Instructions For Steps in Processing FMLA Leave Requests

When an Ee calls in to report an absence that could be an FMLA qualifying event,

1. Supervisor fills out the Employee Report of Absence Due to Illness or Medical Treatment (AReport@)(See Forms) with a copy given to the FMLA Coordinator. Original attaches to HR 206 when it gets turned in.

2. FMLA Coordinator determines whether FMLA qualifying event is indicated potentially qualifying.

   A. If no, Report is kept in file for future reference PRN.

   B. If yes, FMLA Coordinator immediately determines FMLA eligibility
      (1) Prepares notification packet as to eligibility.
      NOTE: DO NOT USE FORM B ANY MORE - DISCONTINUE
      (2) Designates leave as potentially FMLA.
      (3) Attaches information, notices and forms.
      (4) Obtains required signatures.
      (5) Gets packet to Ee within two days of call from Ee.

3. FMLA Coordinators should keep track of and monitor the absences of all Ees that are on FMLA approved leaves on a potentially qualifying or ongoing basis. A calendar chart is recommended (to detect patterns of absences). New additions should be added to charting process as soon as feasible especially if chronic, intermittent or reduced leave required.

4. While waiting for the Form E Certification of Health Care Provider to be returned.

   A. Calendar the 15 days minimum notice. If returned, continue processing. Go to Step 5.

   B. If not returned timely, contact Ee to determine reason for failure to be timely.

      (1) If Ee lacked diligence, send notice that FMLeave not approved nor will it be until Form E is returned and approved.

      (2) If Ee was diligent but failure due to circumstances beyond Ee=s control, send notice that up to maximum of X days will be allowed (7 recommended) to get the completed Form E in before a determination is made.

5. Once you have received all the information needed to make a determination, complete Form G in detail as to what FMLeave is approved, if any. It is recommended that you document all your efforts and why on a separate sheet with sufficient information to be able to explain your decision should anyone question it

for any reason.

6. Before you make a final determination, at your option, it is recommended that you put together Forms D, E (HCP Certification) with the Report and any other relevant information (Forms F, I, K,) into a packet for a review by Legal Department together with a Cover sheet and/or completed Form G indicating the FMLA Coordinator=s recommendation for approval/disapproval or any other action to be taken or questions to be addressed. DO NOT SEND COPIES OF FORMS A, B, C, G, H, J, or L (to reduce paper).

   A. Send to the Legal Department (include contact name and information)to:
   Email: Constance.Acosta@cityofhouston.net
   Fax: 713-247-1017 ATTN: Connie Acosta
   Delivery: 3rd Floor City Hall Annex ATTN: Connie Acosta
   Phone Contact: 713-247-1485 direct if extenuating or other circumstances, questions, concerns, issues need to be discussed. Alternate contact: Ella West, Ast, 713-247-1508.

   B. The Legal Department expects to get back to you within 3 days. If you do not hear back or need a response or action quicker, please check to make sure the packet was received and the status of the response.

   C. The Legal Department will review the information and comment on the legality of the recommendation, request additional information, or suggest other alternative or supplemental actions such as recertification, second opinion, etc through the contact person identified.

      (1) Review comments will be returned by email and followed up with a hard copy.

      (2) If other actions are to be taken, the Legal Department will assist in identifying sources, contacts, and drafting appropriate notices to outside physicians, etc.

      (3) The Legal Department will keep an active file of open FMLA cases for reference throughout the benefit year.

7. If you approve/deny FMLeave, provide a copy of Form G to the Ee and the supervisor to use to complete the Report when the Ee calls in to request FMLeave during the remainder of the benefit year.

8. Always keep all FMLA documentation confidential in a permanent, separate file for each employee. The retention period is permanent.

FAMILY AND MEDICAL LEAVE
TRANSMITTAL MEMO

_____ _____/_____/_____ _____
Employee Name (first, mi, last) Social Security No. Employee No.

_____ _____/_____/_____
Department FMLA Representative Date

This correspondence is provided to inform you of your rights and responsibilities pursuant to the Family and Medical Leave Act (FMLA). In that regard, attached are the following as checked:

- ☐ Family & Medical Leave Transmittal Memo
- ☐ A. Notice to Employees of Rights Under FMLA
- ☐ B. Family and Medical Leave Request/Notice
- ☐ C. U.S. Department of Labor FMLA Fact Sheet #28: The Family and Medical Leave Act of 1993
- ☐ D. Notice to Employee of Responsibilities and Requirements of FMLA Leave, Form WH-381 Substitute
- ☐ E. Certification of Health Care Provider, U.S. Department of Labor Form WH-380
- ☐ F. Statement of Family Relationship
- ☐ G. Family and Medical Leave Determination
- ☐ H. Leave Authorization Request, Revised P.D. Form 206
- ☐ I. Employee Authorization for Clarification/Authentication of Medical Certification
- ☐ J. Fitness for Duty Certification
- ☐ K. Schedule for Reduced/Intermittent Leave
- ☐ L. Health Benefits Continuation

Only the documents that are (or may be) applicable at this time have been provided.

