Human Resource Services

Application for FMLA/CFRA

(PSOR\HH¶V 6HULRXV +HDOWK

Date:______________________

7KH)DPLO\ DQG 0HGLFDO /HDYH $FW DQG &DOLIRUQLD)DPLO require covered employers to provide up to 12 weeks of unpaid, job-protected leave to "eligible" employees for certain family and medical reasons.

Eligibility

Employees are eligible if they have worked for a covered employer for at least one year and for 1,250 hours over the previous 12 months, and if there are at least 50 employees within 75 miles.

Job Benefits

Employers are required to maintain coverage, except life insurance and accidental death and dismemberment benefits, for employees on leave under a group health plan on the same basis as if they had continued regular employment during the leave perioTiai.untinas

☐ _____ Consecutive weeks. (Up to 12 weeks, but not less than two weeks.)

☐ Intermittent or reduced schedule(please explain and specify number of days a week and/or hours a day or week): ____

Advance Notice and Medical Certification:

- ¾ The employee must provide 30 days advance notice when the leave is "foreseeable." If you do not notify the District in advance for foreseeable leave, the District may delay your leave as necessary to make appropriate arrangements for your temporary replacement. Such delay will not postpone your leave for more than 30 days from date of your request.
- ¾ Medical certification to support a request for leave because of a serious health condition is required, Form WH-380-E attached. You must provide a medical certificate at the time you request leave if your leave is your own serious health condition.
- ¾ Before you return to duty from Family Leave, you will be asked to obtain a fitness report providing medical certification that you are able to return to work.

Certification of Health Care Provider must be attached.

Advance Notice and Medical Certification (continued)

The District may require an employee requesting intermittent or reduced leave as a result of planned medical treatment, to transfer to an alternate position which has equivalent pay and benefits and accommodates recurring periods of leave better than the employee's regular position.

Restoration Rights

You will be reemployed in the same, comparable, or equivalent position upon return from full leave.

By my signature, I attest that I have read and understand the above.

Name (Print or Type)
Signature

Social Security Number
Mailing Address

Telephone
City State Zip Code

Certification of Health Care Provider for (PSOR\HH¶V 6HULRXV +HDOWK &RQGLWLRQ (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

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

OMB Control Number: 1235-0003
Expires: /3 /20

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 submi PHGLFDO FHUWLILFDWLRQ LVVXHG E 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 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 personn files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordanc with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: ____

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Check if job description is attached: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section I 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. 2 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, 3$57 $ 0(',&$/)$&76

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:DV WKH SDWLHQW UHIHUUHG WR RWKHU KHDOWK FDUH SURYLGHU(V) IRU HYDOXDWLRQ RU WUHDWPHQW (H.J., SK\VLFDO WKHUDS\)"
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