COUNTY BOARD OF HEALTH
POLICY # HR-03431
FAMILY AND MEDICAL LEAVE POLICY

1.0 PURPOSE

The Family and Medical Leave Act entitles eligible employees of covered employers to take unpaid, job-protected leave for specified family and medical reasons with continuation of group health insurance coverage under the same terms and conditions as if the employee had not taken leave.

This policy contains guidelines for the provision and use of The Family Medical Leave Act (FMLA).

2.0 AUTHORITY

The County Board of Health (CBOH) Family and Medical Leave Policy is published under the authority of CBOH and in compliance with the following:

2.1. Federal Family and Medical Leave Act (FMLA) 29 USC 2601 et seq
2.2. U.S. Department of Labor 29 CFR Part 825
2.3. Rules of the State Personnel Board

3.0 SCOPE

This policy applies to all employees of the CBOH.

4.0 POLICY

The policy of the (CBOH) is that the Family and Medical Leave Act (FMLA) provides job-protected leave without pay to eligible employees for the birth and care of their newborn child, placement of a son or daughter for adoption or foster care, to care for an immediate family member with a serious health condition, or for their own qualifying serious health condition.

4.1 FMLA also provides for job-protected leave without pay to eligible employees due to a family member's call to active duty in the Armed Services or to care for an injured service member.
4.2 CBOH requires employees to use, in this order, available sick, compensatory, annual or personal leave, while on FMLA leave.

5.0 DEFINITIONS

5.1 CBOH – County Board of Health

5.2 DPH - Georgia Department of Public Health

5.3 HR – Human Resources

5.4 FLSA - Fair Labor Standards Act

5.5 FMLA - Family and Medical Leave Act

5.6 Family member - The employee's spouse, child or parent.

5.6.1 Spouse - A husband or wife which may be same sex or opposite sex including "common law" marriage in states where it is recognized.

5.6.2 Child - A biological child, adopted or foster child, step-child, legal ward, or a child of an employee standing in loco parentis who is either under age 18 or is age 18 or older and incapable of self-care because of mental or physical disability.

5.6.3 Parent - A biological parent or an individual who stands or stood in loco parentis to an employee when the employee was a child under age 18. "Parent" does not include parents-in-law.

5.6.4 In Loco Parentis – Having day to day responsibility ties to care for and financially support a child.

5.7 A Serious Health Conditions – An illness, injury, impairment or physical or mental condition that involves inpatient care in a hospital, hospice or residential medical care facility, including any period of incapacity or any further treatment in connection with the inpatient care; or continuing treatment by a health care provider which includes one or more of the following:

5.7.1. Any period of incapacity of more than three consecutive calendar days, and any additional treatment or period of incapacity relating to the same condition that also involves 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 other referred health care services provider; or treatment by a health care provider at least once that results in a regimen of continuing treatment (e.g., prescription medication) under the supervision of the health care provider.

5.7.2. Any period of incapacity due to pregnancy is considered a serious health condition under FMLA. All pregnancy related absences from work (e.g., morning sickness, prenatal examinations, birth, etc.) qualify for FMLA.
5.7.3. Any period of incapacity or treatment due to a chronic serious health condition that requires periodic treatment, continues over an extended period of time, and may cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, migraines, etc.).

5.7.4. Any period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective (e.g., Alzheimer’s disease).

5.7.5. Any period of absence to receive multiple treatments (including recovery period) either for restorative surgery after an accident or other injury or for a condition that would likely result in incapacitation of more than 3 calendar days if not treated (e.g., chemotherapy for cancer, dialysis for kidney disease, etc.).

5.7.6. Substance abuse may meet the criteria for a serious health condition. FMLA leave may be taken for substance abuse treatment or to care for a child, spouse or parent who is receiving substance abuse treatment. FMLA leave for substance abuse treatment does not prevent the Department from taking appropriate disciplinary action against an employee for conduct or performance deficiencies.

5.7.7. A serious injury or illness incurred by a covered service member in the line of duty on active duty that may render the service member medically unfit to perform the duties of his or her office, grade, rank, or rating. This includes illnesses that existed before the beginning of the member’s active duty and were aggravated by service in the line of duty on active duty in the Armed Forces.

5.8 Military Exigency (Event) - Military Leave under FMLA taken for any qualifying event arising out of the fact that a covered military member is on active duty or call to active duty status.

5.8.1. Next-of-Kin - The closest blood relative of the injured or recovering service member other than the covered service member’s spouse, parent, son or daughter.

5.8.2. Covered Veteran - An individual who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date of FMLA eligibility.

6.0 EMPLOYER RESPONSIBILITIES

6.1. Human Resources (HR) is responsible for issuing and updating procedures to implement this policy.

6.2. HR will determine FMLA eligibility on behalf of the employer.
7.0 EMPLOYEE RESPONSIBILITIES

7.1. Employees are responsible for notifying HR and their Supervisor of the need for FMLA leave no later than 30 days prior to need for FMLA, if possible.

7.2. Employees are responsible for notifying HR of any changes in their Family and Medical Leave Status (e.g., returning to work, compensation, discrepancies, receiving Short Term Disability benefits, etc.).

7.3. Employees are responsible for notifying HR if they have not received a written notice of their eligibility to take Family and Medical Leave within five business days of their initial request, unless there are extenuating circumstances that require clarification or additional documentation from employees.

7.4. Employees are prohibited from performing work related duties while on Family and Medical Leave.

7.5. Employees on a continuous FMLA leave for their own serious health condition must submit a Fitness for Duty statement from their health care provider one week prior to returning to work.

7.6. When possible, employees are responsible for submitting their leave sheets to HR prior to the period of time that the employee will be out on FMLA leave.

8.0 SUPERVISOR RESPONSIBILITIES

8.1. Supervisors are responsible for informing HR of any changes to their employees’ FMLA leave or when the employee returns to work.

8.2. Although limited contact is permitted while on FMLA, HR will assist with making reasonable contact arrangements. Please consult HR before contacting employees on FMLA.

8.3. Supervisors are responsible for ensuring the employee’s FMLA absences are entered and approved on the employee’s timesheet.

9.0 PROCEDURES

9.1. USE OF FMLA

9.1.1. It is the policy of CBOH to grant up to 12 weeks of FMLA leave during a 12-month period to eligible employees or up to 26 weeks of military caregiver leave to care for a covered service member with a serious injury/illness.