Please read these forms and documents carefully and follow the instructions. If you use leave pursuant to the FMLA, your appropriate accrued paid leave (vacation, sick, donated sick, and/or personal leave days granted under the City's Plan) shall be used concurrently with FMLA leave. Unpaid FMLA leave shall be used only after your applicable paid leave is exhausted.

If you have any questions regarding the Family and Medical Leave Act, please contact your Department FMLA representative.

I acknowledge receipt of noted document(s)

_____ _____
Employee's Signature Department FMLA Coordinator's Signature

cc: _____
Employee's Supervisor or Human Resources Liaison

CITY OF HOUSTON

Notice to Employees of Rights

YOUR RIGHTS UNDER THE FAMILY AND MEDICAL LEAVE ACT OF 1993

FMLA requires the City of Houston ("City") to provide up to 12 weeks of unpaid job-protected leave to "eligible" employees for certain family and medical reasons. Employees are eligible if they have worked for the City of Houston for at least 12 months, and have been physically at work for at least 1,250 hours over the previous 12 months. NOTE: Paid and/or unpaid leave is not counted for purposes of calculating the 1,250 hours required for eligibility.

REASONS FOR TAKING LEAVE

Unpaid leave must be granted for ANY of the following reasons:

- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

The City requires an employee to utilize all of his or her applicable accrued PAID leave concurrently with FMLA leave before using FMLA UNPAID leave.

ADVANCE NOTICE AND MEDICAL CERTIFICATION

The employee may be required to provide advance leave notice and medical certification. Leave may be denied if requirements are not met.

- The employee ordinarily must provide 30 days advance notice when the leave is "foreseeable".
- The City requires medical certification to support a request for leave because of serious health conditions and may require second or third opinions (at the City's expense) and a fitness for duty report to return to work.

JOB BENEFITS AND PROTECTION

- For the duration of FMLA leave, the City must maintain the employee's health coverage under any "group health plan" at the level and under the conditions coverage would have been provided if the employee had been continuously employed during the leave.
- Upon timely return from FMLA leave, employees generally must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.
- The use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

UNLAWFUL ACTS BY EMPLOYERS

FMLA makes it unlawful for an employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA.
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

ENFORCEMENT

- The use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

FMLA does not affect any Federal or State Law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FOR ADDITIONAL INFORMATION

Contact the nearest office of the Wage and Hour Division listed in most telephone directories under U.S. Government, Department of Labor. ***(U.S. Department of Labor, Employment Standards Administration, Wage and Hour Division, Washington, D.C. 20210).***

Form A

CITY OF HOUSTON - FAMILY AND MEDICAL LEAVE
REQUEST/NOTICE

_____ _____/_____/_____ _____
Employee Name (first, mi, last) Social Security No. Employee No.

_____ (_____) _____-_____
Home Address City State Zip Code Home Phone No.

(_____) _____-_____
Work Phone No.

☐ Form completed by employee.

☐ Form completed by supervisor based on information provided by employee. Describe circumstances and date information was provided_____.

A **"YES"** answer to any of the items in the chart below requires that the employer provide the employee with the following: (Employee's initials on line indicate receipt; supervisor's initials indicate distribution to the employee.)

☐ (1) A copy of the U.S. Department of Labor Highlights, FMLA Fact Sheet No. ESA 93-24
☐ (2) A completed Notice to Employee of Responsibilities and Requirements of FMLA Leave Form WH-381 Substitute, Dec 1994
☐ (3) Leave Authorization Request, Revised P.D. Form 206
(4) The following form(s), where applicable, are to be completed and returned to the supervisor:
☐ (a) Statement of Family Relationship Form, if the leave request pertains to the employee's spouse, child or parent.
☐ (b) Certification of Health Care Provider, Form WH-380 Substitute, Dec. 1994, if the leave request is for a serious health condition of the employee or an employee's covered family member.

