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Request for
Family and Medical Leave Act (FMLA) Leave

CENTER FOR SOCIAL CHANGE
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carf

Part I : TO BE COMPLETED BY EMPLOYEE

Type of FMLA Request (check one): ☐ Initial Request ☐ Recertification ☐ New Request (Previous FMLA period expired)

1. Name:

2. Social Security Number:	**3.** Work Location:
4. Position Title:	**5.** Date of Hire:

6. Eligibility

- Counting any periods of time that you worked for CSC (whether they were consecutive or not), have you worked for CSC for a total of 12 months or more? Yes☐ No☐
- During the past 12 months, have you worked at least 1,250 hours? Yes☐ No☐
- Have you previously been granted FMLA leave? Yes☐ No☐

  If yes: Date of leave From_____ To_____

  Purpose of leave: _____
- Have you taken any intermittent leave? Yes☐ No☐
- Have you taken time off from scheduled hours? Yes☐ No☐

  If "yes", provide details:_____ _____

7. Reason for requested leave *(check all that apply):*

- ☐ **a.** Birth of a child (attach completed Form WH 380 E or WH 380 F)
- ☐ **b.** Placement of a child for adoption or foster care (attach court documents)
- ☐ **c.** Care for an immediate family member who has a serious health condition (attach completed Form WH 380 F)
- ☐ **d.** My own serious health condition (attach completed Form WH 380 E)
- ☐ **e.** Qualifying Exigency for Military Family Leave (attach completed Form WH 384)
- ☐ **f.** Military Caregiver Leave for Military Family Leave (attach completed Form WH 385 V)

If you selected "c", please state the name, relationship and address of the family member:

Name: Relationship: Address:

8. Date on which you wish to commence leave:	**9.** Date of anticipated return to work:

10. Are you requesting leave on an intermittent or reduced leave schedule? Yes ☐ No ■

11. If you answered "Yes" to #10, please specify a schedule of when you will be available for work. **NOTE:** Please be advised that the request for a modified work schedule must be reviewed and approved by the employee's Supervisor and/or Department Head as well as the Department of Human Resources.

Schedule (Please attach a separate sheet if necessary):

Employees seeking leave must complete the appropriate medical certificate form and return it within 15 days, or as soon as practicable. I understand that my leave may be delayed until I provide a completed medical certification form. I understand that CSC may require further medical certification during the course of the leave, as deemed appropriate, for treatment that is scheduled during work hours for serious medical conditions and that I will provide accurate and timely information related to a request for continuation of modification(s) to and return from leave.

Employees seeking to return to work after a leave because of their own serious illness (Reason 7d) also must provide certification of their fitness to return to work. I understand that I may not be permitted to resume my position with CSC, until I provide certification of my fitness to return to work.

I hereby agree that while I am on leave, I will continue to pay my share of health insurance premiums. I understand that if I do not pay my health insurance premiums my health insurance will be discontinued. I also agree that if I fail to return to work at the end of the leave period, I will reimburse CSC for the payments made by CSC for my health benefits during my leave, unless I elect to discontinue such coverage. I also agree that if I fail to return to work at the end of the leave period I will reimburse CSC for the cost of health benefits provided during my leave, unless I fail to return to work because of the continuation, recurrence or onset of a serious health condition or because of other circumstances beyond my control. If I am unable to return to work because of serious health conditions, I will provide medical certification from the date that my leave expired, or that I am needed to care for a covered relation because he/she has a serious health condition on the date that my leave expired.

Signature of Employee:	Date:

Part II: TO BE COMPLETED BY EMPLOYEE'S DEPARTMENT

The FMLA leave request has been reviewed with employee. The employee will be restored to the same or equivalent position upon the conclusion of the leave.

