

## DELAWARE COUNTY

Subject FAMILY MEDICAL LEAVE ACT (FMLA)	Effective  1/16/2009	Supersedes Policy 6/28/2004	This Sheet  1	T.Sheets 20 (including forms)
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### 1.0 Purpose

To ensure that the Delaware County Offices/Departments comply with the federally mandated Family and Medical Leave Act (FMLA) of 1993 and the National Defense Authorization Act of 2008. This policy meets the applicable federal standards. Additional/other leaves of absences may be approved by the appointing authority pursuant to County policy.

### 2.0 Scope

This policy pertains to all departments operating under the authority of the Delaware County Board of Commissioners however, Federal Law requires this of all entities, and therefore, it is recommended that all Offices adopt such a policy if they haven't already.

### 3.0 Distribution

To all departments operating under the authority of the Delaware County Board of Commissioners.

### 4.0 Definitions

- A. *Covered Employer* is all public employers, regardless of the number of employees employed, and all private employers with fifty (50) or more employees for each working day during each of twenty (20) or more calendar workweeks in the current or preceding calendar year. (Twenty (20) calendar weeks do not need to be consecutive.)
- B. *Eligible Employee* is a person:
1. employed by the County for twelve months, which need not be consecutive; however, service prior to a seven (7) year break in service is not counted unless the break in service was caused by fulfillment of military duty or unless specified differently in a collective bargaining agreement
  2. has worked or been in a paid status (e.g. vacation, sick leave, holiday pay, compensatory time, previous FMLA leave, etc.) at least 1250 working hours in the twelve (12) month period prior to the date on which leave is to commence, and
  3. is employed at a worksite where fifty (50) or more employees are employed by the employer or the employer employs fifty (50) or more employees within seventy-five (75) miles of the worksite.
- C. *Paid Status* is time away from work with pay or FMLA leave, (e.g. vacation, sick leave, holiday pay, compensatory time, previous FMLA leave, etc.).
- D. *Unpaid Leave* is time taken away from work without pay. FMLA leave may be unpaid leave, but will be classified as paid status although the employee will not accrue service

time or seniority during unpaid FMLA. Unpaid leave not qualified as FMLA leave will not be classified as paid status.

- E. *Intermittent Leave* is leave taken by an employee in blocks of time, or by reducing their normal weekly or daily work schedule.
- F. *Serious Health Condition* means an illness, injury, impairment, or physical or mental condition that involves either:
1. any period of incapacity (i.e. inability to work, attend school or perform other regular daily activities) or treatment connected with inpatient care (i.e. an overnight stay) in a hospital, hospice, or residential medical care facility, and any period of incapacity or subsequent treatment in connection with such inpatient care, or
  2. continuing treatment by a health care provider that includes any period of incapacity due to:
    - a) a health condition (including treatment therefore, or recovery there from) lasting more than three (3) consecutive full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also includes:
      - treatment two or more times by or under the supervision of a health care provider within 30 days of incapacity, or
      - one treatment by a health care provider with a continuing regimen of treatment within the first 7 days of incapacity; or
    - b) Pregnancy or prenatal care. A visit to the health care provider is not necessary for each absence; or
    - c) A chronic serious health condition that continues over an extended period of time, requires periodic visits to a health care provider of at least two visits per year, and may involve occasional episodes of incapacity (e.g.: asthma, diabetes). A visit to a health care provider is not necessary for each absence; or
    - d) A permanent or long-term condition for which treatment may not be effective (e.g.: Alzheimer's, a severe stroke, terminal cancer, etc.). Only supervision by a health care provider is required, rather than active treatment; or
    - e) Any absences to receive multiple treatments for restorative surgery or for a condition that would likely result in a period of incapacity of more than three days if not treated (e.g.: chemotherapy or radiation treatments for cancer, dialysis for kidney disease, etc.).
- G. *Health care provider* means:
1. Doctors of medicine or osteopathy authorized to practice medicine or surgery by the state in which the doctors practice; or
  2. Podiatrists, dentists, clinical psychologists, optometrists and chiropractors (limited to manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist) authorized to practice, and performing within the scope of their practice, under state law, or
  3. Nurse practitioners, nurse-midwives and clinical social workers authorized to practice, and performing within the scope of their practice, as defined under state law; or
  4. Christian Science practitioners listed with the First Church of Christ, Scientist in Boston, Massachusetts; or