9.1.2. Authorized officials cannot deny the use of FMLA leave when the provisions of this policy have been met. This policy does not insulate any employee from disciplinary action based on conduct or performance deficiencies.

9.1.3. FMLA leave is leave without pay; yet it can run concurrent with pay when the employee has leave available. CBOH requires employees on FMLA to use
available leave during their absence. Sick leave must be used first. If an employee's sick leave has been exhausted, then available compensatory time, annual leave or personal leave must be used. If none of these are available the employee will be placed into leave without pay status to cover the absence from work.

9.1.4. Spouses employed by the same employer may be limited to a combined total of 12 work weeks of family leave.

9.2. QUALIFYING REASONS

Both male and female employees may be eligible for FMLA leave for any of the following reasons:

9.2.1. Pregnancy and birth of the employee's child;

9.2.2. Care of the employee's newborn child;

9.2.3. The placement of a child with the employee for adoption or foster care, and to bond with that child;

9.2.4. A serious health condition which makes the employee unable to perform the essential functions of the position;

9.2.5. Care of the employee's child (son or daughter), spouse or parent who has a serious health condition.

9.2.6. A qualifying event arising out of a covered family member's active duty or call to active duty in the Armed Services in support of a contingency operation.

9.2.7. An eligible employee may take FMLA leave for qualifying military exigencies arising out of the fact that the employee's spouse, son, daughter or parent (the covered military member) including members of the National Guard and Reserves and the regular Armed Forces is on covered active duty and requires deployment to a foreign country, or has been notified of an impending call or order to active duty in support of a contingency operation.

9.3. QUALIFYING MILITARY EXIGENCECS (EVENTS) INCLUDE:

9.3.1. Short notice deployment

9.3.2. Military events and related activities

9.3.3. Childcare and school activities

9.3.4. Financial and legal arrangements

9.3.5. Counseling

9.3.6. Rest and recuperation

9.3.7. Post-deployment activities and additional activities to address other events that arise out of the covered service member's active duty or call to active duty
status, provided that CBOH and the employee agree that such leave shall qualify as an exigency and agree to both the timing and duration of the leave. The leave may commence as soon as the individual receives the call-up notice.

9.3.8. Eligible employees may take leave to care for a military member’s parent who is incapable of self-care when the care is necessitated by the member’s covered active duty. Such care may include arranging for alternative care, providing care on an immediate need basis, admitting or transferring the parent to a care facility, or attending meetings with staff at a care facility.

9.3.8.1. Care of an injured service member who is the employee’s family member or nearest blood relative.

9.3.8.2. An eligible employee may take up to 12 weeks of leave for reasons related to or affected by the family member’s call-up or service when it constitutes a qualifying event.

9.3.8.3. The amount of time an eligible employee may take for Rest and Recuperation qualifying events is a maximum of 15 calendar days.

9.3.8.4. An employee may take up to 26 weeks of FMLA in a 12-month period to care for a covered service member with a serious injury or illness if the employee is the spouse, son, daughter, parent, or next of kin of the service member.

9.3.8.5. For purposes of qualifying events, an employee’s son or daughter on covered active duty refers to a child of any age.

9.4. ELIGIBILITY REQUIREMENTS:

9.4.1. Have been employed with the CBOH for a minimum of 12 months. The 12 months do not need to be consecutive; there can be a break in service. Only employment within 7 years is counted unless the break in service is due to an employee’s fulfillment of military obligations, or governed by a collective bargaining agreement or other written agreement.

9.4.2. If currently employed by the CBOH, previous time worked for CBOH through a temporary agency service may count toward the 12 months’ minimum requirement if all other conditions are met.

9.4.3. Have worked a minimum of 1,250 hours during the 12 months immediately before the beginning of the FMLA leave (does not include holidays or time away from work on paid or unpaid leave);

9.4.4. Eligibility for FMLA leave to care for a newborn child begins on the date of birth and ends 12 months after the date of birth.

9.4.5. Eligibility for FMLA leave due to the placement of a child with the employee for adoption or foster care may begin prior to the date of placement if absence
from work is needed for the placement to proceed. Eligibility ends 12 months after the date of placement.

9.4.6. FMLA leave for a serious health condition is limited to the time determined to be medically necessary by the attending health care provider.

9.4.7. FMLA leave to care for a family member with a serious health condition ends if the family member dies. The date of death is the last day that qualifies for FMLA leave.

**9.5. TIME FRAMES**

9.5.1. Eligible employees are entitled up to 12 weeks of FMLA leave in a 12-month period or up to 26 weeks of military caregiver leave. For example, if the FMLA start date is February 1, 2019, the period measured will be February 1, 2018 to January 31, 2019.

9.5.2. FMLA leave calculations are based on an employee’s regular work schedule. For example, full-time employees who regularly work 5 days per workweek will be charged 1 work week of FMLA LEAVE for every 5 days absent from work. Similarly, part-time employees will be charged for the days taken.

If a holiday falls within a full week of FMLA Leave, then it counts toward the FMLA entitlement as if it were a workday. If a holiday falls within a week during which an employee uses FMLA Leave for only part of the week, then the holiday does not count toward the FMLA entitlement unless the employee uses the holiday for leave.

9.5.3. When an employee begins FMLA Leave, CBOH will measure the 12-month period going forward. The leave year is based on single 12-month period and begins with the first day the employee takes leave. Any FMLA Leave already taken for other FMLA circumstances will be deducted from the total weeks available.

**9.6. EMPLOYEE REQUEST**

9.6.1. When the need for Family and Medical Leave is foreseeable, an employee must provide HR with at least 30 calendar days of advance written notice of the requested leave.

9.6.2. When 30 calendar days' advance notice is not possible, employees must notify HR as soon as they become aware that FMLA is necessary. In these situations, FMLA paperwork must be submitted within 15 days of notifying HR of the need for FMLA. FMLA may be delayed when adequate notice and supporting documentation is not provided.

9.6.3. If FMLA is foreseeable based on planned medical treatment, employees must make a reasonable effort to schedule the FMLA, subject to the approval of the attending health care provider, when the operations of the work unit will not be unduly disrupted.
9.6.4. When requesting FMLA, employees are to provide the following information to HR:

9.6.4.1. A completed Family and Medical Leave Act Request Form # HR-03431A;
9.6.4.2. The beginning and ending dates of the requested FMLA;
9.6.4.3. The reason for the absence must be explained to determine whether it qualifies for FMLA.

