4011
Employee Leave Under the Family and Medical Leave Act (FMLA)

The school district shall provide leave to its employees in accordance with the Family and Medical Leave Act ("FMLA"). The terms used herein shall have the meaning ascribed to them under the FMLA. Employees may also qualify for leave under the Nebraska Family Military Leave Act, which is covered under the district's policy for that law. If an employee qualifies for leave under both the Family and Medical Leave Act and the Nebraska Military Leave Act, any leave taken by the employee will count concurrently toward the leave limits of both acts.

I. Qualifying for Leave

A. Qualified Employees

1. To be eligible for ***unpaid*** leave under this policy, an employee must:

   a. Make the request for leave at a time when the school district employs 50 or more workers;

   b. Have been working for the school district for at least 12 months prior to the request; and

   c. Have worked a minimum of 1,250 hours during the 12-month period immediately preceding the commencement of the leave.

2. The applicable 12-month period for computing an employee's entitlement to FMLA leave shall be the 12-month period measured forward from the date such employee's first FMLA leave begins.

3. Employees ineligible for FMLA leave for any reason may be eligible for leave under the Nebraska Family Military Leave Act and should consult policy 4011.1.

B. Qualified Circumstances Necessitating Leave

1. The school district will grant an eligible employee up to a total of 12 workweeks of ***unpaid*** leave under the following conditions:

   a. For birth of a son or daughter, and to care for the newborn child;

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

   c. To care for the employee's spouse, son, daughter, or parent with a serious health condition;

   d. Because of a serious health condition that makes the employee unable to perform the functions of his or her job;

   e. Because of any qualifying exigency arising out of the fact that the employee's spouse, son, daughter, or parent is a Military Member on Covered Active Duty (or has been notified of an impending call or order to Covered Active Duty) in National Guard, Reserves, and/or Regular Armed Forces in support of a contingency operation; or

2. The school district will grant an eligible employee who is the spouse, son, daughter, parent or next of kin of a Covered Servicemember a total of 26 workweeks of ***unpaid*** leave during a 12-month period to care for the service member as permitted under the FMLA. The leave described in this paragraph shall only be available during a single 12-month period.

   For purposes of this provision and this policy, "Covered Servicemember" includes both Military Members and covered Veterans, so long as the

covered Veteran was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered Veteran.

3. During the single 12-month period described in paragraph I(B)(2), an eligible employee shall be entitled to a combined total of 26 workweeks of leave under paragraphs I(B)(1) and I(B)(2). Nothing in this paragraph shall limit the availability of leave under paragraph I(B)(1) during any other 12-month period.

C. Limitations on Leave

1. Leave for birth or placement for adoption or foster care must conclude within 12 months of the birth or placement.

2. In any case in which a husband and wife both employed by the school district are entitled to FMLA leave:

   a. The aggregate number of workweeks of FMLA leave to which both are entitled is limited to 12 during any 12-month period if such leave is taken (i) because of the birth of a son or daughter of the employee and in order to care for such son or daughter; (ii) because of the placement of a son or daughter with the employee for adoption or foster care; or (iii) to care for a sick parent who has a serious health condition; and

   b. The aggregate number of workweeks of FMLA leave to which both that husband and wife are entitled is limited to 26 during the single 12-month period in which leave is taken to care for a Covered Servicemember and the husband and wife employees are both

either the son, daughter, parent, or next of kin of such Covered Servicemember, if the leave is taken for this reason or a combination of this reason and one of the three reasons described in paragraph I(C)(2)(a). If the leave taken by the husband and wife includes leave described in paragraph I(C)(2)(a), the limitation in paragraph I(C)(2)(a) shall apply to the leave described in I(C)(2)(a).

