE RIGHTS AND RESPONSIBILITIES
UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

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

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

Benefits and Protections

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

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

Eligibility Requirements

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

Definition of Serious Health Condition

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

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

Use of Leave

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

Substitution of Paid Leave for Unpaid Leave

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

Employee Responsibilities

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

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

Employer Responsibilities

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

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

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

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

Enforcement

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

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

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

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

U.S. Wage and Hour Division

Hazelwood School District
"A Culture of High Expectations and Excellence!"

Leave of Absence Request Form

Return Forms to: **Benefits@ hazelwoodschools.org**
Human Resources Department, Hazelwood School District
15955 New Halls Ferry Road, Florissant, MO 63031 P:314-953-5000 F:314-218-9079

Name	Employee ID Number	Phone Number	Date of Request

Address (Street, Apt #)	City, State, Zip

Job Title	Building and/or Department

Leave Requested (Review the back of the last page for explanation of leaves)

☐ Family Medical Leave ☐ End of Benefit Leave ☐ Child Care Leave (Pregnancy/Adoption Leave)
↳(☐ FMLA Intermittent OR ☐ FMLA Continuous) ☐ Worker's Compensation Leave ☐ Military Leave

Expected Start Date	Expected End Date	Expected Date of Delivery/Child Arrival	Actual Start Date	Actual Return Date

Reason for Request

FAMILY MEDICAL LEAVE CHECK ALL THAT APPLY

☐ Birth of a child, or adoption or foster care; or ☐ A serious health condition making you unable to perform the essential functions of your job; or

☐ A serious health condition affecting your ☐ spouse, ☐ child, or ☐ parent, for which you are needed to provide care.

☐ COVID Exposure

Insurance Premiums during Leaves of Absence

Complete for All Leaves
Indicate whether you wish to pay for and keep benefits during the unpaid time of leave. Contact payroll for cost and pay dates.

Medical ☐ No ☐ Yes Dental ☐ No ☐ Yes
Vision ☐ No ☐ Yes Life ☐ No ☐ Yes

Complete Only if Taking Pregnancy or Adoption Leave
Indicate whether you intend to enroll your child in any of the benefit plans. This does not enroll your dependents, but simply indicates your intention. Contact payroll for costs, dates, and enrollment.

Medical ☐ No ☐ Yes Dental ☐ No ☐ Yes
Vision ☐ No ☐ Yes Life ☐ No ☐ Yes

FMLA AND WORKER COMPENSATION *(Board paid benefits are only available under these two leaves.)* Employees are responsible for submitting all payments for which they are normally responsible to ensure that insurance continues during leave. Insurance will cancel if employee portion is unpaid.

END OF BENEFIT LEAVE—ANY TIME NOT COVERED BY FMLA OR WORKER COMPENSATION--Employees are responsible for 100% of insurance premiums, including the board paid portion, to ensure that insurance continues during leave. Insurance will cancel if employee does not submit payments.

DECLINATION OF INSURANCE--If an employee declines to submit payments for insurance during leave of absence, insurance may cancel until they return to work (with no break in service).

Signature	Date Submitted

FOR ADMINISTRATIVE USE ONLY

☐ Leave Denied, because:

Approved Leaves and Duration Estimates

☐ FMLA begins _____ ends _____
☐ End of Benefit begins _____ ends _____
☐ Adoption begins _____ ends _____
☐ Pregnancy begins _____ ends _____
☐ Superintendent's begins _____ ends _____
☐ Military beings _____ ends _____
☐ Work Comp begins _____ ends _____
Full Benefit payments begin _____ ends _____
Paid Days Off begin _____ ends _____
Does spouse work for HSD? ☐ No ☐ Yes
Will he/she take leave for the same reason? ☐ No ☐ Yes
Is medical certification needed? ☐ No ☐ Yes, by _____

Actual Leave and Duration Dates

☐ FMLA _____ ends _____
☐ End of Benefit _____ ends _____
☐ Adoption _____ ends _____
☐ Pregnancy _____ ends _____
☐ Superintendent's _____ ends _____
☐ Military _____ ends _____
☐ Work Comp _____ ends _____
Full Benefit payments began _____ ends _____
Paid Days Off begin _____ ends _____