Supervisor's Remarks:

Signature of Supervisor: Date:

Department Head's Remarks:

Signature of Department Head: Date:

Part II: TO BE COMPLETED BY HR DEPARTMENT

Has the employee been employed with CSC for a total of 12 months? Yes ☐ No ☐
During the past 12 months, has the employee worked at least 1,250 hours? Yes ☐ No ☐

Has this employee previously received medical or family leave? Yes ☐ No ☐

If yes: Date of leave From_____ To_____

Has this employee taken any intermittent leave? Yes ☐ No ☐

If yes how much _____

Has this employee taken time off from scheduled hours? Yes ☐ No ☐

If yes how much _____

Total time entitled still due:_____

FMLA Leave request Approved_____ Denied_____

Reason_____

Signature of Human Resources' Designee: Date:

Copies of the request for leave, certification forms and any modifications to them during the period of leave shall be forwarded to CSC's Department of Human Resources to become part of the employee's official Family and Medical Leave file.

Notification for
Family and Medical Leave Act (FMLA)

For Human Resources Use Only

To (Employee's Name):	Date:

Re: ☐ Initial FMLA Request ☐ Recertification ☐ New FMLA Request (Previous FMLA period expired)

Your request for ☐ continuous or ☐ intermittent leave under the FMLA and supporting documentation that you have provided were received and reviewed by the Department of Human Resources. Based on the review of information, the following have been concluded:

☐ Your FMLA Leave request is approved.

☐ You are required to exhaust all of your available accrued leave during your FMLA absence. This means that your leave usage will be counted against your FMLA leave entitlement.

☐ Contact _____ at _____ to make arrangements to continue to make your share of the premium payments to maintain health benefits while you are on unpaid leave. You have a minimum 30-day (or, indicated longer period, if applicable) grace period in which to make premium payments. If payment is not made in a timely manner, your group health benefits may be cancelled.

☐ You will be required to present a fitness-for-duty certificate to be restored to employment. If such certification is not received in a timely manner, your return to work may be delayed until certification is provided.

☐ Your FMLA Leave request is not approved.

☐ The FMLA does not apply to your leave request.

☐ You have exhausted your FMLA leave entitlement in the applicable 12-month period.

☐ Additional information is needed to determine if your FMLA leave request can be approved. Such information consist of _____

☐ The certification you have provided is not complete and insufficient to determine whether the FMLA applies to your leave request. You must provide the following information no later than _____unless it is not practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied. Information needed to make the certification complete and sufficient:

☐ Your recertification for continued leave under FMLA ☐ has ☐ has not been approved.

Additional Comments:

Signature of Human Resources' Designee: Date:

Family and Medical Leave Act (FMLA)
Return to Work Form

*****This form must be completed for any serious health condition of the employee prior to their return to work*

Part I: EMPLOYEE INFORMATION (to be completed by Employee)			
Employee Name:			
Work Location:		Position Title:	
Home Address:		Home Phone:	

Part II: MEDICAL RETURN TO WORK CERTIFICATION (to be completed by the Health Care Provider)			
Name of Health Care Provider:			
Name of Health Care Practice:			
Address:			
Phone:		Date of Examination:	
Name of Employee:		Name of Patient:	
Date employee is released to return to work:			
Is the employee able to perform the essential functions of his/her position as of the return to work date?		☐ YES ☐ NO	
Additional Comments:			
CERTIFICATION: I affirm that the information provided above is true and accurate to the best of my knowledge.			
Signature-Health Care Provider:		Date:	

Part III: CERTIFICATION OF RETURN TO WORK (to be completed by HR)	
Date Leave of Absence (or reduced/intermittent schedule) Began:	
☐ Date Employee Returned to Work at Regularly Scheduled Hours: Note: If an employee is returning to work on a reduced or intermittent work schedule, do not complete this form. Instead, complete a new "Medical Leave – Leave Request Form" and check the "Supplement to Previous Request" box at the top right corner.	
☐ Employee IS NOT returning to work. Separation Date is:	

Signature of Human Resources' Designee:	Date:

Certification for Serious Injury or Illness of a Veteran for Military Caregiver Leave 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: 6/30/2023

The Family and Medical Leave Act (FMLA) provides that eligible employees may take FMLA leave to care for a covered veteran with a serious illness or injury. The FMLA allows an employer to require an employee seeking FMLA leave for this purpose to submit a medical certification. 29 U.S.C. §§ 2613, 2614(c)(3). The employer must give the employee **at least 15 calendar days** to provide the certification. If the employee fails to provide complete and sufficient 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, it asks the health care provider for the information necessary for a complete and sufficient medical certification. **Recertifications are not allowed for FMLA leave to care for a covered servicemember. Where medical certification is requested by an employer, an employee may not be held liable for administrative delays in the issuance of military documents, despite the employee's diligent, good-faith efforts to obtain such documents.** In lieu of this form or your own certification form, you **must** accept as sufficient certification of the veteran's serious injury or illness documentation indicating the veteran's enrollment in the Department of Veterans Affairs Program of Comprehensive Assistance for Family Caregivers. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. § 825.310**.