9.6.4.4. Employees requesting FMLA due to pregnancy, child birth, adoption or foster care are to provide to HR the Certification of Serious Health Condition Form # HR-03431D or the Certification of Adoption or Foster Care Form # HR-03431C, whichever is appropriate. Separate FMLA request forms and certification forms are not needed to cover each absence. These forms need to be submitted only one time, unless the circumstances regarding pregnancy/child birth or placement change to the extent that updated information is needed.

9.6.4.5. Employees requesting FMLA due to a serious health condition must provide HR a Certification of Serious Health Condition Form # HR-03431D, completed by the attending health care provider. When a single serious health condition requires multiple absences (e.g., asthma, chemotherapy, etc.), a separate medical statement is not required for each absence. When FMLA for a serious health condition is foreseeable, this certification should be provided before the absence begins. When it is not possible to provide this certification before the absence begins, employees must provide the certification within 15 calendar days of the date it is requested.

9.6.4.6. Employees requesting FMLA for the care of a family member must provide HR a WH-380-F Certification of health Care Provider for Family Member's Serious Health Condition form completed by the attending health care provider.

9.6.4.7. Employees requesting FMLA for a qualifying military exigency are to provide HR with a WH-384 Certification of Qualifying Exigency for Military Family Leave form along with a copy of the military member's covered active duty orders.

9.6.4.8. Employees requesting FMLA for the care of a current military service member are to provide HR with a WH-385 Certification for Serious Injury or Illness of a Current Servicemember – for Military Family Leave form completed by the attending health care provider.

9.6.4.9. Employees requesting FMLA for the care of a veteran are to provide HR with a WH-385-V Certification for Serious Injury or Illness of a Veteran for Military Caregiver Leave form completed by the attending health care provider.
9.6.5 Employees who are absent from work due to work-related injuries, illness and/or exposures to occupational disease covered under workers' compensation may be placed on FMLA.

9.7. HR RESPONSE

9.7.1. HR will respond to FMLA requests in writing within 5 business days of receipt of the requests, unless there are extenuating circumstances that require clarification or additional documentation from employees.

9.7.2. Approval notices will specify the terms and conditions of the FMLA and advise employees of their right to return to work.

9.7.3. If an employee is not eligible for FMLA, the employee will be notified in writing; and the notice will include the reason why they are not eligible.

9.7.4. If sufficient information is not available to determine whether FMLA should be approved, authorized officials may conditionally approve the FMLA contingent upon receiving required documentation.

9.7.5. If the request is based on a serious health condition, the conditional approval notice is to include a statement that a completed Certification of Serious Health Condition or other medical statement with similar information must be submitted to HR within 15 calendar days.

9.7.6. When the required documentation is received, employees will be advised if the FMLA is approved, or if they are ineligible.

9.7.7. If the required documentation is not provided by the deadline date, the absence may not qualify for FMLA and the employee may not receive the protection of FMLA, or the use of FMLA could be delayed.

9.7.8. If timely notices are not provided by employees, they are NOT entitled to additional time beyond the maximum amount of 12 work weeks for FMLA.

9.7.9. If there is a question as to the validity of the certification for FMLA, and ONLY with the approval of HR, the employee may be required to obtain a second opinion from a health care provider chosen by the CBOH and paid for by the CBOH.

9.7.10. Employees who believe that their FMLA requests have not been processed correctly should discuss their concerns with Human Resources.

9.8. DESIGNATING FAMILY AND MEDICAL LEAVE

9.8.1. Generally, absences from work may not be retroactively designated as FMLA after an employee has returned to work. However, FMLA may be designated retroactively under the following circumstances:

9.8.1.1. When the employee was absent for an FMLA reason and the CBOH did not learn of the reason for the absence until the
employee’s return. The retroactive designation must be made within 15 calendar days of the employee’s return to duty.

9.8.1.2. When the CBOH knows the reason for leave but has not been able to confirm that the leave qualifies under FMLA. In such cases, the FMLA designation must be made promptly upon receipt of appropriate certification.

9.8.2. If the CBOH did not notify the employee that the absence was being designated as FMLA leave, when the reason for the absence is known beforehand by the CBOH (e.g., pregnancy/child birth), employees are not to be retroactively placed on FMLA after they return to work.

9.9. EMPLOYEE BENEFITS

9.9.1. Employees must use paid leave in this order, sick, compensatory, annual or personal first, when available, before leave without pay is an option, or use a combination of both to cover the absence from work.

The following two exceptions apply:

1. If an absence qualifies for Workers’ Compensation wage loss benefits, the employee may choose to receive such benefits rather than use paid leave or compensatory time during Family and Medical Leave.

2. An employee will not be required to use paid leave and compensatory time while receiving short-term or long-term disability insurance payments.

9.9.2. Since leave donations are credited to recipients’ sick leave balances, employees who are on FMLA can only use donated leave for absences that qualify for use of sick leave.

9.9.3. Employees receiving Short Term & Long Term Disability benefits are not authorized to use sick leave, donated leave or any other salary continuation, however, employees can use annual, personal or compensatory leave.

9.9.4. While on FMLA, employees who have health insurance and/or flexible benefits are eligible to maintain benefits coverage at the employee rate. It is the responsibility of the employee to pay insurance premiums.

9.9.4.1. Employees on FMLA with pay must continue to pay premiums through payroll deductions.

9.9.4.2. Employees on FMLA without pay will be advised of the cost for maintaining health insurance and any benefits through the Flexible Benefits Program, arrangements for making payments and consequences for not making timely payments. Employees on FMLA without pay must complete and submit the following forms to Human Resources:

9.9.4.2.1. a. Request to Continue Health Benefits During Leave of Absence Without Pay
b. Disability Certification, if appropriate

9.9.4.2.2. Employees with at least one (1) year of participation in the Group Term Life Insurance Program under the Employees’ Retirement System (ERS) may retain coverage while on FMLA without pay. A request to continue coverage must be made in writing to ERS prior to beginning the FMLA without pay. Coverage terminates if this written request is not received.

9.9.5. Employees on FMLA without pay will be advised of the cost for maintaining health insurance and any benefits through the Flexible Benefits Program. Employees will also be advised of the arrangements for making payments and consequences for not making timely payments.