Date medical certification received _____

Estimated Days Available: Sick Days _____ Vacation Days _____ Option Days _____ Comp Days _____ Unpaid Days _____
Breakdown of Days Used: Sick Days _____ Vacation Days _____ Option Days _____ Comp Days _____ Unpaid Days _____

Request Processed by	Date Processed	Application Approved by	Date Processed

White-Human Resources **Green-Leave Accounting** **Yellow-Payroll** **Pink-Department** **Gold-Employee**

Explanation of Leaves

(Each leave shall only be granted 1 time each year, except Military Leave and Worker Compensation. This explanation of benefits shall not be construed as all inclusive, as employees must refer to their Memorandum of Understanding or Handbook for more specific details.)

A. Family Medical Leave of Absence—Board Paid Benefits for the Duration of this Leave

FMLA requires Hazelwood School District to provide up to 12 weeks of unpaid, job-protected leave to employees that have worked for the district for at least one year, and for 1,250 hours over the previous 12 months. FMLA permits employees to take leave on an intermittent basis or to work a reduced schedule under certain circumstances. 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.

The employee may be required to provide advance leave notice and medical certification. Taking of leave may be denied if requirements are not met. Prior to an employees return, medical certification must be provided (if leave is taken for employee's own illness) notifying the district of the employees ability to return to work without restrictions.

The district requires all employees to use all paid comp time available during FMLA leave. This paid time off will run concurrently with FMLA. FMLA will run concurrent with all leaves, when an employee is eligible.

B. End of Benefit Leave—Board Paid Benefits are Unavailable

All employees of the Hazelwood School District are limited to the various sick leave days and compensable days adopted annually by the Board, whether the injury is work related or not. In the event that an employee requires a longer convalescent period than the sick and compensable days available to the employee, then:

- Prior to the expiration of all comp, sick, and vacation days, the employee must request additional uncompensated leave (if additional time off is required);
- The employee shall furnish the Board of Education with all appropriate medical documents; and
- After the employee has used his or her compensable days and sick days, the Board may grant up to an additional ninety (90) calendar days of uncompensated leave. End of Benefit Leave will begin the first day of unpaid leave. ***This unpaid time off will run concurrently with FMLA, Pregnancy, and Adoption Leave, if applicable.***

C. Superintendent's Leave— Board Paid Benefits for the Duration of this Leave

The Superintendent shall grant up to five (5) days of unpaid leave to any employee needing time off for reasons other than illness, providing available personal and/or vacation days have been exhausted.

D. Pregnancy And Adoption Leave—Board Paid Benefits are Unavailable

All employees are eligible for leave for the birth, adoption and first-year care of the employee's child upon proper application for a period not to exceed one (1) year. For employees who are eligible for leave under the Family and Medical Leave Act (FMLA), this leave will be applied concurrently to the FMLA leave. It is emphatically the position of the district that this policy is not intended to expand the 12-workweek applicability of the FMLA.

1. The employee giving birth may use compensable leave, if available, for days when the employee is not physically able to return to work, as verified by a physician. Medical certification is not necessary for the first 30 days of the leave but will be required for use of compensable leave beyond the first 30 contractual days. The employee taking this leave for adoption or first-year care of the employee's child may use up to 30 compensable days, if available, during the first 30 days of leave. Otherwise, pregnancy, childcare and adoption leave will be without pay.
2. Childcare and adoption leave will commence on a mutually agreeable date that shall be determined by the superintendent or designee after consultation with the employee.
3. Board-paid benefits will continue through the first 90 days of leave, if the employee qualified for the benefits prior to the leave. After the first 90 calendar days, insurance benefits may be continued at the employee's expense.

E. Military Leave—Board Paid Benefits for 30 days *ONLY*

The district shall grant Military leave as required by law. Employees taking Military Leave shall give either written or verbal notice of the need for military leave unless impossible due to military necessity. The district will require a copy of any written, official orders after the military leave has exceeded 30 days. Written orders must be submitted to the district to collect a regular salary for up to 15 days per fiscal year.

Employees shall be eligible to retain insurance coverage (at their expense after the 30th day of leave) for up to 18 months or until the day after they are required to report for reemployment.

