

Baltimore Research and Education Foundation, Inc.	Family Medical Leave Act Policy	No.		5
		Effective Date		6/17/2009
		Revision Letter		B
		Final Approval Signature	Approved at the BREF Board meeting held 1/26/2011.	

1.0 Purpose

The purpose of this policy is to establish the terms whereby the Baltimore Research and Education Foundation, Inc. (BREF) will implement the Family Medical Leave Act.

2.0 Scope

The Family Medical Leave Act (FMLA) allows employees to balance their work and family life by taking reasonable paid and unpaid leave for specific family and medical reasons. **The following Family Medical Leave Act policy and information is applicable to BREF only if BREF employs 50 or more employees in 20 or more workweeks in the current or preceding calendar year. Baltimore Research and Education Foundation will still comply with the spirit of the FMLA regulations if the number of BREF employees falls below 50.**

3.0 Policy

3.1 **If FMLA is currently applicable to BREF, eligible employees must:**

3.1.1 Have worked for BREF for a total of 12 months.

3.1.2 Have worked for BREF at least 1,250 hours over the previous 12 months.

3.1.3 Work at a location in the United States or in any territory or possession of the United States where at least 50 employees are employed by the employer within 75 miles

3.2 Eligible BREF employees are entitled to up to a total of 12 work weeks of leave during a 12-month period (which begins at the employees request for FML) for one or more of the following reasons:

3.2.1 For the birth and care of the newborn child of the employee.

3.2.2 For placement with the employee of a son or daughter for adoption or foster care.

3.2.3 To care for an immediate family member (spouse, child or parent but not a parent "in-law") with a serious health condition.

- 3.2.4 To take medical leave when the employee is unable to work because of a serious health condition.
- 3.3 **Military Caregiver Leave.** Eligible employees who are family members of covered servicemembers will be able to take up to 26 workweeks of leave in a single 12-month period to care for a covered servicemember with a serious illness or injury incurred in the line of duty on active duty.
- 3.4 **Qualifying Exigency Leave.** This provision makes the normal 12 workweeks of FMLA job-protected leave available to eligible employees with a covered military member serving in the National Guard or Reserves to use for “any qualifying exigency” arising out of the fact that a covered military member is on active duty or called to active duty status in support of a contingency operation.
- 3.5 “Serious Health Condition” refers to an illness, injury, impairment, or physical or mental condition that involves:
- 3.5.1 Any period of incapacity or treatment connected with inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility; or
 - 3.5.2 a period of incapacity requiring absence of more than three calendar days from work, school, or other regular daily activities that also involves continuing treatment (or under the supervision of) a health care provider; or
 - 3.5.3 any period of incapacity due to pregnancy, or for prenatal care; or
 - 3.5.4 any period of incapacity (or treatment therefore) due to a chronic serious health condition (e.g., asthma, diabetes, epilepsy, etc.); or
 - 3.5.5 a period of incapacity that is permanent or long-term due to a condition for which treatment may not be effective (e.g., Alzheimer’s, stroke, terminal diseases, etc.); or,
 - 3.5.6 any absences to receive multiple treatments (including any period of recovery there from) by, or on referral by, a health care provider for a condition that likely would result in incapacity of more than three consecutive days if left untreated (e.g., chemotherapy, physical therapy, dialysis, etc.).
- 3.6 Under some circumstances, employees may take FMLA leave intermittently—which means taking leave in blocks of time, or by reducing their normal weekly or daily work schedule.
- 3.6.1 If FMLA leave is for birth and care or placement for adoption or foster care, use of intermittent leave is subject to the employer’s approval.

3.6.2 FMLA leave may be taken intermittently whenever **medically necessary** to care for a seriously ill family member, or because the employee is seriously ill and unable to work.

3.7 Employees of BREF must use all eligible leave they have accumulated (sick and/or annual leave) **concurrently** with approved FML before using leave without pay.

3.8 A BREF employee who is covered by the BREF health insurance plan will be able to maintain their group coverage while on FML on the same terms as if the employee had continued to work. Arrangements will need to be made **by the employee** prior to the onset of FML to pay their share of health insurance premiums while on leave.

3.9 BREF's obligation to maintain health benefits under FMLA stops if and when an employee informs the employer of intent not to return to work at the end of the leave period, or if the employee fails to return to work when the FMLA leave entitlement is exhausted. The employer's obligation also stops if the employee's premium payment is more than 30 days late and the employer has given the employee written notice at least 15 days in advance advising that coverage will cease if payment is not received.

