Employee Application for Family and Medical Leave

Name: _____ Department: _____

Employee #: _____ Date of Employment: _____

Employment status: ___ Full-time ___ Part-time Date of request: _____

Employee's address during leave: _____

Telephone number during leave: _____

If married, does your spouse currently work for Athens-Clarke County? _____ Yes _____ No

If so, Spouse's Name: _____ Spouse's Department: _____

Leave is requested for: *(Please circle reason)*A. Birth of a child

A. Birth of a child
B. Adoption of a child
C. Placement of a child for foster care

Anticipated date of delivery, adoption, or placement:

D. Serious health condition of employee
E. Serious health condition of employee's spouse
F. Serious health condition of employee's child
G. Serious health condition of employee's parent
H. Serious health condition of a service member or veteran for which you are the primary care giver (up to 26 weeks unpaid leave if approved)
I. Active Duty Leave – A qualifying situation which has arisen out of the fact that the spouse, son, daughter or parent of the employee is on or has been called to active duty in the Armed Forces in support of a contingency operation (war or combat)
J. Qualifying exigency, name of military member on covered active duty or call to covered active duty status and relationship of member to you: _____ .

(Attach a copy of member's covered active duty orders or other documentation certifying covered active duty or notification thereof. If leave is requested to meet with a third party, attach details of contact and contact information for the individual or entity with whom you are meeting, time, date and nature of meeting.)

(Attach Medical Certification Supporting Leave for Serious Health Conditions to this Form)

Requested dates of leave: From _____ To _____

Do you intend to return to work after this leave? _____ Yes _____ No

Have you taken any other leaves during the past twelve months? _____ Yes _____ No

From_____ To_____ Type of Leave_____

I understand that while I am on Family and Medical Leave, the expense of dependent premiums and contributory payments will continue. If I go on unpaid leave, I will pay these expenses no later than the first day of each month during my absence. I further understand that if I do not return to work, I will reimburse Athens-Clarke County for premiums paid on my behalf during my leave of absence. If I am accepted for Short Term or Long Term Disability, reimbursement for my individual premium may not be necessary.

Signature of Employee _____ Date _____

Supervisor Approval _____ Date _____

Department Director Approval _____ Date _____

Human Resources Director Approval _____ Date _____

Family Medical Leave Act (FMLA) Eligibility Checklist and Certification

QUESTION	Initials
1. I have worked for ACCUG for at least 12 months.	
2. I have worked at least 1,250 hours in the last 12 months.	
3. I have provided 30 days advance notice for "foreseeable" leave, if applicable	
4. I MEET AT LEAST ONE OF THESE QUALIFYING EVENTS:	**Please initial only the condition(s) that apply**
Employee's serious health condition, which make the employee unable to perform the functions of their job. Serious health condition means an illness, injury, impairment, or physical or mental conditions that involve: pregnancy or pre-natal care; inpatient care; an absence of more than 3 days; a chronic, serious, permanent or long-term condition; or multiple treatments required. *Cosmetic or elective surgery that is not medically necessary does not qualify for FMLA-protected leave.*	
Birth of a son or daughter and in order to care for such son or daughter for a period beginning on the date of birth. I understand that leave must be completed within the 12 months following the birth date.	
Placement of a son or daughter with the employee for adoption following the date of placement. I understand that leave must be completed within the 12 months following the placement date.	
The need to care for a spouse, child or parent with a serious health condition. Children must be under 18 or over 18 and unable to care for themselves. *Does not include parents-in-law.*	
I am the primary care giver of a service member who has a serious illness or injury, which was incurred in the line of duty and prevents him/her from performing the functions of his/her job in the military. *May take up to 26 weeks of unpaid leave if approved.*	
The need to take care of a pressing or urgent situation arising out of the fact that a spouse, son, daughter or parent is on or has been called to active duty in the Armed Forces in support of a "contingency operation" (war or combat).	

ACKNOWLEDGEMENTS
I understand and acknowledge that **FMLA is limited to 12 weeks of unpaid, job-protected leave** within a one year period. After exhausting the 12 weeks allowed under FMLA, ACC is not obligated to place me back in my previous position or to find a different position for me and I may be subject to termination.
I understand and agree to provide medical certification of my serious health condition within 5 days of requesting medically necessary FMLA leave.
I understand that I am required to provide an documented explanation of the health condition of my family member if I am requesting FMLA leave to care for a spouse, child, or parent.
I understand that I am required to provide
I understand and agree that any accrued Sick, Vacation and Comp time, where applicable, will be substituted and applied to my payroll record prior to authorization of Leave Without Pay (LWOP) under FMLA. I understand and agree that this substitution does not extend the amount of FMLA leave.
I understand and agree to report my progress of recovery and my intent to return to work to my supervisor and to the UGACC Human Resources Department every 30 days to recertify my health status.
I understand that if the FMLA leave is for my serious health condition, I am required to provide ACC with written medical updates of my condition and that a written certification by my medical provider or a Return to Work form must be provided to UGACC prior to returning to work.
I have been provided all the necessary forms (FMLA Application and Certification of Health Care Provider) and a copy of the UGACC Employee Family and Medical Leave Information Sheet.
I understand that I may also apply for Short Term Disability (STD) and that this benefit requires that I be under a doctor's care for 6 weeks prior to any disbursement and that such disbursement is only 60% of my base annual salary.
I understand that both the FMLA Application and the STD Application require three signatures before my application(s) will be considered for approval.
I understand that I must provide a medical certificate of fitness-for-duty to return to work, signed by a certified physician.
My signature and date below certifies that I understand all of my obligations under FMLA and have received all the necessary forms.