5. Any health care provider recognized by the employer or the employer's group health plan benefits manager.
  
- H. *Immediate family member* includes a spouse, parent, or son or daughter under eighteen (18) unless disabled. It does not include non-disabled adult children, unmarried partners, in-laws, siblings, grandparents, or other relatives, unless the person stood in *loco parentis* to the employee before the employee reached the age of majority.
  
- I. *ACTIVE DUTY*.—The term "active duty" means duty under a call or order to active duty under a provision of law referred to in section 101(a)(13)(B) of title 10, United States Code.
  
- J. *CONTINGENCY OPERATION*.—The term "contingency operation" has the same meaning given such term in section 101(a)(13) of title 10, United States Code.
  
- K. *COVERED SERVICEMEMBER*.—The term "covered servicemember" means a member of the Armed Forces, including a member of the National Guard or 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.
  
- L. *OUTPATIENT STATUS*.—The term "outpatient status", with respect to a covered servicemember, means the status of a member of the Armed Forces assigned to—
  1. a military medical treatment facility as an outpatient; or
  2. a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients.
  
- M. *NEXT OF KIN*.—The term "next of kin", used with respect to an individual, means the nearest blood relative of that individual.
  
- N. *SERIOUS INJURY OR ILLNESS*.—The term "serious injury or illness", in the case of a member of the Armed Forces, including a member of the National Guard or Reserves, means an injury or illness incurred by the member in line of duty on active duty in the Armed Forces that may render the member medically unfit to perform the duties of the member's office, grade, rank, or rating.

## 5.0 Policy

### **Leave Entitlement**

- A. In accordance with the federal Family and Medical Leave Act of 1993, an eligible employee is entitled to an unpaid leave of absence of up to twelve (12) workweeks during any (12) twelve month period measured backward from the date the leave commences for one of the following reasons:
  1. for the birth and care of the newborn child of the employee;
  2. for placement with the employee of a son or daughter for adoption or foster care;
  3. to care for an immediate family member (spouse, child under 18 years of age or child 18 years or older if incapable of self-care because of mental or physical disability, or the employee's parent (but not parent in-laws)), of the employee, with a serious health condition; or
  4. to take medical leave when the employee is unable to work because of a serious health condition.
  
- B. Spouses employed by the same appointing authority are jointly entitled to a combined total of 12 workweeks of family leave for the birth and care of the newborn child, for placement

of a child for adoption or foster care, and to care for a immediate family member who has a serious health condition.