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

SECTION II - EMPLOYEE and/or VETERAN

Please complete all Parts in Section II before having the veteran's health care provider complete Section III. The FMLA allows 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 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. The employer must give an employee **at least 15 calendar days** to return this form to the employer. 29 U.S.C. §§ 2613, 2614(c)(3).

PART A: EMPLOYEE INFORMATION

(1) Name of veteran for whom employee is requesting leave: _____
First *Middle* *Last*

(2) Select your relationship to the veteran. You are the veteran's:

☐ Spouse ☐ Parent ☐ Child ☐ Next of Kin

Spouse means a husband or wife as defined or recognized in the state where the individual was married, including a common law marriage or same-sex marriage. The terms "child" and "parent" include *in loco parentis* in which a person assumes the obligations of a parent to a child. An employee may take FMLA leave to care for a covered servicemember who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave to care for a covered servicemember for whom the employee has assumed the obligations of a parent. No biological or legal relationship is necessary. "Next of kin" is the veteran's nearest blood relative, other than the spouse, parent, son, or daughter, in the following order of priority: (1) a blood relative as designated in writing by the veteran for purposes of FMLA leave, (2) blood relatives granted legal custody of the veteran, (3) brothers and sisters, (4) grandparents, (5) aunts and uncles, and (6) first cousins.

PART B: VETERAN INFORMATION AND CARE TO BE PROVIDED TO THE VETERAN

(3) The veteran was (☐ honorably / ☐ dishonorably) discharged or released from the Armed Forces, including the National Guard or Reserves. List the date of the veteran's discharge: _____ *(mm/dd/yyyy)*

(4) Please provide the veteran's military branch, rank and unit at the time of discharge: _____

_____

(5) The veteran (☐ is / ☐ is not) receiving medical treatment, recuperation, or therapy for an injury or illness.

(6) Briefly describe the care you will provide to the veteran: *(Check all that apply)*

☐ Assistance with basic medical, hygienic, nutritional, or safety needs ☐ Transportation

☐ Psychological Comfort ☐ Physical Care ☐ Other: _____

(7) Give your **best estimate** of the amount of FMLA leave needed to provide the care described: _____

_____

(8) If a **reduced work schedule** is necessary to provide the care described, give your **best estimate** of the reduced work schedule you are able to work. From _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)* I am able to work: _____ *(hours per day)* _____ *(days per week).*

SECTION III - HEALTH CARE PROVIDER

Please provide your contact information, complete all Parts of this Section fully and completely, and sign the form below. 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.

Note: 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: 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 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 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 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.

Employee Name: _____

"Need for care" includes both physical and psychological care. It includes situations where, for example, due to his or her serious injury or illness, the veteran is not able to care for his or her own basic medical, hygienic, or nutritional needs or safety, or needs transportation 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.

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. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

PART A: HEALTH CARE PROVIDER INFORMATION

Health Care Provider's Name: *(Print)* _____

Health Care Provider's business address: _____

Type of Practice/Medical Specialty: _____

Telephone: (___) _____ Fax: (___) _____ E-mail: _____

Please select the type of FMLA health care provider you are:

- ☐ DOD health care provider
- ☐ VA health care provider
- ☐ DOD TRICARE network authorized private health care provider
- ☐ DOD non-network TRICARE authorized private health care provider
- ☐ Health care provider as defined in 29 CFR 825.125

PART B: MEDICAL INFORMATION

Please provide appropriate medical information of the patient as requested below. Limit your responses to the veteran's condition for which the employee is seeking leave. If you are unable to make certain military-related determinations contained below, you are permitted to rely upon determinations from an authorized DOD representative, such as a DOD Recovery Care Coordinator, or an authorized VA representative. 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).