9.9.5.1. Employees on FMLA without pay must notify the HR Representative to continue health insurance benefits.

9.9.5.2. Employees with at least 1 year of participation in the Group Term Life Insurance Program under the Employees’ Retirement System (ERS) may retain coverage while on FMLA without pay. A request to continue coverage must be on file with HR prior to beginning FMLA without pay. Coverage terminates if this written request is not received.

9.9.6. Supervisors, authorized officials or designees are to complete the Request for Personnel/Payroll Action Request form to place employees on FMLA with and/or without pay. These completed forms are to be submitted to HR for processing.

9.10. RECERTIFICATION

Employees on FMLA due to a serious health condition may be required to provide recertification of the serious health condition on a reasonable basis. Recertification cannot be required more often than every thirty (30) calendar days.

9.11. INTERMITTENT /REDUCED WORK SCHEDULE

9.11.1. FMLA may be taken intermittently or on a reduced work schedule under certain circumstances. FMLA cannot exceed 480 hours in a rolling 12-month period.

9.11.2. FMLA hours for eligible employees that work reduced work schedules will coincide with their weekly work hours. For example, if an employee works 32 hours per week they will have 384 hours of FMLA available to take, if approved.

9.11.2.1. Intermittent leave is leave taken in separate blocks of time due to a single qualifying reason (e.g., morning sickness, prenatal examinations, and therapy sessions).
9.11.2.2. A reduced work schedule reduces employees' normal work hours per workweek or per workday.

9.11.3. FMLA may be taken intermittently or on a reduced work schedule when medically necessary or to provide care or psychological comfort to a qualifying family member with a serious health condition. A medical statement is not required for each absence when FMLA is taken intermittently. Documentation is required initially, and recertification is required after the doctor's time stated on form has expired, or if the condition exceeds a 12-month period. Recertification may be required every 12 work weeks.

9.11.4. FMLA may be taken intermittently or on a reduced work schedule to care for a newborn child or for placement of a child for adoption or foster care.

9.11.5. Employees who request FMLA on an intermittent or reduced work schedule basis may be required to temporarily transfer to an available alternative position that better accommodates recurring periods of absence.

9.11.5.1. The alternative position must have equivalent pay and benefits, but is not required to have equivalent duties.

9.11.5.2. Employees must not be transferred to alternative positions to discourage the use of FMLA or to positions that represent a hardship (e.g., employees may not be transferred to a less desirable work schedule).

9.11.5.3. When the need for intermittent leave or a reduced work schedule ends and employees are able to return to their normal work schedules, they must be returned to their former positions or equivalent positions.

9.11.6. Only the amount of leave actually taken on an intermittent or reduced work schedule basis may be counted toward the 12 work weeks of FMLA.

9.11.7. Employees on intermittent FMLA due to a serious health condition are required to provide recertification of the serious health condition at least every 12 months. Recertification may be required every 12 work weeks.

9.12. RETURN TO WORK

9.12.1. Employees who have complied with the terms and conditions in the FMLA approval notice are entitled to return to the same position, or an equivalent position with the same pay and grade, benefits and comparable working conditions, at the expiration of FMLA.

9.12.1.1. Employees do not retain this entitlement if at the expiration of FMLA they are unable to perform the essential functions of the position, with or without reasonable accommodation, due to physical or mental condition.
9.12.2. Employees returning from FMLA due to their own serious health condition are required to submit a return-to-work statement from the attending health care provider prior to returning to work. This statement must certify that the employee is capable of performing the essential functions of the position, with or without reasonable accommodation. This statement should be submitted to HR. Employees who do not provide the required statement or have restrictions that cannot be reasonably accommodated should not be allowed to return to work. In the event that an employee reports to work in lieu of providing the required return to work statement, the employee will be sent home and their absence could be unexcused.

9.12.3. Employees that exhaust FMLA and would like to be considered for further employment need to provide a written request for authorized leave without pay or contingent leave. (See the Leave of Absence Without Pay Policy #HR-03423 for further clarification of these options.)

9.12.4. Employees that do not return to work at the expiration of approved FMLA, without appropriate notification to HR, are subject to disciplinary action up to and including separation.

9.12.5. Authorized officials or designees may complete, if required, a Request for Personnel/Payroll Action for employees returning from FMLA.

9.13. ADDITIONAL RULES

9.13.1. Employees are prohibited from performing work related duties while on FMLA.

9.13.2. Although limited contact is permitted while on FMLA, HR will assist with making reasonable contact arrangements. Please consult HR before contacting employees on FMLA.

9.14. RECORD KEEPING

9.14.1. All FMLA related employment records will be maintained for at least 3 years by HR and made available upon request by the U. S. Department of Labor. These records include, but are not limited to the following:

9.14.1.1. Correspondence between the employee, supervisor or authorized official regarding FMLA;

9.14.1.2. Records of any dispute regarding designation of leave as FMLA;
9.14.1.3. Any documents describing employee benefits or Department policies and practices regarding the taking of leave with and without pay.

10.0 REVISION HISTORY

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11.0 RELATED FORMS

HR03431-A Family and Medical Leave Request Forms
HR03431-B Certification of Serious Health Condition Form
HR03431-C Certification of Adoption or Foster Care Form
HR03431-D Returning from Family and Medical Leave Forms
HR03806-E FMLA Contact Information Verification Form
HR03102-D Personnel/Payroll Action Request Form
WH-380-F Certification of Health Care Provider for Family Member's Serious Health Condition
WH-384 Certification of Qualifying Exigency for Military Family Leave
WH-385 Certification for Serious Injury or Illness of a Current Servicemember—for Military Family.
WH-385-V Certification for Serious Injury or Illness of a Veteran for Military Caregiver Leave
Family and Medical Leave Acknowledgement

RE: Policy #HR-03431
Family and Medical Leave Policy

I acknowledge receipt and understanding of the Family and Medical Leave Policy and the terms and conditions of my Family and Medical Leave. I agree to abide by the policy guidelines as a condition of my employment and my continuing employment with the County Board of Health.