- C. Leave for birth and care of a newborn, or placement of a child for adoption or foster care must conclude within 12 months of the birth or placement.
- D. Under certain circumstances, employees may take FMLA leave intermittently either by taking leave in blocks of time or by reducing their normal weekly or daily work schedule.
  - 1. If FMLA is for birth and care of a newborn or placement of a child for adoption or foster care, use of intermittent leave is subject to the employer's approval.
  - 2. FMLA leave may be taken intermittently only when there is a medical need for leave **and** the need is best accommodated via intermittent leave in order to care for a seriously ill family member, or because the employee is seriously ill and unable to work.
  - 3. Intermittent or reduced schedule leave may be taken by the employee in any size increments, and Delaware County shall charge intermittent or reduced schedule FMLA leave against the employee's twelve (12) workweek total by the quarter hour (15 minute) increment.
  - 4. Employees using any form of intermittent leave for planned medical treatment must make reasonable efforts to schedule medical treatment so as not to unduly disrupt business operations.
  - 5. Employees using intermittent leave due to chronic conditions may be asked to provide re-certification every thirty (30) days in connection with an absence.
- E. If leave to care for an immediate family member or for the employee's own serious health condition is planned medical treatment, the employee shall make a reasonable effort to schedule the treatment so as not to disrupt the County's operation or interfere with the employee's work schedule.
- F. All employees shall be required to substitute all accrued but unused compensatory time, vacation, personal, family, or sick leave for unpaid FMLA leave with the following limitations:
  - 1. Employees shall not utilize sick leave to be substituted for FMLA leave unless the situation involves a serious health condition. Under the FMLA, sick leave shall not be used for the birth or placement of a child unless it is used for the employee's own recovery after giving birth or for care of an ill family member.
  - 2. The utilization of sick leave for the care of an ill family member following birth or placement of a child shall only be approved when medical evidence of a serious health condition is provided on the proper form (U.S.D.O.L. Form WH-380, Certification of Health Care Provider).
  - 3. Employees shall substitute paid leave for unpaid FMLA leave in the following order:
    - a) for the birth and care of the newborn child of the employee:
      - sick leave shall be utilized for the extent of inpatient care in the hospital and continued to the extent as certified by a qualified health care provider as a serious health condition,

- thereafter, all accrued compensatory time shall be utilized until exhausted or the employee returns to work,
  - all accrued vacation leave shall be utilized until exhausted or until the employee returns to work.
- b) for placement with the employee of a son or daughter for adoption or foster care:
- all accrued compensatory time shall be utilized until exhausted or the employee returns to work,
  - all accrued vacation leave shall be utilized until exhausted or until the employee returns to work.
- c) to care for an immediate family member of the employee with a serious health condition or for the employee's own serious health condition:
- sick leave shall be utilized until exhausted or until the employee or his/her immediate family member no longer has the serious health condition,
  - all accrued compensatory time shall be utilized until exhausted or until the employee or his/her immediate family member no longer has the serious health condition,
  - all accrued vacation leave shall be utilized until exhausted or until the employee or his/her immediate family member no longer has the serious health condition.
- G. Even if the employee does not designate or request that absence be covered under the FMLA, the County may, upon proper notification, designate a qualifying absence as FMLA leave.
- H. "Next of Kin" Leave: In accordance with the National Defense Authorization Act of 2008, an eligible family member of a covered service member will be able to take up to 26 workweeks of leave in a "single 12-month period" measured forward from the date the leave commences to care for a covered service member with a serious illness or injury incurred in the line of duty on active duty. This 26 workweek entitlement is a special provision that extends FMLA job-protected leave beyond the normal 12 weeks of FMLA leave. This provision also extends FMLA protection to additional family members (i.e., next of kin) beyond those who may take FMLA leave for other qualifying reasons and may be taken intermittently.
- I. "Qualifying Exigency" Leave: The second new military leave entitlement helps families of members of the National Guard and Reserves (this leave does not extend to family members of military members in the Regular Armed Forces) manage their affairs while the member is on active duty in support of a contingency operation. This provision makes the normal 12 workweeks in a rolling calendar year 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. "Qualifying Exigency Leave may be taken intermittently when necessary.
1. Qualifying Exigencies:
    - a. Short-notice deployment of 7 days or less;
    - b. Military events sponsored by the military and / or Red Cross;

- c. To arrange for childcare and / or to attend non-routine school functions of the child of a covered military family member;
- d. To take care of financial and legal affairs and matters for a covered military family member;
- e. To attend non-health care provider counseling arising from active duty in the military;
- f. Up to five days to spend time with a covered military service member on rest and recoupment leave;
- g. To attend ceremonies incident to the return of a covered military family member for a period of 90 days following military family member's termination from active duty;
- h. Additional activities not encompassed in the other categories, but agreed to by Delaware County and the employee.

- J. An eligible employee is limited to a combined total of 26 workweeks of leave for any FMLA qualifying reason during the "single 12 month period". Only 12 of the 26 weeks total may be for a FMLA qualifying reason other than to care for a covered servicemember.
- K. When an employee seeks leave due to a FMLA qualifying reason for which the employer has previously provided the employee FMLA protected leave, the employee must specifically reference either the qualifying reason for leave or the need for FMLA leave.