(1) Patient's Name: _____

(2) List the approximate date condition started or will start: _____ *(mm/dd/yyyy)*

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

(4) The veteran's injury or illness: *(Select as appropriate)*

- ☐ Was incurred in the line of duty on active duty
- ☐ Existed before the beginning of the veteran's active duty and was aggravated by service in the line of duty on active duty
- ☐ None of the above

The veteran (☐ is / ☐ is not) undergoing medical treatment, recuperation, or therapy for this condition. If yes, briefly describe the medical treatment, recuperation, or therapy: _____

_____

(5) The veteran's medical condition is: *(Select as appropriate)*

☐ 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 not able 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. *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 29 C.F.R. § 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.*

Part C: Amount of Leave Needed

For the medical condition checked in Part B, complete all that apply. Some 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.

(1) Due to the condition, the veteran will need care for a **continuous period of time**, including any time for treatment and recovery. Provide your **best estimate** of the beginning date _____ *(mm/dd/yyyy)* and end date _____ *(mm/dd/yyyy)* for this period of time.

(2) Due to the condition, it is medically necessary for the veteran to attend **planned medical treatment** appointments (scheduled medical visits). Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery _____ *(e.g. 3 days/week)*

(3) Due to the condition, it is medically necessary for the veteran to receive care on an **intermittent basis** (periodically), such as the care needed because of episodic flare-ups of the condition or assisting with the veteran's recovery. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, intermittent care is estimated to occur _____ times per (☐ day / ☐ week / ☐ month) and are likely to last approximately _____ (☐ hours / ☐ days) per episode.

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

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 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, NW, Washington, DC 20210.

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

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Center for Social Change, Inc

Serving Individuals with Developmental Disabilities

Leave Application – Administrative

EMPLOYEE INFORMATION

Employee Name: _____ Today's Date _____

Department: _____ Supervisor: _____

Leave Request From _____ _____ _ _ ____To _____ _____ _ ____ Time: From _____To_____

Return to Work on: Day_____ Date __ Time_____

Reason for Absence:							
☐	VACATION	☐	MEDICAL ER	☐	JURY DUTY	☐	OTHER (Explain)
☐	SICK	☐	FUNERAL	☑	FMLA	☐	
☐	DOCTOR'S VISIT	☐	MILITARY	☐	WEATHER	☐	
		☐	IWIF	☐	CAR PROBLEM	☐	

Requests for LEAVE must be received by the HR Director no less than two weeks prior to the first day employee will be absent. Leave requests due to unavoidable circumstacnes or illness require verbal approval from Department Director per policy, followed by submission of documents justifying the absence on the first day after returning to work.

Employee Signature: Date:

Supervisor's Use only (below)

Do you recommend leave? Yes ☐ No ☐ Date _ Signature _____ Title _____

Employee's Department Director Use only (below)

Do you recommend leave? Yes ☐ No ☐ Date Signature _____ Title _____

Payroll Use only (below)

Fiscal Year:

Date of Hire ☐ Benefits Eligibility Date: ☐ Employee Status: ☐ Full Time 40 hours or more per week ☐ Part Time 30-39 hours per week. Health benefits only) ☐ Part Time <30 hours State mandated benefits only

Hours Eligible ☐ For Current Fiscal Year Hours Accrued ☐ For Current Fiscal Year Hours Used ☐ For Current Fiscal Year Hours Eligible ☐ For Current Fiscal Year

TOTAL HOURS USED	QTR1			QTR2			QTR3			QTR4		
	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June

Comments

Payroll Use Only ☐ Forwarded to Executive Office Payroll Signature / Date

EXECUTIVE APPROVAL OF LEAVE

☐ APPROVED ☐ WITH PAY ☐ WITHOUT PAY ☐ DENIED

Comments

Signature /Date:

Completed Leave application will be returned to HR Folder. Employee and Supervisor will both be notified of leave status.

***ETO is the combined accrued time earned from vacation time and any potential sick time for benefit-eligible employees**