Employee Signature: 

Date: 

Employee Printed Name:
COUNTY BOARD OF HEALTH
FAMILY AND MEDICAL LEAVE REQUEST FORM

Name of Employee | Employee ID#
---|---
Home Address | City | ST | ZIP
Contact Phone Number

I request to use family and medical leave from | Begin Date: | End Date:

Days & Hours currently working: | Mon | Tues | Wed | Thurs | Fri | Hours: AM to PM

Reason for FML Request - PLEASE CHECK:
☐ A. Pregnancy/birth of my child.
☐ B. Care of my newborn child.
☐ C. The adoption or foster care of a child, or care of the child after placement with me.
☐ D. A serious health condition (as defined in CBOH Family Medical Leave Policy # 03431 which renders me unable to perform my essential job functions.
☐ E. Care of my (circle one) child, spouse or parent who has a serious health condition.

Please complete:
FMLA Type: ☐ Continuous ☐ Intermittent

I request to use available leave during the period of absence as follows (please specify a number of hours or write all in the type of leave you are requesting to use:

_____ Hours of annual leave | _____ Hours of personal leave | _____ Hours of sick leave

I request to charge _____ hours to leave without pay during the period of absence.

Please submit approved leave request form with this form.

RE: Policy #HR-03431 Family and Medical Leave Policy

I acknowledge receipt and understanding of the Family and Medical Leave Policy and the terms and conditions of my Family and Medical Leave. I agree to abide by the policy guidelines as a condition of my employment and my continuing employment with the County Board of Health.

I understand that use of family and medical leave for any combination of circumstances listed above will be limited to a total of twelve (12) work weeks in a year. I also understand that return to my former position or equivalent position with the same pay and grade, benefits and comparable working conditions is contingent upon compliance with the terms of approved family and medical leave.

Signature of Employee | Date

SUPERVISOR’S RECEIPT

I received this request on ________________, It is being sent to Human Resources/District Personnel Department on ________________

Print Supervisor’s Name: ________________ Signature: ________________
**COUNTY BOARD OF HEALTH**  
**REQUEST FOR APPROVAL OF LEAVE**

Employee’s Name (Print or Type): ____________________________________________

This is to request approval of the following leave:

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<td>Time</td>
<td></td>
</tr>
</tbody>
</table>

**Leave Balance Before Requested Leave:**

<table>
<thead>
<tr>
<th>Annual</th>
<th>Sick</th>
<th>Personal</th>
</tr>
</thead>
</table>

**Leave Codes**

- **AL**: Annual Leave  
- **SL**: Sick Leave  
- **ASSL**: Annual to Supplement Sick  
- **PL**: Personal Leave  
- **FUL**: Furlough  
- **BDL**: Blood Donation Leave  
- **ML**: Military Leave*
- **CL**: Court Leave*  
- **LWOP**: Leave Without Pay**  
- **FLSA**: FLSA Compensatory Time  
- **SCT**: State Compensatory Time  
- **FML/A**: Family Medical Leave/Annual  
- **FML/S**: Family Medical Leave/Sick  
- **FML/P**: Family Medical Leave/Personal

* Copy of orders or subpoena must be attached  
** Personnel Action Request form must be submitted

**REQUESTED BY:**

__________________________________________________________________________

Employee’s Signature

__________________________________________________________________________

Date

**APPROVED BY:**

__________________________________________________________________________

Supervisor’s Signature

__________________________________________________________________________

Date

HR-03431A (Rev. 02/25/2014)  
Page 2 of 2
COUNTY BOARD OF HEALTH
CERTIFICATION OF SERIOUS HEALTH CONDITION

FORM TO BE COMPLETED BY HEALTH CARE PROVIDER:

<table>
<thead>
<tr>
<th>Employee's Name:</th>
<th>Patient's Name and Relationship to Employee (if different from employee):</th>
</tr>
</thead>
</table>

Please check the applicable category:

- Hospital Care
- Absence plus Treatment
- Pregnancy
- Chronic Conditions Requiring Treatments
- Permanent / Long-term Conditions Requiring Supervision
- Multiple Treatments (Non-Chronic Conditions)
- None of the above

SECTION 1: Complete this section for the serious health condition of the employee.

Describe the medical facts that support the employee’s need to be absent from work due to a serious health condition.

<table>
<thead>
<tr>
<th>Approximate date condition began:</th>
<th>Expected duration of condition:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe the regimen of treatment prescribed (including number of visits, general nature and duration of treatment, referral to other health service providers, etc.)</td>
<td></td>
</tr>
</tbody>
</table>

- Is inpatient hospitalization required? □ Yes □ No
- Is the employee able to perform work of any kind? □ Yes □ No
- Is the employee able to perform essential job functions, with or without reasonable accommodation? □ Yes □ No

If yes, please describe recommended accommodation, if any:

If the employee is able to perform some or all essential job functions, will it be necessary for the employee to be absent from work on an intermittent basis (e.g., to attend weekly therapy appointments) or to work less than a full work week (e.g., to work 20 hours per week rather than 40 hours?)

□ Yes □ No If yes, please describe:
SECTION 2: Complete this section for CERTIFICATION OF PREGNANCY/CHILD BIRTH
This section is to document family and medical leave for pregnancy, child birth and care of a newborn child.

ATTENDING HEALTH CARE PROVIDER:
PLEASE COMPLETE THIS SECTION FOR FEMALE employees only
This is to certify that the employee named above is expected to become, or became, a biological parent on:

<table>
<thead>
<tr>
<th>Date:</th>
</tr>
</thead>
</table>

It is anticipated that the employee will be unable to work FROM (date): TO (date):

Barring unforeseen complications, she should be able to return to work on DATE:

If the period during which the employee is unable to work exceeds two weeks prior to delivery or six weeks after delivery, please provide the medical facts that support the additional period of serious health condition:

ATTENDING HEALTH CARE PROVIDER:
PLEASE COMPLETE THIS SECTION FOR MALE employees only
This is to certify that the employee named above is expected to become, or became, a biological parent on DATE:

The employee’s presence is needed due to the pregnancy, child birth and/or care for the mother and/or newborn child from FROM (date): TO (date):

Additional comments/explanation:

NOTE TO EMPLOYEES: Any period of incapacity due to pregnancy or continuing treatment for prenatal care is considered a serious health condition for purposes of family and medical leave. Sick leave may be used only for reasons that qualify for sick leave as described in CBOH Policy #HR-03422 - ANNUAL, SICK AND PERSONAL LEAVE POLICY.