**Maintenance of Health Benefits**

- A. As required under the FMLA, Delaware County will maintain group health insurance coverage for an employee on FMLA leave whenever such insurance was provided before the leave was taken and on the same terms as if the employee had continued to work. If applicable, arrangements will be made for employees to continue to pay their share of health insurance premiums while on leave. Payment must be made by the first day of each month with a thirty (30) day grace period or benefits shall terminate.
- B. If the employee chooses not to continue coverage while on leave, upon proper return to work, the employee shall be reinstated into the plan on the same terms as prior to commencement of leave.
- C. As allowed under the FMLA, Delaware County shall make every effort to recover premiums it paid to maintain health coverage for an employee who fails to return to work from FMLA leave without medical justification.

**Job Restoration**

- A. Upon return from FMLA leave, an employee must be restored to the employee's original job, or to an equivalent job with equivalent pay, benefits, and other terms and conditions of employment. An employee has no greater right to reinstatement or to other benefits and conditions of employment than if the employee had been continuously employed during the FMLA leave period.
- B. In addition, an employee's use of FMLA leave cannot result in the loss of any employment benefit that the employee earned or was entitled to before using FMLA leave, nor be counted against the employee under a "no fault" attendance policy. This includes salary increases that are across the board or for cost of living received by all employees in the same job classification.

- C. If paid leave is substituted for FMLA, then the employee shall continue to accrue service time during that paid status. If FMLA is unpaid leave, the employee shall not accrue service time or seniority during the unpaid status.
- D. Under specified and limited circumstances where restoration to employment will cause substantial and grievous economic injury to its operations, Delaware County may refuse to reinstate certain highly paid “key” employees (highest paid 10% of all employees) after using FMLA leave during which health coverage was maintained. In order to do so the Delaware County must:
  - 1. Notify the employee of his/her status as a “key” employee in response to the employee’s notice of intent to take FMLA leave;
  - 2. Notify the employee as soon as the employer decides it will deny job restoration, and explain the reasons for this decision;
  - 3. Offer the employee a reasonable opportunity to return to work from FMLA leave after giving this notice, and
  - 4. Make a final determination as to whether reinstatement will be denied at the end of the leave period if the employee then requests restoration

**Other Provisions**

- A. Salaried executive, administrative, and professional employees of covered employers who meet the Fair Labor Standards Act (FLSA) criteria for exemption from minimum wage and overtime under Regulations, 29 CFR Part 541, do not lose their FLSA-exempt status by using any unpaid FMLA leave.

**Procedure for Administration**

- A. Employees must provide notice when a qualifying event occurs and/or is planned to occur as follows:
  - 1. For foreseeable need for leave, including prenatal visits, the employee must provide thirty (30) days notice to the employer; if thirty (30) days is not possible, then as soon as practical, or
  - 2. For unforeseeable need for leave, employees must notify the employer as soon as practical.
  - 3. An employee must complete the appropriate leave form and submit it to their supervisor, director or appointing authority for approval along with the appropriate FMLA forms.
  - 4. If the employee has been absent from work for one of the qualifying reasons without providing the above notice, that leave may be considered as part of the 12 work week period upon the employer discovering the qualifying event depending upon the reason for the failure to provide proper notice. Any further leave the employee is entitled to take under this policy will be for 12 workweeks less the amount of such absent time previously taken.
  - 5. The employee should provide notice by completing the appropriate forms as indicated within this policy. (Form A, Application for Family or Medical Leave).
  - 6. If the employee has incurred previous absences for one of the qualifying reasons, he/she shall complete Form A1, Explanation of Prior Leave.

