# FAMILY AND MEDICAL LEAVE (FMLA)

Under the federal Family and Medical Leave Act (FMLA) and the California Family Rights Act (CFRA) you are entitled to up to twelve (12) work weeks or 480 hours of leave in a year (twelve months) from the date that the leave was first taken. Leave may be taken for specified family and/or medical reasons, including the birth, adoption, or foster care placement of a child; a serious health condition that makes you unable to perform your job; or to care for your spouse, child, parent or domestic partner who has a serious health condition.

To be eligible for FMLA and/or CFRA leave you must have worked for the District for at least **twelve (12) months** and have worked a **minimum of 1,250 hours during the twelve (12) months preceding the starting date of your request for FMLA leave**. Employees (except members of ATU and SEIU) are required to use accrued sick leave (if eligible), floating holidays and vacation during FMLA leave except that you are not required to [but may] use vacation for absences caused by your own medical condition. If you do not have leave available, the leave will be unpaid. District-paid health benefits will continue during the entire leave. Special rules apply to leave required for pregnancy and/or childbirth. If you require such leave please contact this office for more information.

A period of incapacity (i.e., inability to work) due to a serious health condition of more than three consecutive full calendar days and any subsequent treatment or period of incapacity relating to the same condition is FMLA/CFRA qualified. If that occurs, the eligible employee's time off will be considered as FMLA leave.

In order to qualify for FMLA/CFRA leave a medical certification must be completed by your health care provider if you have a serious health condition or if you will be caring for a family member. The certification must be complete in order for the leave to be approved. A certification is considered incomplete if the one or more of the applicable entries have not been completed or the information provided is vague, ambiguous, or non-responsive. If the request is for a foreseeable leave, the District may delay granting leave to an employee who fails to provide certification within 15 days.

**SEIU and ATU Members**: Section 9.1F of the collective bargaining agreement states: "An employee on FMLA/CFRA qualifying leave may elect to use any accumulated leave as may be permitted by Federal and State law and regulations (i.e. sick leave, vacation, floating holidays or compensatory leave) or elect to take the leave unpaid in any order and at the employee's discretion. Employees who would otherwise qualify for short term disability while on FMLA/CFRA leave will not qualify for that disability until all of the employee's sick leave is exhausted." SEIU and ATU members must designate the type of leave desired when taking qualified leave. Those members who fail to make an election shall be required to use leave in accordance with the current District policy for non ATU/SEIU members. The election must be made at the time of the leave; retroactive changes will not be permitted.

The completed and signed form may be faxed to Employee Services at (510) 464-7511 and mailed to:

Employee Services
300 Lakeside Dr.
20th Floor
Oakland, CA 94612

Please contact Employee Services at (510) 464-7521 with any questions.

**CERTIFICATION OF HEALTH CARE PROVIDER FOR**
**EMPLOYEE'S AND/OR FAMILY MEMBER'S SERIOUS HEALTH CONDITION**

If you have trouble completing this form or have questions regarding the required information, please contact EMPLOYEE SERVICES at (510) 464-7521 for assistance.

**Instructions to the Employee**: Please complete this section before giving this form to your medical provider or, if for a family member's serious health condition, to the family member or his/her medical provider. This form must be completed in its entirety. Return completed form to your Supervisor/Manager.

**SEIU and ATU Members**: Section 9.1F: An employee on FMLA/CFRA qualifying leave may elect to use any accumulated leave as may be permitted by Federal and State law and regulations (i.e. sick leave, vacation, floating holidays or compensatory leave) or elect to take the leave unpaid in any order and at the employee's discretion. Employees who would otherwise qualify for short term disability while on FMLA/CFRA leave will not qualify for that disability until all of the employee's sick leave is exhausted.