SECTION 3: Complete this section for the serious health condition of an employee’s family member.
Please indicate the dates for which the employee’s presence is necessary to care for a family member with a serious health condition:

<table>
<thead>
<tr>
<th>FROM (date):</th>
<th>TO (date):</th>
</tr>
</thead>
</table>

Describe the medical facts that support the employee’s need to be absent from work to care for a family member with a serious health condition, including care for basic medical or personal needs and/or psychological comfort.

Will it be necessary for the employee to be off work on an intermittent basis or to work less than the normal work schedule to care for the family member? □ Yes □ No If yes, please describe:
**SECTION 4: Attending Health Care PROVIDER complete this section.**

Additional Comments:

<table>
<thead>
<tr>
<th>Signature of Health Care Provider</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<table>
<thead>
<tr>
<th>Address:</th>
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<tbody>
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<td></td>
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</table>

<table>
<thead>
<tr>
<th>Phone Number:</th>
<th>Type of Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>
CERTIFICATION OF ADOPTION OR FOSTER CARE

This form is to be used by CBOH employees to document family and medical leave for placement of a child with the employee for adoption or foster care.

<table>
<thead>
<tr>
<th>NAME OF EMPLOYEE:</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Last:</td>
<td>First:</td>
<td>MI:</td>
</tr>
</tbody>
</table>

This is to certify that a child was or will be adopted or accepted into foster care by the employee named above on: DATE:

Additional comments/explanation:

<table>
<thead>
<tr>
<th>Name of Official Authorizing Adoption or Foster Care - Please Print</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature of Official Authorizing Adoption or Foster Care</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Form HR-03431C [Rev. 12/12/2013]
Returning from Family and Medical Leave

All employees returning from Family and Medical Leave due to their own serious health condition are required to submit a RELEASE TO RETURN TO WORK Form or similar statement from their attending health care provider. This statement must certify that the employee is capable of performing the essential functions of the position, with or without reasonable accommodation. Employees that have restrictions that cannot be reasonably accommodated should not be allowed to return to work. This statement must be submitted to Human Resources prior to returning to work. Employees who do not provide completed documentation will not be allowed to return to work.

In the event that the employee is unable to return to work at the expiration of their Family and Medical Leave the available options are as listed:

Employees that have Family and Medical Leave
   a) If the employee has not absorbed their allotted 12 weeks of Family and Medical Leave they may submit a letter from their health care provider requesting that the Family and Medical Leave be extended. This letter must be submitted at least 3 business days prior to the employee’s scheduled return to work date. Failure to provide this documentation to support the employee’s extended absence from work could result in termination of employment.

Employees that have exhausted Family and Medical Leave:
To be considered for further employment, the employee needs to provide a written request for either of the two options listed:

Option 1 – Authorized Leave without Pay

An employee may submit a written request to the agency to take a continuous leave without pay for a period not exceeding 12 months. Supporting documentation (e.g., reason for request, duration of leave request) must be included in the request. If approved, a written notice specifying the terms and conditions of the approval will be provided to the employee, including a statement indicating that the employee will be reinstated to the former position or to a position of equal grade and pay without loss of any rights provided the employee returns within the terms of the leave granted.

Option 2 – Contingent Leave without Pay

To request contingent leave without pay, an employee must follow the same procedure required to request authorized leave without pay. A contingent leave of absence may not exceed 12 months. The notice of approval of a request for a contingent leave of absence will include the terms and conditions of the approval including a statement that the employee's right to return at the expiration of the leave is not guaranteed and will be contingent on a suitable vacancy being available.

1. An employee who is authorized to take leave (including contingent leave) but does not have sufficient accrued paid leave or elects to forego the use of available paid leave will be placed in non-pay status. In these situations, an employee must submit a written request and the procedure described in the preceding paragraph must be followed.
2. The CBOH may extend an approved leave without pay for additional time not exceeding 12 months. An employee must submit a written request for an extension and, if approved, a written notice specifying the terms and conditions of the extension, including any rights to reinstatement, must be provided.

3. A continuous unpaid leave of absence may not exceed 24 months, unless otherwise required by state or federal law. An unpaid leave of absence is not included as service for purposes of computing any retirement or pension benefits.

4. Employees on a contingent leave of absence without pay are not eligible to solicit or use leave donations.

If approved, the effective date of the leave request will be the first business day following the expiration of the employee's Family and Medical Leave. The request must be received no later than 10 business days from the employee's effective date to return to work. Please send all information related to employee leave requests to the correspondence address included in this document. Failure to notify Human Resources in writing within the requested time frame could result in termination of employment. The employee will receive a written reply within 10 business days of receipt of their request.

**Option 3 – Employment Separation**

1. If the employee fails to return to work at the expiration of their Family and Medical Leave and does not provide a letter from their health care provider requesting an extension of their Family and Medical Leave may result in termination of employment.

2. If the employee fails to return to work and has exhausted their Family and Medical Leave and does not provide a written request to be considered for contingent leave or authorized leave without pay within the required time frame may result in termination of employment.

3. If the employee does not adhere to the terms and conditions of their leave it is grounds for disciplinary action up to and including termination of employment.

4. Employees have the option of resigning from employment at anytime.

If you have any questions please contact Human Resources/District Personnel Department.

**Please send all correspondence to:**

Human Resources/District Personnel Department Address (insert address here)
## SECTION 1 – To be completed by EMPLOYEE

<table>
<thead>
<tr>
<th>EMPLOYEE'S NAME (LAST)</th>
<th>FIRST</th>
<th>MI.</th>
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</table>

<table>
<thead>
<tr>
<th>EMPLOYEE'S WORK LOCATION</th>
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<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>HUMAN RESOURCES/DISTRICT PERSONNEL DEPARTMENT CONTACT</th>
</tr>
</thead>
<tbody>
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</table>

<table>
<thead>
<tr>
<th>HUMAN RESOURCES/DISTRICT PERSONNEL DEPARTMENT MAILING ADDRESS</th>
</tr>
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<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>PHONE</th>
<th>FAX</th>
<th>E-MAIL</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

## SECTION 2 – To be completed by HEALTH CARE PROVIDER

PLEASE COMPLETE THE FOLLOWING AND RETURN THE FORM TO THE EMPLOYEE OR TO THE DEPARTMENT CONTACT LISTED ABOVE PRIOR TO THE RETURN TO WORK DATE

**Important:** Please limit your answers below to the serious health condition for which the employee has been on leave.

<table>
<thead>
<tr>
<th>NAME OF HEALTH CARE PROVIDER [Print]</th>
<th>PLACE ADDRESS STAMP HERE:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>ADDRESS</th>
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<tbody>
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</tbody>
</table>

1. Is the employee now able to perform those essential functions of his or her job that he or she could not previously perform because of the serious health condition for which the employee has been on leave?