F. Worker Compensation—Board Paid Benefits for the Duration of this Leave

The district shall grant Worker Compensation as required by law. Employees shall have the option of being paid comp time or being paid under Worker Compensation (66% of regular pay). The district shall hold a position for the employee until the employee is able to return to work with or without restriction. Board paid benefits will continue throughout this period; however, employees must continue to submit their portion of insurance premiums.

Example of Using Concurrent Leaves

An employee takes a Pregnancy/Adoption Leave from July 1 to June 30 and has enough comp time to receive payment through August 15, she/he will be granted leave as follows:

① # of FMLA days requested *60*
② # of Eligible FMLA days *60*
Eligible Days Calculation (the smaller of the 2 in ② above):
60 days less the# of days used for FMLA since July 1
60

# of days remaining within 12 months of birth or adoption 60
③ # of days granted for FMLA *60*
④ # of days granted for Pregnancy *365*
⑦ Total # of days employee will be out *365*

Is medical certification needed? ☐ No ☒ Yes
by *August 1*
☒ FMLA begins *July 1 ends Sept 28*
☒ End of Benefit begins *Aug 16 ends Oct 25*
☒ Pregnancy Leave begins *July 1 ends June 30*
Full Benefit payments begin *Sept 29 ends June 3*

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

U.S. Department of Labor
Wage and Hour Division

WAGE AND HOUR DIVISION

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

OMB Control Number: 1235-0003
Expires: 6/30/2026

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

SECTION I - EMPLOYER

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

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

(1) Employee name: _____
First Middle Last

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

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

(4) Employee's job title: _____ Job description ☐ is / ☐ is not attached.

Employee's regular work schedule: _____

Statement of the employee's essential job functions:

_____

(The essential functions of the employee's position are determined with reference to the position the employee held at the time the employee notified the employer of the need for leave or the leave started, whichever is earlier.)

SECTION II - HEALTH CARE PROVIDER

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

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

Employee Name: _____

Health Care Provider's name: (Print) _____

Health Care Provider's business address: _____

Type of practice / Medical specialty: _____

Telephone: _____ Fax: _____ E-mail: _____

PART A: Medical Information

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

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

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

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

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

☐ **Incapacity plus Treatment**: (e.g. outpatient surgery, strep throat)

Due to the condition, the patient (☐ has been / ☐ is expected to be) incapacitated for **more than** three consecutive, full calendar days from: _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy).

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

_____

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

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

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

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

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

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

Employee Name: _____

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

_____

PART B: Amount of Leave Needed

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

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

_____

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

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

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

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

_____

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

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

_____

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

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

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

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

Employee Name: _____

PART C: Essential Job Functions

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

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

_____

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

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

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

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

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

FITNESS FOR DUTY FORM

EMPLOYEE:
Return completed form to employer prior to returning to work.

EMPLOYEE INFORMATION AND INFORMED CONSENT FOR DISCLOSURE OF HEALTH CARE INFORMATION
Name
Address
Telephone Number

STATEMENT OF PHYSICIAN OR PRACTITIONER	
Medical Facts Regarding Patient's Condition:	
Date Condition Commenced:	Probable Duration of Condition:
Has patient reached the end of his/her healing period? ☐ YES ☐ NO	Is patient able to perform all of the functions of his/her regular job? ☐ YES ☐ NO
If essential functions were provided, please indicate any that are of concern in light of employee's current condition.	
Is patient able to work his/her normal work schedule? ☐ YES ☐ NO (If not, please identify the number of hours per day and the number of hours per week that the patient can work, and the expected duration of the period for the reduced schedule.)	
Is the patient able to return to work without posing a significant risk or substantial harm to him/herself or others? ☐ YES ☐ NO	When can patient return to work? Restrictions? ☐ YES ☐ NO If yes, describe what restrictions apply in comments.
Comments:	
The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family member. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "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 or an embryo lawfully held by an individual or family member receiving assistive reproductive services.	
Physician Signature	Date

PHYSICIAN OR PRACTITIONER INFORMATION			
Physician Name			
Address			
City		State	Zip Code
Telephone	Field of Specialty	License No.	

MAINTAIN THIS FORM IN FMLA CONFIDENTIAL FILE