**Instructions to the Supervisor/Manager**: Provide a copy of the Family Medical Leave Information Sheet to the employee. Upon receipt of completed form return immediately to Employee Services fax 7511. Send the original in interoffice mail to **EMPLOYEE SERVICES, LKS 20.**

## For completion by EMPLOYEE

1. Your Name: _____ 2. ID #:_____
Last First

3. Date of Hire:_____ 4. Job: _____

5. Days off:_____ 6. Scheduled Hours: _____ 7. Work Location:_____

8a. Supervisor:_____ 8b. Sup Phone:_____

9a. Address while on leave: _____
Street/Apt# City State Zip

9b. Phone Number while on leave: _____ 9c. Home Number: _____

10. Have you taken Family Medical Leave in the past 12 months? Yes ____ No _____

11. Requested leave dates: _____ to _____
(Anticipated Due Date for Bonding) Begin date End date

Check One: ☐ Care of Family Member ☐ Employee Illness ☐ Pregnancy ☐ Bonding (Proof of Birth Required)

No Certification of Health Care needed for Bonding Leave. If the Mother needs medical care related to pregnancy then have the treating physician complete the Certification of Health Care Provider for Family Leave

13a._____ 13b. _____
Employee Signature Date

Human Resources Use Only: ☐ Eligibility ☐ NOL Sent ☐ Approved ☐ Denied ☐ Closed (Date_____)

**CERTIFICATION OF HEALTH CARE PROVIDER FOR FAMILY LEAVE**
FAMILY AND Medical Leave Act of 1993

Check One: ☐ Care of Family Member ☐ Employee Illness ☐ Pregnancy

| Employee Name: | Patient's Name:<br>Relationship to Employee: |
|---|---|

**TO BE COMPLETED FOR THE EMPLOYEE BY THE PHYSICIAN OR PRACTITIONER**

Medical Facts (dates condition commenced, duration of condition, was hospitalization required?):

Was medication prescribed (other than OTC)? Yes ☐ No ☐

**I. Care of a Family Member**

☐ The patient is a family member with a Serious Health Condition (SHC) which would require the employee to take time off from work to provide basic medical, hygienic, safety needs, transportation, or physical or psychological care.

**The probable frequency and duration of this need is:**

☐ Block of Time _____to _____ (Dates)

(circle one)

☐ Intermittent Dates: _____ to _____ Frequency: Hrs/Days _____every _____(week/month)

Be as specific as you can; terms such as "lifetime," "unknown," or indeterminate" may not be sufficient to determine FMLA coverage.

**II. Employee Illness/Pregnancy**

1. ☐ Patient is unable to work: Begin Date: _____ Through Date: _____

☐ Patient requires intermittent leave/care of may have episodic flare-ups due to a serious health condition.
Begin Date: _____ Through Date: _____ (Circle one)
Periods of incapacitation are likely to occur: Hrs/Days _____ every _____ (week/month)
Be as specific as you can; terms such as "lifetime," "unknown," or indeterminate" may not be sufficient to determine FMLA coverage.

2. If the condition is pregnancy estimated date of delivery or scheduled C-Section: _____
Condition summary: ☐ Normal pregnancy ☐ Complications with pregnancy

3. Surgery Date: Patient admitted to Hospital, Hospice or Residential Medical care facility:
Admission date: _____ Release date: _____

4. Dates of visits for treatment of this condition:

5. Treatment Plan: Is it necessary for the employee to be absent from work for treatment:
☐ Yes ☐ No If yes: Approximate number of additional treatments:
Approximate time each treatment will take:
Will another provider of health services (e.g., physical therapist) provide treatments?
☐ Yes ☐ No If so, please state the nature of treatment:

6. Employee can return to work with no restrictions on _____
6 a. Employee can return to work with the following restrictions on _____:

Restrictions end: _____

| HEALTH CARE PROVIDER | | | | |
|---|---|---|---|---|
| Physician's/Provider's Name (Print) | | Physician's/Provider's Signature: | | |
| Type of Practice (field of specialization) | State License # | Area Code/Phone number | | |
| Physician's/Provider's Address | City | State | Zip Code | Date |
| Additional Information: Identify question number with your additional answer | | | | |
| Return to employee. You may also fax this completed medical certification to (510) 464-7511. | | | | |

**Form No. 05-52-0021 (Rev. 1, 11/14 - HR)**