- [ ] No
- [ ] Yes
- [ ] Yes, with restrictions

2. The employee released to return to work effective **DATE:**

3. If the Employee is released to return to work but is restricted in his or her ability to perform the essential functions of his or her job as a result of the serious health condition for which the employee has been on leave, please describe those restrictions:

4. The foregoing restrictions are:

- [ ] Permanent
- [ ] Temporary, until ________________

<table>
<thead>
<tr>
<th>SIGNATURE OF HEALTH CARE PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DATE</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
FMLA Employee Contact Information Verification Form

To ensure communications are sent to the proper address, please fill in fields below.

Name:

Street Address:          Apartment#/ Building #:

City:                    State:            Zip Code:

Phone:                   Email:

FMLA Type (check one):   □ Continuous    □ Intermittent

I acknowledge that the above information is correct and it is my responsibility to notify Human Resources/District Personnel Department of any changes in my contact information.

Employee Signature:      DATE:

Employee Printed Name:

Please be aware that time sensitive information will be sent to the address you specify on this form. It is your responsibility to inform Human Resources/District Personnel Department should your contact information change at any time. Upon completion of this form please submit it to Human Resources/District Personnel Department.

Form #HR-03431E [Rev. 12/12/2013]
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, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: Bob Shaw, phone 404-232-1696 fax 770-359-4606, e-mail bob.shaw@dph.ga.gov
Georgia Department of Public Health, 2 Peachtree St NW, STE 16-417, Atlanta, GA 30303

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: ________________________________________________________________

Relationship of family member to you:  
First  
Middle  
Last

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. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e). 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):

________________________________________________________________

________________________________________________________________

________________________________________________________________

Page 2 CONTINUED ON NEXT PAGE Form WH-380-F Revised May 2015
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:

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

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 CFR 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 CFR 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 military member on covered active duty or call to covered active duty status:  

First 

Middle 

Last 

Relationship of military member to you:  

Period of military member’s covered active duty:  

A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes written documentation confirming a military member’s covered active duty or call to covered active duty status. Please check one of the following and attach the indicated document to support that the military member is on covered active duty or call to covered active duty status.

A copy of the military member’s covered active duty orders is attached.  

Other documentation from the military certifying that the military member is on covered active duty (or has been notified of an impending call to covered active duty) is attached.  

I have previously provided my employer with sufficient written documentation confirming the military member’s covered active duty or call to covered active duty status.
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 the military member’s Rest and Recuperation leave; a document confirming an appointment with a third party, such as a counselor or school official, or staff at a care facility; 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?

Yes ☐ No ☐

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?  Yes ☐ No ☐

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.
PART C:

If leave is requested to meet with a third party (such as to arrange for childcare or parental care, to attend counseling, to attend meetings with school, childcare or parental care providers, to make financial or legal arrangements, to act as the 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 CFR 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.
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 current 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 CFR 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 CFR 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 CFR 1635.9, if the Genetic Information Nondiscrimination Act applies.

SECTION I: For Completion by the EMPLOYEE and/or the CURRENT SERVICEMEMBER for whom the Employee is Requesting Leave

INSTRUCTIONS to the EMPLOYEE or CURRENT 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 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 CFR 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; (3) a DOD non-network TRICARE authorized private health care provider; or (4) a health care provider as defined in 29 CFR 825.125

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 current 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 in the Armed Forces or that existed before the beginning of the member’s active duty and was aggravated by service in the line of duty on active duty in the Armed Forces 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 current servicemember’s serious injury or illness includes written documentation confirming that the servicemember’s injury or illness was incurred in the line of duty on active duty or if not, that the current servicemember’s injury or illness existed before the beginning of the servicemember’s active duty and was aggravated by service in the line of duty on active duty in the Armed Forces, and that the current 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 servicemember’s condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 CFR 1635.3(f), or genetic services, as defined in 29 CFR 1635.3(e).
SECTION I: For Completion by the EMPLOYEE and/or the CURRENT 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 the current servicemember):

Name of Employee Requesting Leave to Care for the Current Servicemember:

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

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<tr>
<th>First</th>
<th>Middle</th>
<th>Last</th>
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</thead>
</table>

Relationship of Employee to the Current Servicemember:

Spouse □ Parent □ Son □ Daughter □ Next of Kin □

Part B: SERVICEMEMBER INFORMATION

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

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

____________________________________________________________________________________

Is the 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 Servicemember on the Temporary Disability Retired List (TDRL)?
Yes □ No □

Part C: CARE TO BE PROVIDED TO THE SERVICEMEMBER

Describe the Care to Be Provided to the Current 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; (3) a DOD non-network TRICARE authorized private health care provider; or (4) a health care provider as defined in 29 CFR 825.125. 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; (4) a DOD non-network TRICARE authorized private health care provider, or (5) a health care provider as defined in 29 CFR 825.125:

______________________________________________________________

Telephone: ( ) __________________ Fax: ( ) __________________ Email: __________________________

PART B: MEDICAL STATUS

(1) The current 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-F or an employer-provided form seeking the same information.)

(2) Is the current Servicemember being treated for a condition which was incurred or aggravated by service in the 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: __________________________

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(5) Is the servicemember undergoing medical treatment, recuperation, or therapy for this condition? Yes ☐ No ☐

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

PART C: SERVICEMEMBER’S NEED FOR CARE BY FAMILY MEMBER

(1) Will the 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 servicemember require periodic follow-up treatment appointments? Yes ☐ No ☐

If yes, estimate the treatment schedule:

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

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

If yes, please estimate the frequency and duration of the periodic care:

Signature of Health Care Provider: __________________________ Date: __________________________

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

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

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking military caregiver leave under the FMLA leave due to a serious injury or illness of a covered veteran 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 CFR 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 CFR 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 CFR 1635.9, if the Genetic Information Nondiscrimination Act applies.

SECTION I: For completion by the EMPLOYEE and/or the VETERAN for whom the employee is requesting leave

INSTRUCTIONS to the EMPLOYEE and/or VETERAN: 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 military caregiver leave under the FMLA leave due to a serious injury or illness of a covered veteran. 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 CFR 825.310(f). The employer must give an employee at least 15 calendar days to return this form to the employer.

