SAVE PRINT

Request for
Family and Medical Leave Act (FMLA) Leave

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:

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

SECTION I - EMPLOYER

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

Employers must generally maintain records and documents relating to medical information, medical certifications, recertifications, or medical histories of employees 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) The medical certification must be returned by _____ *(mm/dd/yyyy)*
(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee's diligent, good faith efforts.)

SECTION II - EMPLOYEE

Please complete and sign Section II before providing this form to your family member or your family member's health care provider. The FMLA allows an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of your family member. If requested by your employer, your response is required to obtain or retain the benefit of the FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). **You are responsible for making sure the medical certification is provided to your employer within the time frame requested, which must be at least 15 calendar days.** 29 C.F.R. §§ 825.305-825.306. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA leave request. 29 C.F.R. § 825.313.

(1) Name of the family member for whom you will provide care: _____

(2) Select the relationship of the family member to you. The family member is your:

☐ Spouse ☐ Parent ☐ Child, under age 18

☐ Child, age 18 or older and incapable of self-care because of a mental or physical disability

Spouse means a husband or wife as defined or recognized in the state where the individual was married, including in a common law marriage or same-sex marriage. The terms "child" and "parent" include *in loco parentis* relationships in which a person assumes the obligations of a parent to a child. An employee may take FMLA leave to care for an individual 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 child for whom the employee has assumed the obligations of a parent. No legal or biological relationship is necessary.

Employee Name: _____

(3) Briefly describe the care you will provide to your family member: (*Check all that apply)*

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

☐ Physical Care ☐ Psychological Comfort ☐ Other: _____

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

_____

(5) If a **reduced work schedule** is necessary to provide the care described, give your **best estimate** of the reduced 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).*

Employee Signature **Date** _____ *(mm/dd/yyyy)*

SECTION III - HEALTH CARE PROVIDER

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

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

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

Health Care Provider's business address: _____

Type of practice / Medical specialty: _____

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

PART A: Medical Information

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

(1) Patient's Name: _____

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

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

(4) For FMLA to apply, care of the patient must be medically necessary. Briefly describe the type of care needed by the patient (*e.g., assistance with basic medical, hygienic, nutritional, safety, transportation needs, physical care, or psychological comfort).*

_____

_____

Employee Name: _____

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

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

- ☐ **Incapacity plus Treatment**: *(e.g. outpatient surgery, strep throat)*
  Due to the condition, the patient (☐ has been / ☐ is expected to be) incapacitated for *more than* three consecutive, full calendar days from _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*.

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

  _____

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

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

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

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

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

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

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

_____

PART B: Amount of Leave Needed

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

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

_____

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

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

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

Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery

_____ *(e.g. 3 days/week)*

Employee Name: _____

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

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

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

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

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

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

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

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

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

Center for Social Change, Inc

Serving Individuals with Developmental Disabilities

Leave Application – Non-Admin/Direct Care

EMPLOYEE INFORMATION

Employee Name:_____ Today's Date _____

Assigned House: _____ Supervisor : _____ ___ ___

Assigned Schdule: _____ Total Hours Per Week: _____

Leave Request Fo: From _____ To _____ Return to Work on: _____ Date: _____

Reason for Absence: Sick ○ | Doctor's Visit ○ | Medical ER ○ | Funeral ○ | Military ○ | IWIF ○ | Jury Duty ○

FMLA ⊗ | Weather ○ | Car Problem ○ | Vacation ○ | Other

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

Do you recommend leave? Yes __ No __ If yes, can coverage be arranged: Yes___ No __

Is the employee trained to do coverage? Yes__ No __ If no, what arrangement is made to train _____

Name of emloyee who will do coverage_____ Signature of employee agreeing to provide coverage _____

Date _____ Supervisor Signature _____ Title _____

PROGRAM DIRECTOR'S USE ONLY

Do you recommend leave? Yes___ No____ Signature_____ Date_____

HR USE ONLY

Fiscal Year: July 1, 202__ to June 30, 202__

Date of Hire: | Benefits Eligibility Date:

Employee Status: ☐ Full Time (40 hours or more / week) ☐ Part Time (30-39 hours / week) ☐ Part Time (<30 hours / week)

Sick Hours Eligible | Hours Accrued | Hours Used | Hours Eligible Available

ETO Hours Eligible | Hours Accrued | Hours Used | Hours Eligible Available

☐ Forwarded to Executive 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**

Updated: July/2022