_____/_____/_____/_____

Name (Please type or print) **Dept.** **Work Phone** **Home Phone**

Signature (Required)

Forward signed originals to ACC Human Resources Department / Compensation and Benefits Division

February 2013

Athens-Clarke County Government
Certification of Health Care Provider
(Family and Medical Leave Act of 1993)
(Adapted from USDOL Form WH-380)

Important Notice for Heath Care Provider:
Title II of the Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers from requesting or requiring genetic information of employees or their family members. Certain exceptions apply including requests for family medical history to comply with the certification provisions of the FMLA or State or local family and medical leave laws, or pursuant to a policy that permits the use of leave to care for a sick family member that requires employees to provided information about the health condition of the family member to substantiate the need for leave. If this exception does not apply to this particular case, we ask that you not provide any genetic information when responding to this request for medical information. 'Genetic information," includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo legally held by an individual or family member using assisted reproductive technology.

1. Employee's Name _____

2. Patient's Name (If different from employee) _____

3. The Fact Sheet describes what is meant by a **"serious health condition"** under the Family and Medical Leave Act. Does the patient's condition[1] qualify under any of the categories described? If so, please check the applicable category.

i. ___ A health condition (including treatment therefor, or recovery therefrom) lasting more than three consecutive days.

ii. ___ Pregnancy or prenatal care.

iii. ___ A chronic serious health condition that continues over an extended period of time, requires periodic visits to a health care provider, and may involve occasional episodes of incapacity (e.g., asthma, diabetes).

iv. ___ A permanent or long-term condition for which treatment may not be effective (e.g., Alzheimer's, a severe stroke, cancer).

v. ___ Absences to receive multiple treatments for restorative surgery or for a condition which would likely result in a period of incapacity of more than three days if not treated (e.g.,chemotherapy or radiation treatments for cancer).[2]

vi. ___ None of the above.

4. Describe the **medical facts,** which support your certification, including a brief statement as to how the medical facts meet the criteria of one of the above categories:

5. (a) State the approximate **date** the condition began, and the probable duration of the condition (and also the probable duration of the patient's present incapacity[1] if different):

(b) Will it be necessary for the employee to take off work only **intermittently or to work on a less than full schedule** as a result of the condition (including for treatment described in Item 6 below)?
If yes, give the probable duration: _____

(c) If the condition is a **chronic condition** or **pregnancy**, state whether the patient is presently incapacitated and the likely duration and frequency of **episodes of incapacity**:

6. (a) If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments.

If the patient will be absent from work or other daily activities because of treatment on an intermittent or part-time basis, also provide an estimate of the probable number of and interval between such treatments, actual or estimate dates of treatment if known, and period required for recovery:

(b) If any of these treatments will be provided by another provider of health services (e.g., physical therapist), please state the nature of the treatments:

(c) If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment):

7. (a) If medical leave is required for the employee's absence from work because of the employee's own condition (including absences due to pregnancy or a chronic condition), is the employee unable to perform work of any kind? If so, please describe.

(b) If able to perform some work, is the employee unable to perform any one or more of the essential functions of the employee's job (the employee or the employer should supply you with information about the essential job functions)?

If yes, please list the essential functions the employee is unable to perform:

(c) If neither "a" nor "b" applies, is it necessary for the employee to be absent from work for treatment?

8. (a) If leave is required to care for a family member of the employee with a serious health condition, does the patient require assistance for basic medical or personal needs or safety, or for transportation? (Yes or No)

If yes, indicate the duration of assistance required.

(b) If no, would the employee's presence to provide **psychological comfort** be beneficial to the patient or assist in the patient's recovery? (Yes or No)

(c) If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need:

(**Signature of Health Care Provider)**	**(Date)**
(Address)	**(Telephone Number)**
(Type of Practice)	**(Address)**

[1] Here and elsewhere on this form, the information sought relates only to the condition for which the employee is requesting/taking FMLA leave.

[2] "Incapacity," for purpose of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery therefrom.

FMLA SELF-CERTIFICATION FORM FOR INTERMITTENT LEAVE

To be completed by the employee needing family leave to care for a family member:

Describe the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work a less than full schedule.

_____ _____

(Employee Signature) **(Date)**

FMLA SELF-CERTIFICATION FORM FOR INTERMITTENT LEAVE

To be completed by the employee needing intermittent leave to care for a serious health condition:

Describe the duration of the illness or treatment, the nature of the illness or treatment or any other complications not noted on the previous certification by your health care provider. Please provide an estimate of the period or schedule of intermittent leave that will be necessary for you to work a less than full schedule.

_____ _____

(Employee Signature) **(Date)**