3.10 Employees have a potential liability for reimbursing to BREF any health insurance premiums paid by BREF during the leave if the employee fails to return to work after taking FMLA leave.

3.11 Upon return from FMLA leave, the employee will be restored to the employee's original job or to an equivalent job with equivalent pay, benefits, and other terms and conditions of employment.

3.12 Employees seeking to use FMLA leave are required to provide to their **supervisor and the BREF Executive Director:**

3.12.1 Thirty-days advance written notice of the need to take FMLA leave when the need is foreseeable;

3.12.2 Written notice "as soon as practicable" when the need to take FMLA leave is not foreseeable ("as soon as practicable" generally means at least verbal notice to the employer within one or two business days of learning of the need to take FMLA leave);

3.12.3 Medical certification supporting the need for leave due to a serious health condition affecting the employee or an immediate family member. The employee has 15 calendar days to obtain the medical certification using the form entitled "Certification of Health Care Provider" (US DOL form WH-380). Sufficient information must be included for the employer to understand that the employee needs leave for FMLA-qualifying reasons

3.12.4 Second and/or third medical opinions (at BREF's expense) and periodic re-certification; and

3.12.5 Weekly reports during FMLA leave regarding the employee's status and intent to return to work.

3.12.6 Where the employer was not made aware that an employee was absent for FMLA reasons and the employee wants the leave counted as FMLA leave, timely notice (generally within two business days or returning to work) that leave was taken for an FMLA-qualifying reason.

3.13 BREF's Executive Director will provide written notice within two business days after receiving the employee's written notice of need for leave designating if the leave qualifies as FMLA leave and detailing specific expectations and obligations of an employee who is exercising his/her FMLA entitlements.

3.14 When intermittent leave is needed to care for an immediate family member or the employee's own illness and is for planned medical treatment, the employee must try to schedule treatment so as not to unduly disrupt the employer's operation.

4 Definitions

Forms: Additional information about FMLA can be found on DOL Fact Sheet No. 028. Copies are available in the BREF office.

5 Responsibilities

5.1 It is the employee's responsibility to provide 30 days advance written notice of the need to take FMLA leave when the need is foreseeable.

5.2 It is the employee's responsibility to provide written notice as soon as practicable when the need to take FMLA leave is not foreseeable.

5.3 It is the employee's responsibility to provide medical certification supporting the need for leave due to serious health conditions affecting the employee or an immediately family member.

5.4 It is the employee's responsibility to provide, at BREF's expense, second and/or third medical opinions and periodic re-certification.

5.5 Any recertification requested by the employer shall be at the employee's expense. No second or third opinion on recertification may be required.

5.6 It is the employee's responsibility to provide weekly reports during FMLA leave regarding the employee's status and intent to return to work.

5.7 It is the employer's responsibility to provide written notice within two business days after receiving the employee's written notice of the need for leave designating if the leave qualified as FMLA leave, as well as expectations and obligations.

5.8 It is the responsibility of BREF employees on FMLA leave to designate clearly their FMLA hours (or days) used on their time card, whether paid or unpaid. Annual and/or sick leave is to be used concurrently with approved FMLA time until such leave time has been exhausted before leave without pay is taken.

5 Revision History

Revision Date	Revision Letter	Name of Document Author	Description of Change
12/4/2008	A	Heather Riley	Policy is put into approved format.
01/26/2011	B	Shirley Rutledge	Revised wording to include < 50 employees situation. Policy approved at BREF Board meeting held 1/26/2011.

Chart of FMLA Notice Obligations

TYPE OF DOCUMENT	PROVIDED BY	TO WHOM	TIMEFRAME
FMLA Notice	Employer	Employees	Upon hire and workplace poster
FMLA Fact Sheet	Employer	Employees	Upon hire; can be used if employer has no handbook or HR policies/procedures
Request for Leave	Employee	Employer	30 days advance notice, if need for leave foreseeable
Medical Certification Form	Employee; must be completed by attending health care provider	Employer	At the time FMLA leave requested
Employer Response to Employee Request for Leave	Employer	Employee	Within 30 days of request for leave
Fact Sheet: USERRA and FMLA Questions and Answers	Employer	USERRA/Service Member Employees	Upon request and when called to military duty

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 due to a serious health condition to submit a medical certification issued by the employee's health care provider. 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 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.