7. Failure to honestly complete FMLA forms in the prescribed manner may result in FMLA leave being rejected or revoked and the possibility of disciplinary action up to and including termination.
- B. Upon receipt of an Application for Family or Medical Leave, Delaware County shall either approve FMLA leave or require medical certification of the initial need for leave of an employee's annual FMLA entitlement. The County will give this indication of approval or request for medical certification by completing U.S.D.O.L. Form WH-381, Employer Response to Employee Request for FMLA. The County will notify the employee of eligibility / ineligibility within five (5) business days after leave is requested or it has knowledge the leave is for an FMLA reason, absent exigent circumstances. . If the employee will use paid time for the majority of the leave, the employee must complete a "Leave Request Form" and submit the form to his/her supervisor. If the majority of the employee's leave will be unpaid, a request for leave form and an employee action form with appropriate approvals must be completed.
1. The employee shall provide such certification to Delaware County within fifteen (15) days after receiving the requirement to provide such certification. The employee shall use U.S.D.O.L. Form WH-380, Certification of Health Care Provider to provide this certification. All entries within the certification must be answered sufficiently and completely.
    - a) Delaware County Human Resources may contact the employee's doctor directly to authenticate / clarify the certification.
    - b) Delaware County may request subsequent medical certifications every 30 days, upon expiration of the period specified in the certification, when circumstances change, or when the validity of the certification is in doubt.
    - c) Failure of the employee to provide a complete and sufficient certification in a timely manner may result in:
      - For foreseeable leave, leave may be denied until a complete and sufficient certification is received,
      - For unforeseeable leave, continuation of leave may be denied, and
      - If certification is never received, if the certification is incomplete or is insufficient FMLA leave will be denied.
    - d) Expenses for all such certifications, including subsequent certifications and clarifications, shall be paid by the employee or by insurance, if covered.
  2. Delaware County may obtain a second medical opinion from a health care provider of Delaware County's choice at the expense of Delaware County.
  3. If the employee's medical certification and the second medical opinion disagree, Delaware County may require a third, final, and binding evaluation of the employee by a health care provider selected mutually by Delaware County and the employee. The cost of the third evaluation shall be borne by Delaware County.
- C. Prior to an employee's return to work for FMLA leave due to his/her own serious health condition, the employee shall provide a fitness-for-duty certification from a health care provider showing that the employee can perform the functions of his/her position. The employee shall not return to work until such certification is provided and may be terminated at the expiration of leave if fitness-for-duty certification is not provided and the employee does not have other leave (e.g., sick leave, compensatory, vacation, or personal leave, if granted) to cover further absence. The employee shall utilize Form C, Health

Care Provider's Certification of Ability to Return to Work, as the fitness- for- duty certification.

**Employer Responsibilities**

- A. The County will post an approved Department of Labor FMLA notice in a conspicuous place.
- B. The employer will provide a copy of this policy to each employee and provide training periodically as needed on the employee's rights and responsibilities under the FMLA.

## When Leave is FMLA Leave

In accordance with the federal Family and Medical Leave Act of 1993 and the National Defense Authorization Act of 2008, an eligible employee is entitled to an unpaid leave of absence of up to twelve (12) workweeks measured backward from the date the leave commences or twenty six (26) workweeks measured forward from the date the leave commences (if the leave is for a covered service member with a serious illness or injury incurred in the line of duty on active duty: for one of the following reasons:

1. for the birth and care of the newborn child of the employee;
2. for placement with the employee of a son or daughter for adoption or foster care;
3. to care for an immediate family member (spouse, child under 18 years of age or child 18 years or older if incapable of self-care because of mental or physical disability, or the employee's parent (but not parent in-laws)) of the employee with a serious health condition; or
4. to take medical leave when the employee is unable to work because of a serious health condition.
5. to care for a family member that is a covered service member with a serious illness or injury incurred in the line of duty on active status.
6. family member military qualifying extingency leave.