(This section must be completed before Section II 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 a veteran):

Name of employee requesting leave to care for a veteran:

<table>
<thead>
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<th>Middle</th>
<th>Last</th>
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</table>

Name of veteran (for whom employee is requesting leave):

<table>
<thead>
<tr>
<th>First</th>
<th>Middle</th>
<th>Last</th>
</tr>
</thead>
</table>

Relationship of employee to veteran:

Spouse □  Parent □  Son □  Daughter □  Next of Kin □ (please specify relationship):
Part B: VETERAN INFORMATION

(1) Date of the veteran’s discharge:

(2) Was the veteran dishonorably discharged or released from the Armed Forces (including the National Guard or Reserves)? Yes□ No□

(3) Please provide the veteran’s military branch, rank and unit at the time of discharge:

(4) Is the veteran receiving medical treatment, recuperation, or therapy for an injury or illness? Yes□ No□

Part C: CARE TO BE PROVIDED TO THE VETERAN

Describe the care to be provided to the veteran and an estimate of the leave needed to provide the care:
SECTION II: For completion by: (1) a United States Department of Defense ("DOD") health care provider; (2) a United States Department of Veterans Affairs ("VA") health care provider; (3) a DOD TRICARE network authorized private health care provider; (4) a DOD non-network TRICARE authorized private health care provider; or (5) a health care provider as defined in 29 CFR 825.125.

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee named in Section I has requested leave under the military caregiver leave provision of the FMLA to care for a family member who is a veteran. For purposes of FMLA military caregiver leave, a serious injury or illness means an injury or illness incurred by the servicemember in the line of duty on active duty in the Armed Forces or that existed before the beginning of the servicemember's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces and manifested itself before or after the servicemember became a veteran, and is:

(i) a continuation of a serious injury or illness that was incurred or aggravated when the covered veteran was a member of the Armed Forces and rendered the servicemember unable to perform the duties of the servicemember's office, grade, rank, or rating; or
(ii) a physical or mental condition for which the covered veteran has received a U.S. Department of Veterans Affairs Service Related Disability Rating (VASRD) of 50 percent or greater, and such VASRD rating is based, in whole or in part, on the condition precipitating the need for military caregiver leave; or
(iii) a physical or mental condition that substantially impairs the covered veteran's ability to secure or follow a substantially gainful occupation by reason of a disability or disabilities related to military service, or would do so absent treatment; or
(iv) an injury, including a psychological injury, on the basis of which the covered veteran has been enrolled in the Department of Veterans' Affairs Program of Comprehensive Assistance for Family Caregivers.

A complete and sufficient certification to support a request for FMLA military caregiver leave due to a covered veteran's serious injury or illness includes written documentation confirming that the veteran's injury or illness was incurred in the line of duty on active duty or existed before the beginning of the veteran's active duty and was aggravated by service in the line of duty on active duty, and that the veteran is undergoing treatment, recuperation, or therapy 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 military caregiver leave coverage. Limit your responses to the veteran's condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 CFR 1635.3(f), or genetic services, as defined in 29 CFR 1635.3(c).

(Please ensure that Section I has been completed before completing this section. Please be sure to sign the form on the last page and return this form to the employee requesting leave (See Section I, Part A above). DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.)

Part A: HEALTH CARE PROVIDER INFORMATION

Health care provider's name and business address:

<table>
<thead>
<tr>
<th>Telephone: ( )</th>
<th>Fax: ( )</th>
<th>Email:</th>
</tr>
</thead>
</table>

Type of Practice/Medical Specialty: ________________________________

Please indicate if you are:

☐ a DOD health care provider

☐ a VA health care provider

☐ a DOD TRICARE network authorized private health care provider

☐ a DOD non-network TRICARE authorized private health care provider

☐ other health care provider

Page 3		CONTINUED ON NEXT PAGE			Form WH-385-V Revised May 2015
PART B: MEDICAL STATUS

Note: If you are unable to make certain of the military-related determinations contained in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as, DOD Recovery Care Coordinator) or an authorized VA representative.

(1) The Veteran’s medical condition is:

☐ A continuation of a serious injury or illness that was incurred or aggravated when the covered veteran was a member of the Armed Forces and rendered the servicemember unable to perform the duties of the servicemember’s office, grade, rank, or rating.

☐ A physical or mental condition for which the covered veteran has received a U.S. Department of Veterans Affairs Service Related Disability Rating (VASRD) of 50% or higher, and such VASRD rating is based, in whole or in part, on the condition precipitating the need for military caregiver leave.

☐ A physical or mental condition that substantially impairs the covered veteran’s ability to secure or follow a substantially gainful occupation by reason of a disability or disabilities related to military service, or would do so absent treatment.

☐ An injury, including a psychological injury, on the basis of which the covered veteran is enrolled in the Department of Veterans’ Affairs Program of Comprehensive Assistance for Family Caregivers.

☐ None of the above.

(2) Is the veteran being treated for a condition which was incurred or aggravated by service in the 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 veteran undergoing medical treatment, recuperation, or therapy for this condition? Yes□ No□

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

__________________________________________________________________________

PART C: VETERAN’S NEED FOR CARE BY FAMILY MEMBER

“Need for care” encompasses both physical and psychological care. It includes situations where, for example, due to his or her serious injury or illness, the veteran is unable to care for his or her own basic medical, hygienic, or nutritional needs or safety, or is unable to transport him or herself to the doctor. It also includes providing psychological comfort and reassurance which would be beneficial to the veteran who is receiving inpatient or home care.

(1) Will the veteran 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 veteran require periodic follow-up treatment appointments? Yes□ No□

If yes, estimate the treatment schedule: ________________________________

CONTINUED ON NEXT PAGE
(3) Is there a medical necessity for the veteran to have periodic care for these follow-up treatment appointments?  
Yes☐  No☐  

(4) Is there a medical necessity for the veteran to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)?  
Yes☐  No☐  

If yes, please estimate the frequency and duration of the periodic care:  

_____________________________  

_____________________________  

Signature of Health Care Provider:  ___________________________  Date:  ___________________________  

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT  
If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years, in accordance with 29 U.S.C. 2616; 29 CFR 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 THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE EMPLOYEE REQUESTING LEAVE (As shown in Section I, Part “A” above).