Leave is due to the serious health condition of: **(Check One)** ☐ **Employee** ☐ **Child** ☐ **Spouse** ☐ **Parent**	***YES***	***NO***
1.) Does the condition arise from or require an overnight stay in a hospital, hospice, or residential medical care facility?		
2.) Does the condition make the person unable to work, attend school or perform other regular daily activities for more than 3 consecutive calendar days, and is the person receiving continuing treatment for the condition by or under the supervision of a health care provider during the leave period?		
3.) Is the absence because of an incapacity due to pregnancy or for prenatal care, and is the person receiving continuing treatment for the pregnancy or prenatal care from a health care provider?		
4.) Is this a chronic condition (for example, diabetes, asthma, epilepsy, etc.) for which the person is receiving continuing treatment from a health care provider?		
5.) Is this a permanent or long-term incapacity for which treatment may not be effective (for example, Alzheimer's, severe stroke or terminal stages of a disease) and the person is under the continuing supervision of a health care provider?		
6.) Is the absence needed to receive multiple treatments from, under the supervision of, or on referral by a health care provider, either for restorative surgery after an accident or 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 (for example, chemotherapy, radiation, dialysis)?		
7.) Leave is due to birth, placement or parenting. Check One: ☐ Birth and/or care of the child within 12 months of birth ☐ Adoption or foster care placement and/or care within 12 months of placement		

_____ _____/_____/_____ _____
Employee's Signature Date Department

_____ _____/_____/_____ _____
Supervisor or Designee Signature Date Department

U.S. Department of Labor

Employment Standards Administration
Wage and Hour Division

Fact Sheet #28: The Family and Medical Leave Act of 1993

THE FAMILY AND MEDICAL LEAVE ACT OF 1993

The U.S. Department of Labor's Employment Standards Administration, Wage and Hour Division, administers and enforces the Family and Medical Leave Act (FMLA) for all private, state and local government employees, and some federal employees. Most Federal and certain congressional employees are also covered by the law and are subject to the jurisdiction of the U.S. Office of Personnel Management or the Congress.

FMLA became effective on August 5, 1993, for most employers. If a collective bargaining agreement (CBA) was in effect on that date, FMLA became effective on the expiration date of the CBA or February 5, 1994, whichever was earlier. FMLA entitles eligible employees to take up to 12 weeks of unpaid, job-protected leave in a 12-month period for specified family and medical reasons. The employer may elect to use the calendar year, a fixed 12-month leave or fiscal year, or a 12-month period prior to or after the commencement of leave as the 12-month period.

The law contains provisions on employer coverage; employee eligibility for the law's benefits; entitlement to leave, maintenance of health benefits during leave, and job restoration after leave; notice and certification of the need for FMLA leave; and, protection for employees who request or take FMLA leave. The law also requires employers to keep certain records.

EMPLOYER COVERAGE

FMLA applies to all:

- public agencies, including state, local and federal employers, local education agencies (schools), **and**
- private-sector employers who employed 50 or more employees in 20 or more workweeks in the current or preceding calendar year **and** who are engaged in commerce or in any industry or activity affecting commerce — including joint employers and successors of covered employers.

EMPLOYEE ELIGIBILITY

To be eligible for FMLA benefits, an employee **must**:

1. work for a covered employer;
2. have worked for the employer for a total of 12 months*;
3. have worked at least 1,250 hours over the previous 12 months*; and
4. work at a location in the United States or in any territory or possession of the United States where at least 50 employees are employed by the employer within 75 miles.

* See special rules for returning reservists under USERRA.

LEAVE ENTITLEMENT

A covered employer must grant an eligible employee up to a total of 12 workweeks of **unpaid** leave during any 12-month period for one or more of the following reasons:

- for the birth and care of the newborn child of the employee;

- for placement with the employee of a son or daughter for adoption or foster care;
- to care for an immediate family member (spouse, child, or parent) with a serious health condition; **or**
- to take medical leave when the employee is unable to work because of a serious health condition.

Spouses employed by the same employer are jointly entitled to a **combined** total of 12 work-weeks 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 parent who has a serious health condition.

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

Under some circumstances, employees may take FMLA leave intermittently — which means taking leave in blocks of time, or by reducing their normal weekly or daily work schedule.

- If FMLA leave is for birth and care or placement for adoption or foster care, use of intermittent leave is subject to the employer's approval.
- FMLA leave may be taken intermittently whenever **medically necessary** to care for a seriously ill family member, or because the employee is seriously ill and unable to work.

Also, subject to certain conditions, employees **or** employers may choose to use accrued **paid** leave (such as sick or vacation leave) to cover some or all of the FMLA leave.

The employer is responsible for designating if an employee's use of paid leave counts as FMLA leave, based on information from the employee.