Employer name and contact: _____

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions: _____

Check if job description is attached: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your 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 due to your own 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. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: _____
First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. 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 condition for which the employee is seeking leave. 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: _____

Mark below as applicable:

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:

Will the patient need to have treatment visits at least twice per year due to the condition? ___No ___Yes.

Was medication, other than over-the-counter medication, prescribed? ___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. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition: ___No ___Yes.

If so, identify the job functions the employee is unable to perform:

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___No ___Yes.

If so, estimate the beginning and ending dates for the period of incapacity: _____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ___No ___Yes.

If so, are the treatments or the reduced number of hours of work medically necessary? ___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:

Estimate the part-time or reduced work schedule the employee needs, if any:

_____hour(s) per day; _____days per week from _____through _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ___No ___Yes.

Is it medically necessary for the employee to be absent from work during the flare-ups? ___
No ___ Yes. If so, explain:

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

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

Certification of Health Care Provider for
Family Member's Serious Health Condition
(Family and Medical Leave Act)

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division



OMB Control Number: 1215-0181
Expires: 12/31/2011

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.

Employer name and contact: _____

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: _____
First Middle Last

Relationship of family member to you: _____

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

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. 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):

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.**

Notice of Eligibility and Rights & Responsibilities (Family and Medical Leave Act)

U.S. Department of Labor Employment Standards Administration Wage and Hour Division



OMB Control Number: 1215-0181 Expires: 12/31/2011

In general, to be eligible an employee must have worked for an employer for at least 12 months, have worked at least 1,250 hours in the 12 months preceding the leave, and work at a site with at least 50 employees within 75 miles.

[Part A - NOTICE OF ELIGIBILITY]

TO: Employee

FROM: Employer Representative

DATE:

On _____, you informed us that you needed leave beginning on _____ for:

_____ The birth of a child, or placement of a child with you for adoption or foster care;

_____ Your own serious health condition;

_____ Because you are needed to care for your _____ spouse; _____ child; _____ parent due to his/her serious health condition.

_____ Because of a qualifying exigency arising out of the fact that your _____ spouse; _____ son or daughter; _____ parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves.

_____ Because you are the _____ spouse; _____ son or daughter; _____ parent; _____ next of kin of a covered service member with a serious injury or illness.

This Notice is to inform you that you:

_____ Are eligible for FMLA leave (See Part B below for Rights and Responsibilities)

_____ Are not eligible for FMLA leave, because (only one reason need be checked, although you may not be eligible for other reasons):

_____ You have not met the FMLA's 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately _____ months towards this requirement.

_____ You have not met the FMLA's 1,250-hours-worked requirement.

_____ You do not work and/or report to a site with 50 or more employees within 75-miles.

If you have any questions, contact _____ or view the FMLA poster located in _____.

[PART B-RIGHTS AND RESPONSIBILITIES FOR TAKING FMLA LEAVE]

As explained in Part A, you meet the eligibility requirements for taking FMLA leave and still have FMLA leave available in the applicable 12-month period. However, in order for us to determine whether your absence qualifies as FMLA leave, you must return the following information to us by _____.

_____ Sufficient certification to support your request for FMLA leave. A certification form that sets forth the information necessary to support your request _____ is/_____ is not enclosed.

_____ Sufficient documentation to establish the required relationship between you and your family member.

Other information needed: _____

_____ No additional information requested

If your leave does qualify as FMLA leave you will have the following responsibilities while on FMLA leave (only checked blanks apply):

____ Contact _____ at _____ to make arrangements to continue to make your share of the premium payments on your health insurance to maintain health benefits while you are on leave. You have a minimum 30-day (or, indicate longer period, if applicable) grace period in which to make premium payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse, or, at our option, we may pay your share of the premiums during FMLA leave, and recover these payments from you upon your return to work.

____ You will be required to use your available paid _____ sick, _____ vacation, and/or _____ other leave during your FMLA absence. This means that you will receive your paid leave and the leave will also be considered protected FMLA leave and counted against your FMLA leave entitlement.

____ Due to your status within the company, you are considered a "key employee" as defined in the FMLA. As a "key employee," restoration to employment may be denied following FMLA leave on the grounds that such restoration will cause substantial and grievous economic injury to us. We ___have/___ have not determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic harm to us.

____ While on leave you will be required to furnish us with periodic reports of your status and intent to return to work every _____. (Indicate interval of periodic reports, as appropriate for the particular leave situation).

If the circumstances of your leave change, and you are able to return to work earlier than the date indicated on the reverse side of this form, you will be required to notify us at least two workdays prior to the date you intend to report for work.