Serious Health Condition is defined below: **(The Supervisor should provide his/her employee with a copy of the FMLA policy and the U.S. Department of Labor's Certification of Health Care Provider (WH-380) form when the employee misses work to care for himself/herself or an immediate family member when one of the following occurs.)**

A. Hospital Care

**Inpatient care** (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection to such inpatient care.

B. Absence Plus Treatment

A period of incapacity lasting **more than three consecutive calendar days** (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:

1. **Treatment two or more times** by or under the supervision of a health care provider (i.e., in-person visits, the first within 7 days and both within 30 days of the first day of incapacity); OR
2. **One Treatment** by a health care provider on **at least one occasion** which results in a **regimen of continuing treatment** (i.e., an in-person visit within 7 days of the first day of incapacity with a continuing regimen of treatment such as prescription medication, physical therapy, etc.

C. Pregnancy

Any period of incapacity due to **pregnancy** or **prenatal care**.

D. Chronic Conditions Requiring Treatments

A **chronic condition** which:

1. Requires **periodic visits** of at least two visits per year for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;
2. Continues over an **extended period of time** (including recurring episodes of a single underlying condition); and
3. May cause **episodic** rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.)

E. Permanent/Long Term Conditions Requiring Supervision

A period of **incapacity** which is **permanent or long-term** due to a condition for which treatment may not be effective. The employee or family member must be **under the continuing supervision of, but need not be receiving active treatment by, a health care provider**. Examples include Alzheimer's, severe stroke, or the terminal stages of a disease.

F. Multiple Treatments (Non-Chronic Conditions)

Any period of absence to receive **multiple treatments** (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for **restorative surgery** after an accident or other injury, **or for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment**, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).

**Incapacity** means inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom.

**Treatment** includes examinations to determine if a serious health condition exists and evaluations of the condition. **Treatment does not include** routine physical examinations, eye examinations, or dental examinations.

**A regimen of continuing treatment** includes, for example, a course of prescription medication (e.g. an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. **A regimen of treatment does not include** the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

G. Conditions That Typically Are Not Serious Health Conditions Under The FMLA

1. Cosmetic treatments, such as for acne or plastic surgery, except after an injury or removal of a cancerous growth or if complications develop.
2. Common cold, flu, earaches, upset stomach, minor ulcers, headaches (other than migraine), or routine dental or orthodontia problems, unless complications develop.
3. Allergies or mental illness resulting from stress unless all requirements of serious health condition are met.
4. Substance abuse unless absence is for treatment.

**FORM A**

**APPLICATION FOR FAMILY OR MEDICAL LEAVE**

I hereby apply for family/medical leave for the following reason, (check one):

- \_\_\_\_\_ because of the birth of my son or daughter and in order to care for my son or daughter
- \_\_\_\_\_ because of the placement of a son or daughter with me for adoption of foster care
- \_\_\_\_\_ in order to care for my spouse, or a son, daughter, or parent who has a serious health condition
- \_\_\_\_\_ because of my serious health condition that makes me unable to perform the functions of my position
- \_\_\_\_\_ In accordance with the National Defense Authorization Act of 2008 to care for a covered service member with a serious illness or injury incurred in the line of duty on active duty
- \_\_\_\_\_ "Qualifying extingency" 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.

I am in need of this leave beginning on \_\_\_\_\_ and I expect the leave to continue until on or about \_\_\_\_\_  
(date) (date)

**(You must have an estimated leave/return date)**

I certify that I meet the eligibility requirements as set forth in the Family and Medical Leave Policy. If I am applying for leave because I have a serious health condition or a member of my immediate family does, I am supplying medical certification in accordance with the Family and Medical Leave Policy.

I authorize my employer to contact my treating health care provider for information or clarification about my medical certification. I agree to cooperate fully with my treating health care provider's course of treatment. I release any and all medical personnel with knowledge of my condition to communicate with my employer for the purpose of certifying or clarifying my certification. I agree that if my leave is due to my own serious health condition that before being permitted to return to work, I will present a certification from my health care provider that I am able to resume work (Form C).

