



Family and Medical Leave Act (FMLA) California Family Rights Act (CFRA)

Part A: For Completion by the person responsible for administering the leave program in your department who will be the Department Contact.

Instructions: Complete Section I before giving this form to the employee.

Employee Last Name Employee First Name Employee Middle Name Last Day Worked:

Employee Classification Employee Work Unit

Department Contact Department Contact Phone

Attach a copy of the employee's job description and the essential job functions of the employee's position.

Part B: For Completion by the EMPLOYEE

Instructions to the Employee: Part A must be completed by the person responsible for administering the leave program in your department and you must complete Part B before giving this form to your medical provider. The law permits us to require that you submit a timely, complete, and sufficient medical certification to support your request for FMLA/CFRA protections. Failure to provide a complete and sufficient medical certification may result in denial of your leave request. You have 15 calendar days to return this form.

Daytime Contact Phone Number: Regular Work Schedule [ ] Days [ ] Nights [ ] Full Time [ ] Part Time [ ] 9/80 [ ] 4/10 [ ] Other

Part C: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS for the HEALTH CARE PROVIDER: Your patient has requested leave under FMLA/CFRA. Please answer fully and completely all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answers should be your best estimate based upon your medical knowledge, experience and examination of the patient. Please be as specific as you can; terms such as "lifetime," "unknown" or "indeterminate may not be sufficient to determine FLMA/CFRA coverage. Please do not disclose the underlying diagnosis without the consent of your patient. Please limit responses to the condition for which the employee is seeking leave. Please be sure to sign and date the form on the last page

Provider Name (You may attach a business card in lieu of completing this section):

Business Address City State Zip Code

Type of Practice / Medical Specialty

Telephone Fax

Part D. Medical Facts

- 1 Does the patient have a serious health condition that qualifies under the categories described on the attached sheet? [ ] Yes [ ] No
2. If the patient has a serious health condition as defined in the attached sheet, please answer the following: Approximate Date Condition Commenced:
3. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? [ ] Yes [ ] No
4. Dates treated for condition:
5. Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? [ ] Yes [ ] No



Employee Last Name      Employee First Name      Employee Middle Name

**Dear Health Care Provider,**

**Do NOT provide the employee's diagnosis.**

The employee has requested leave under the Federal and/or California family and medical leave statutes for his or her own serious health condition.

Thank you for your assistance.

**Definition of a Serious Health Condition**

Serious health condition is any illness, injury, impairment, physical or mental condition that involves:

1. Any period of incapacity or treatment in connection with or consequent to an overnight stay in a hospital, hospice, or residential medical care facility; or
2. Continuing treatment by a health care provider for one or more of the following:
  - a. Any period of incapacity due to pregnancy, for prenatal care.
  - b. Any period of incapacity due to a chronic serious health condition that:
    - i. Requires periodic ( at least two visit per year) visits for treatment
    - ii. Continues over an extended period of time; and
    - iii. May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.)
3. Any period of incapacity which is long-term due to a condition for which treatment may not be effective (e.g., Alzheimer's disease)
4. Any period of absence required to receive multiple treatments (including the period of recovery) either for restorative surgery after an accident or other injury, or for a chronic condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence or medical intervention such as cancer (chemotherapy, radiation, etc., or kidney disease (dialysis) or severe arthritis (physical therapy).

**A Serious Health Condition Is Generally Not:**

1. Allergies, stress, or substance abuse unless inpatient hospital care is provided, or the patient is incapacitated for more than three calendar days and is under the continuing care of a health care provider, or the patient has a serious long-term health conditions; or
2. Voluntary treatment or surgery inpatient hospital care is required.

**A Health Care Provider Is:**

Department of Labor regulations for the Family and Medical Leave Act define a "health care provider" as a

1. doctor of medicine or osteopathy, podiatrist, dentist, chiropractor, clinical psychologist, optometrist, nurse practitioner, nurse-midwife, or clinical social worker, physicians assistant, who is authorized to practice by the State and performing within the scope of their practice as defined by State law, or a Christian Science practitioner.
2. any provider the employee's group health plan will accept certification of a serious health condition to substantiate a claim for benefits.

**PRIVACY NOTICE**

The Information Practices Act of 1977 (Civil Code Section 1798.17) and the Federal Privacy Act (Public Law 93-579) requires this notice be provided when collecting personal information from individuals.

Information requested on this form is used by your department for purposes of determining your eligibility for FMLA/CFRA benefits. It is mandatory to furnish all information requested on this form. Failure to provide the mandatory information may result in a delay in processing your request.

# EMPLOYEE RIGHTS UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION

## LEAVE ENTITLEMENTS



Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within one year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

## BENEFITS & PROTECTIONS

## ELIGIBILITY REQUIREMENTS

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;\* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

\*Special "hours of service" requirements apply to airline flight crew employees.

## REQUESTING LEAVE

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

## EMPLOYER RESPONSIBILITIES

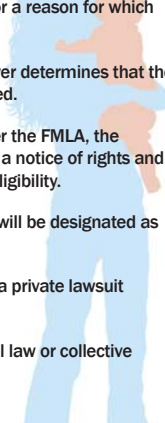
Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

## ENFORCEMENT

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.



For additional information or to file a complaint:

# 1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

## www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division

