Certification of Health Care Provider For Employee's Serious Health Condition (Family and Medical Leave Act)

SECTION I: For Completion by the EMPLOYER

I NSTRUCTIONS 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: _____

Employee's job title: _____ Regular work schedule: _____

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 Employee ID #

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: (_____)_____

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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):

_____

_____

_____

_____

_____

_____

_____

_____

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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**

_____

Print Name

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ABX Air's Family Medical Leave Policy Outline

Family Medical Leave Act (FMLA) requires covered employers to provide up to twelve (12) weeks of unpaid, job protected leave during a rolling twelve (12) month period to "eligible" employees for certain family and medical reasons and up to twenty-six (26) weeks of leave in a single twelve (12) month period to "eligible" employees for a covered servicemember. Employees are eligible if they have been employed by ABX Air for at least one (1) year and have worked 1,250 hours over the previous twelve (12) months.

REASONS FOR TAKING LEAVE: Unpaid leave must be granted for any of the following reasons:

- 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, or parent due to his/her serious health condition.
- Because of a qualifying exigency arising out of the fact that your spouse, son or daughter, or 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, or next of kin of a covered servicemember with a serious injury or illness.

At the employee or employer's option, certain kinds of paid leave may be substituted for unpaid leave.

ADVANCE NOTICE AND CERTIFICATIONS: The employee may be required to provide advance leave notice and medical certification. Taking of leave may be denied if requirements are not met.

- The employee ordinarily must provide thirty (30) days advance notice when the leave is "foreseeable".
- Medical certification to support a request for leave because of a serious health condition is required within fifteen (15) calendar days of the Company's request.
- Certification to support a request for leave because of a qualifying military exigency is required within fifteen (15) calendar days of the Company's request.

JOB BENEFITS AND PROTECTION:

- For the duration of the FML, the employer must maintain the employee's health coverage under any "group health plan", provided employees pay their portion of the premium.
- You have a minimum 30-day 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.
- Upon return from FML, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.
- The use of FML cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

FML APPROVAL:

- FML is conditionally approved for eligible employees pending receipt of medical certification in accordance with the federal FMLA regulations. Failure to provide medical certification will cause the leave request to be denied or delayed and ABX Air's attendance policies will apply.

HOW TO REQUEST FML:

- FML is requested by completing the FML Request Form and submitting it to the address below.
  - If the leave is planned, thirty days notice should be given. If unforeseeable/unplanned (e.g., medical emergency), notice must be given as soon as possible.
- Forms are located at the Communications Centers, at www.myabx.com, or by contacting the HR Department.

USE OF VACATION/SICK TIME:

- Employees may elect to use earned vacation or sick leave for approved FML unless otherwise designated.
- For bonding with a child, the use of sick time is limited to two (2) weeks.
- For a qualified military exigency, paid time is limited to vacation or holiday pay.

INSURANCE PREMIUMS:

- Employees must pay their portion of any health or voluntary life insurance premiums.

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FAX: (937) 366-3116

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