If your leave does qualify as FMLA leave you will have the following rights while on FMLA leave:

- You have a right under the FMLA for up to 12 weeks of unpaid leave in a 12-month period calculated as:
 - ____ the calendar year (January – December).
 - ____ a fixed leave year based on _____.
 - ____ the 12-month period measured forward from the date of your first FMLA leave usage.
 - ____ a "rolling" 12-month period measured backward from the date of any FMLA leave usage.
- You have a right under the FMLA for up to 26 weeks of unpaid leave in a single 12-month period to care for a covered servicemember with a serious injury or illness. This single 12-month period commenced on _____.
- Your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work.
- You must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA-protected leave. (If your leave extends beyond the end of your FMLA entitlement, you do not have return rights under FMLA.)
- If you do not return to work following FMLA leave for a reason other than: 1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; 2) the continuation, recurrence, or onset of a covered servicemember's serious injury or illness which would entitle you to FMLA leave; or 3) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave.
- If we have not informed you above that you must use accrued paid leave while taking your unpaid FMLA leave entitlement, you have the right to have ___ sick, ___ vacation, and/or ___ other leave run concurrently with your unpaid leave entitlement, provided you meet any applicable requirements of the leave policy. Applicable conditions related to the substitution of paid leave are referenced or set forth below. If you do not meet the requirements for taking paid leave, you remain entitled to take unpaid FMLA leave.

____ For a copy of conditions applicable to sick/vacation/other leave usage please refer to _____ available at: _____

____ Applicable conditions for use of paid leave: _____

Once we obtain the information from you as specified above, we will inform you, within 5 business days, whether your leave will be designated as FMLA leave and count towards your FMLA leave entitlement. If you have any questions, please do not hesitate to contact:

_____ at _____

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

It is mandatory for employers to provide employees with notice of their eligibility for FMLA protection and their rights and responsibilities. 29 U.S.C. § 2617; 29 C.F.R. § 825.300(b), (c). 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 10 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.**

Designation Notice
(Family and Medical Leave Act)

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division

OMB Control Number: 1215-0181
Expires: 12/31/2011

Leave covered under the Family and Medical Leave Act (FMLA) must be designated as FMLA-protected and the employer must inform the employee of the amount of leave that will be counted against the employee's FMLA leave entitlement. In order to determine whether leave is covered under the FMLA, the employer may request that the leave be supported by a certification. If the certification is incomplete or insufficient, the employer must state in writing what additional information is necessary to make the certification complete and sufficient. While use of this form by employers is optional, a fully completed Form WH-382 provides an easy method of providing employees with the written information required by 29 C.F.R. §§ 825.300(c), 825.301, and 825.305(c).

To: _____

Date: _____

We have reviewed your request for leave under the FMLA and any supporting documentation that you have provided.

We received your most recent information on _____ and decided:

Your FMLA leave request is approved. All leave taken for this reason will be designated as FMLA leave.

The FMLA requires that you notify us as soon as practicable if dates of scheduled leave change or are extended, or were initially unknown. Based on the information you have provided to date, we are providing the following information about the amount of time that will be counted against your leave entitlement:

Provided there is no deviation from your anticipated leave schedule, the following number of hours, days, or weeks will be counted against your leave entitlement: _____

Because the leave you will need will be unscheduled, it is not possible to provide the hours, days, or weeks that will be counted against your FMLA entitlement at this time. You have the right to request this information once in a 30-day period (if leave was taken in the 30-day period).

Please be advised (check if applicable):

You have requested to use paid leave during your FMLA leave. Any paid leave taken for this reason will count against your FMLA leave entitlement.

We are requiring you to substitute or use paid leave during your FMLA leave.

You will be required to present a fitness-for-duty certificate to be restored to employment. If such certification is not timely received, your return to work may be delayed until certification is provided. A list of the essential functions of your position is is not attached. If attached, the fitness-for-duty certification must address your ability to perform these functions.

Additional information is needed to determine if your FMLA leave request can be approved:

The certification you have provided is not complete and sufficient 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.
(Provide at least seven calendar days)

(Specify information needed to make the certification complete and sufficient)

We are exercising our right to have you obtain a second or third opinion medical certification at our expense, and we will provide further details at a later time.

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.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

It is mandatory for employers to inform employees in writing whether leave requested under the FMLA has been determined to be covered under the FMLA. 29 U.S.C. § 2617; 29 C.F.R. §§ 825.300(d), (e). 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 10 – 30 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.**