D. Qualifying Notice and Certification

Employees seeking to use FMLA leave will be required to provide:

1. 30-day advance notice when the need to take the leave is foreseeable; provided, if (a) the leave is for needed treatment which is required to begin in less than thirty days or (b) the leave is for the reason set forth in paragraph I(B)(1)(e), the employee shall provide such notice to the school district as is reasonable and practical;

2. Medical certification supporting the need for leave due to a Serious Health Condition affecting the employee or family member or to care for a Military Member, and/or due to a Serious Injury or Illness to care for a Veteran;

3. Second or third medical opinions and periodic re-certifications (at the school district's expense);

4. Certification supporting the need for leave because of a qualifying exigency arising out of the fact that the employee’s spouse, son, daughter or parent is a Military Member on Covered Active Duty (or has been notified of an impending call or order to Covered Active Duty) in the National Guard, Reserves, and/or

Regular Armed Forces in support of a contingency operation;

5. Certification supporting the need for leave to care for a Veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered Veteran, and who is undergoing medical treatment, recuperation, or therapy for a Serious Injury or Illness; and

6. Periodic reports during leave, at a frequency reasonably requested by the superintendent, regarding the employee's status and intent to return to work.

E. Scheduling Leave

When leave is needed to care for a family member, for the employee's own illness, or to care for a Covered Servicemember, and such leave is foreseeable based on planned medical treatment, the employee must attempt to schedule treatment so as not to unduly disrupt the school district's operations.

II. Relationship with District During Leave

A. Leave to Be Unpaid

All leave provided to employees under the provisions of the FMLA and this policy shall be unpaid leave.

B. Substitution of Paid Leave

1. The school district requires employees to substitute any accrued paid vacation leave, paid personal leave, paid family leave, paid medical leave or paid sick leave for FMLA leave. However, nothing in this policy shall require the school district to provide paid sick or medical leave in any situation in which the

school district would not normally provide such paid leave.

2. If an employee uses paid leave under circumstances which do not qualify as FMLA leave, the leave will not count against the number of workweeks of FMLA leave to which the employee is entitled.

3. Any paid leave which is substituted for FMLA leave will be subtracted from the number of workweeks of unpaid leave provided by the FMLA and this policy.

C. Group Health Plan Benefits

1. The school district will continue group health plan benefits on the same basis as coverage would have been provided if the employee had been continuously employed during the FMLA leave period.

2. Any share of health plan premiums which have been paid by the employee prior to FMLA leave must continue to be paid by the employee during the FMLA leave period.

D. Intermittent or Reduced-Schedule Leave

1. Leave may be taken under this policy intermittently or on a reduced-leave schedule under certain circumstances.

    a. When leave is taken because of a birth or because of a placement of a child for adoption or foster care, an eligible employee may take leave intermittently or on a reduced-leave schedule only with the agreement of the school district. In such a case, the superintendent shall have the authority to approve or disapprove such intermittent or reduced leave schedule, in the superintendent's sole discretion.

b. When leave is taken to care for a sick family member, for an employee's own serious health condition, or to care for a covered Veteran or Military Member, an eligible employee may take leave intermittently or on a reduced-leave schedule when medically necessary.

c. When leave is taken by an eligible employee because of any qualifying exigency arising out of the fact that the employee’s spouse, son, daughter, or parent is a Military Member on Covered Active Duty (or has been notified of an impending call or order to Covered Active Duty) in National Guard, Reserves, and/or Regular Armed Forces in support of a contingency operation, the employee may take leave intermittently or on a reduced-leave schedule.

d. When leave is taken by an eligible employee to care for a Covered Servicemember, including a Veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered Veteran, and who is undergoing medical treatment, recuperation, or therapy for a Serious Injury or Illness

e. Intermittent or reduced leave shall not result in a reduction in the employee's total amount of leave beyond the amount of leave actually taken.

f. When an instructional employee seeks to take intermittent leave in connection with a family or personal illness (e.g. physical therapy or periodic care for a sick relative) or to care for a covered

Veteran or Military Member, and when such leave would constitute at least 20 percent of the total number of working days in the period during which the leave would extend, the school district may require the employee to elect to take leave in a block, instead of intermittently, for the entire period or to transfer to an available alternative position within the school system that is equivalent in pay, for which the employee is qualified, and which better accommodates the intermittent leave.