I understand that I must pay my portion of health benefits, if applicable, by the first day of the month. I further understand that if I do not return to work after my leave for any reason but a continuance, recurrence, or onset of a serious health condition or other circumstances beyond my control, I will be obligated to repay to my employer the amount of my health insurance premiums that it contributed on my behalf during my leave. I agree that said repayment may be made by deductions from any remaining paychecks.

I understand that any FMLA leave might be otherwise substituted and reduced by paid leave in accordance with the Family and Medical Leave Policy. If I have been absent previously during this calendar year, I have attached Form A1, as a written explanation of this leave. I agree to supplement this explanation with medical certification if I am requested to do so by my employer.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

**FORM A1**

**EXPLANATION OF PRIOR LEAVE**

Under the Family and Medical Leave Act, prior leave used may be qualified as a portion of the 12 weeks of FMLA leave if certain criteria are met. To determine whether this qualification is met, please complete the following certification.

I hereby certify that my previous absence(s) during this calendar year has (have) been for the following reason(s):

**Number of Days:**

- \_\_\_\_\_ because of the birth of my son or daughter or because of the placement of a son or daughter with me for adoption or foster care.
- \_\_\_\_\_ in order to care for my spouse, or a son, daughter, or parent who has a serious health condition.
- \_\_\_\_\_ because of my serious health condition that makes me unable to perform the functions of my position.
- \_\_\_\_\_ In accordance with the National Defense Authorization Act of 2008 to care for a covered service member with a serious illness or injury incurred in the line of duty on active duty (Up to 26 weeks of leave is available under this section)
- \_\_\_\_\_ "Qualifying extigency" 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.

Employee: \_\_\_\_\_

Office/Department: \_\_\_\_\_

Date: \_\_\_\_\_

Notice of Eligibility and Rights & Responsibilities  
(Family and Medical Leave Act) WH-381

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. While use of this form by employers is optional, a fully completed Form WH-381 provides employees with the information required by 29 C.F.R. § 825.300(b), which must be provided within five business days of the employee notifying the employer of the need for FMLA leave. Part B provides employees with information regarding their rights and responsibilities for taking FMLA leave, as required by 29 C.F.R. § 825.300(b), (c).

**[Part A – NOTICE OF ELIGIBILITY]**

TO: \_\_\_\_\_  
Employee

FROM: Human Resources  
Employer Representative

DATE: \_\_\_\_\_

On \_\_\_\_\_, you informed us that you needed leave beginning on \_\_\_\_\_ and estimated to end 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 servicemember 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 Human Resources or view the FMLA poster located in 10 Court Street, Delaware, Ohio 43015 2<sup>nd</sup> Floor.

**[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 \_\_\_\_\_.** (If a certification is requested, employers must allow at least 15 calendar days from receipt of this notice; additional time may be required in some circumstances.) If sufficient information is not provided in a timely manner, your leave may be denied.

- 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 Human Resources at 740-833-2120 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 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 Delaware County Employee Handbook available at: <http://www.co.delaware.oh.us/hr/documents.asp>.
  - Applicable conditions for use of paid leave: <http://www.co.delaware.oh.us/hr/documents.asp>.

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:

Human Resources at 740-833-2120

**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.**



**SECTION I: For the 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: Delaware County Brad Euans, HR Coordinator 740-833-2127

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.**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_





**SECTION I: For the 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: Delaware County  
Brad Euans, HR Coordinator 740-833-2127

**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: \_\_\_\_\_

**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: \_\_\_\_\_

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 as 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:

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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:

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Explain the care needed by the patient, and why such care is medically necessary: \_\_\_\_\_

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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:

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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: \_\_\_\_\_

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**ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.**

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\_\_\_\_\_  
**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.**

**FORM C**

**HEALTH CARE PROVIDER'S CERTIFICATION  
OF ABILITY TO RETURN TO WORK**

**I hereby certify that I have physically examined \_\_\_\_\_ (Employee)  
and have determined that he/she is able to resume all the functions of his or her job as described in  
their job description from Delaware County.**

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**Health Care Provider**

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**Address**

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**Telephone Number**

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**Date**