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:

Certification for Serious Injury or Illness of a Current Servicemember for Military Caregiver Leave under the Family and Medical Leave Act

U.S. Department of Labor
Wage 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 servicemember 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. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. § 825.310**. **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.** An employer requiring an employee to submit a certification for leave to care for a covered servicemember **must** accept as sufficient certification invitational travel orders (ITOs) or invitational travel authorizations (ITAs) issued to any family member to join an injured or ill servicemember at the servicemember's bedside. An ITO or ITA is sufficient certification for the duration of time specified in the ITO or ITA.

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 CURRENT SERVICEMEMBER

Please complete all Parts of Section II before having the servicemember'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 FMLA leave due to a serious injury or illness of a covered servicemember. If requested by your employer, your response is required to obtain or retain the benefit of FMLA-protected leave.

PART A: EMPLOYEE INFORMATION

(1) Name of the current servicemember for whom employee is requesting leave:___________________________

(2) Select your relationship to the current servicemember. You are the current servicemember'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* relationships 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 servicemember'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 servicemember for purposes of FMLA leave, (2) blood relatives granted legal custody of the servicemember, (3) brothers and sisters, (4) grandparents, (5) aunts and uncles, and (6) first cousins.

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

(3) The servicemember (☐ is / ☐ is not) a current member of the Regular Armed Forces, the National Guard or Reserves. If yes, provide the servicemember's military branch, rank and unit currently assigned to: ______________
____

(4) The servicemember (☐ is / ☐ is not) 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. If yes, provide the name of the medical treatment facility or unit: ____

(5) The servicemember (☐ is / ☐ is not) on the Temporary Disability Retired List (TDRL).

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

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

☐ Psychological Comfort ☐ Physical Care

☐ Transportation ☐ Other: ____________________________________

(7) Give your **best estimate** of the amount of 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 listed at Section I 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. Note: 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 the servicemember's office, grade, rank, or rating. "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 servicemember 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 servicemember who is receiving inpatient or home

care. 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.

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 C.F.R. § 825.125

PART B: MEDICAL INFORMATION

Please provide appropriate medical information of the patient as requested below. Limit your responses to the servicemember's condition for which the employee is seeking leave. If you are unable to make some of the military-related determinations contained below, you are permitted to rely upon determinations from an authorized DOD representative, such as a DOD recovery care coordinator. 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 servicemember's injury or illness: *(Select as appropriate)*

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

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

(6) The current servicemember's medical condition is classified as: *(Select as appropriate)*

☐ **(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 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 coverage.

(7) Due to the condition, the servicemember 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.

(8) Due to the condition, it is medically necessary for the servicemember 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)*

(9) Due to the condition, it is medically necessary for the servicemember 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 servicemember's recovery. Provide your **best estimate** of how often (frequency) and how long (the duration) the intermittent episodes 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, N.W., Washington, D.C. 20210.

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