2. If an eligible employee requests intermittent leave or leave on a reduced-leave schedule that is foreseeable based on planned medical treatment, including during a period of recovery from a serious health condition, the school district may require the employee to transfer temporarily to an available alternative position for which the employee is qualified and which better accommodates recurring periods of leave than does the employee's regular position. Such alternative position must have equivalent pay and benefits as the employee's permanent position.

3. Leave taken on an intermittent or reduced-schedule basis will be tracked hourly.

III. Return from Leave

A. Restoration to Position

1. On return from FMLA leave, an employee is entitled to be returned to the same position the employee held when leave commenced, or to an equivalent position with equivalent benefits, pay, and other terms and conditions of employment.

2. Any leave taken under this policy will not result in the loss of any employment benefits accrued

prior to the date on which the leave commenced.

3. An eligible employee is not entitled to accrual of any seniority or employment benefits during any period of leave, or any right, benefit, or position of employment other than to which the employee would have been entitled had the employee not taken leave.

B. Denial of Restoration

1. The school district reserves the right to deny restoration to any eligible employee who is a "key employee" (that is an employee who is salaried and among the highest paid 10% of the employees of the school district) if such denial is necessary to prevent substantial and grievous economic injury to the operations of the school district.

2. If the school district intends to deny restoration to such an employee, it will:

   a. notify the employee of his/her status as a "key employee" in response to the employee's notice of intent to take FMLA leave;

   b. notify the employee as soon as the school district decides it will deny job restoration and explain the reasons for this decision;

   c. offer the employee a reasonable opportunity to return to work from FMLA leave after giving this notice; and

   d. make a final determination as to whether reinstatement will be denied at the end of the leave period if the employee then requests restoration.

C. Failure to Return from Leave

a. If an employee fails to return from FMLA leave after the period of leave to which the employee is entitled has expired, the employee shall reimburse the district for any premiums the employer paid for maintaining health insurance coverage for the employee during the employee's FMLA leave unless the reason the employee does not return is due to: (1) the continuation, recurrence, or onset of the serious health condition which entitled the employee to FMLA leave and the employee provides the district with sufficient certification from the proper health care provider of such continuation, recurrence, or onset of the serious health condition or (2) other circumstances beyond the employee's control.

IV. Notice to Employees

A. The school district will post in conspicuous places where employees are employed notices explaining the FMLA and providing information concerning the procedures for filing complaints of FMLA violations with the U.S. Wage and Hour Division.

B. When an employee provides notice of the need for FMLA leave, the school district shall provide the employee with a copy of the "section 301(c) notice" which is attached to this policy.

C. To the extent that any provision in this policy is in any manner inconsistent with the provisions of the Act or the regulations promulgated thereunder, the Act and regulations shall prevail over the provisions of this policy. The school district reserves the right to modify this policy from time to time in its sole discretion.

D. Employees may direct any questions or concerns regarding FMLA leave to the superintendent.

Adopted on: 11/19/18
Revised on: _____
Reviewed on: _____

Certification of Health Care Provider for Employee's Serious Health Condition (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: 8/31/2021

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, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination 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. 29 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. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b). 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.

_____

_____

_____

_____

_____

_____

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.**

Certification of Health Care Provider for Family Member's Serious Health Condition (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: 8/31/2021

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, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination 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

CONTINUED ON NEXT PAGE

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. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e). 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
Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 8/31/2021

In general, to be eligible an employee must have worked for an employer for at least 12 months, meet the hours of service requirement 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: _____ _____
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 covered active duty or call to covered active duty status with the Armed Forces.

_____ 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 hours of service 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 _____.** (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 (such as documentation for military family leave): _____

_____

_____

____ No additional information requested

CONTINUED ON NEXT PAGE

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 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
Wage and Hour Division

U.S. Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 8/31/2021

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
(Provide at least seven calendar days)
practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied.

_____
(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.**