"**Serious health condition**" means an illness, injury, impairment, or physical or mental condition that involves either:

- any period of incapacity 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**
- Continuing treatment by a health care provider which includes any period of incapacity (i.e., inability to work, attend school or perform other regular daily activities) due to:

(1) A health condition (including treatment therefor, or recovery therefrom) lasting more than three consecutive 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; **or**
- one treatment by a health care provider with a continuing regimen of treatment; **or**

(2) Pregnancy or prenatal care. A visit to the health care provider is not necessary for each absence; **or**

(3) A chronic serious health condition which 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). A visit to a health care provider is not necessary for each absence; **or**

(4) A permanent or long-term condition for which treatment may not be effective (e.g., Alzheimer's, a severe stroke, terminal cancer). Only supervision by a health care provider is required, rather than active treatment; **or**

(5) Any 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).

"**Health care provider**" means:

- doctors of medicine or osteopathy authorized to practice medicine or surgery by the state in which the doctors practice; **or**
- 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**
- 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**
- Christian Science practitioners listed with the First Church of Christ, Scientist in Boston, Massachusetts; **or**
- Any health care provider recognized by the employer or the employer's group health plan benefits manager.

MAINTENANCE OF HEALTH BENEFITS

A covered employer is required to 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 need to be made for employees to pay their share of health insurance premiums while on leave.

In some instances, the employer may recover premiums it paid to maintain health coverage for an employee who fails to return to work from FMLA leave.

JOB RESTORATION

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.

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.

Under specified and limited circumstances where restoration to employment will cause substantial and grievous economic injury to its operations, an employer may refuse to reinstate certain highly-paid "**key**" employees after using FMLA leave during which health coverage was maintained. In order to do so, the employer must:

- notify the employee of his/her status as a "key" employee in response to the employee's notice of intent to take FMLA leave;
- notify the employee as soon as the employer decides it will deny job restoration, and explain the reasons for this decision;
- offer the employee a reasonable opportunity to return to work from FMLA leave after giving this notice; **and**
- make a final determination as to whether reinstatement will be denied at the end of the leave period if the employee then requests restoration.

A "**key**" employee is a salaried "eligible" employee who is among the highest paid ten percent of employees within 75 miles of the work site.

NOTICE AND CERTIFICATION

Employees seeking to use FMLA leave are required to provide 30-day advance notice of the need to take FMLA leave when the need is foreseeable and such notice is practicable.

Employers may also require employees to provide:

- medical certification supporting the need for leave due to a serious health condition affecting the employee or an immediate family member;
- second or third medical opinions (at the employer's expense) and periodic recertification; **and**

- periodic reports during FMLA leave regarding the employee's status and intent to return to work.

When intermittent leave is needed to care for an immediate family member or the employee's own illness, and is for planned medical treatment, the employee must try to schedule treatment so as not to unduly disrupt the employer's operation.

Covered employers must post a notice approved by the Secretary of Labor explaining rights and responsibilities under FMLA. An employer that willfully violates this posting requirement may be subject to a fine of up to $100 for each separate offense.

Also, covered employers must inform employees of their rights and responsibilities under FMLA, including giving specific written information on what is required of the employee and what might happen in certain circumstances, such as if the employee fails to return to work after FMLA leave.

UNLAWFUL ACTS

It is unlawful for any employer to interfere with, restrain, or deny the exercise of any right provided by FMLA. It is also unlawful for an employer to discharge or discriminate against any individual for opposing any practice, or because of involvement in any proceeding, related to FMLA.

ENFORCEMENT

The Wage and Hour Division investigates complaints. If violations cannot be satisfactorily resolved, the U.S. Department of Labor may bring action in court to compel compliance. Individuals may also bring a private civil action against an employer for violations.

OTHER PROVISIONS

Special rules apply to **employees of local education agencies**. Generally, these rules provide for FMLA leave to be taken in blocks of time when intermittent leave is needed or the leave is required near the end of a school term.

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. This special exception to the "salary basis" requirements for FLSA's exemption extends only to "eligible" employees' use of leave required by FMLA.

The FMLA does not affect any other federal or state law which prohibits discrimination, nor supersede any state or local law which provides greater family or medical leave protection. Nor does it affect an employer's obligation to provide greater leave rights under a collective bargaining agreement or employment benefit plan. The FMLA also encourages employers to provide more generous leave rights.

FURTHER INFORMATION

The final rule implementing FMLA is contained in the January 6, 1995, Federal Register. For more information, please contact the nearest office of the **Wage and Hour Division**, listed in most telephone directories under U.S. Government, Department of Labor.

U.S. Department of Labor
Frances Perkins Building
200 Constitution Avenue, NW
Washington, DC 20210

1-866-4-USWAGE, TTY: 1-877-889-5627
Contact Us

Employer Response to Employee
Request for Family or Medical Leave
(Optional Use Form -- See 29 CFR § 825.301)

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division

(Family and Medical Leave Act of 1993)

Date:

OMB No. : 1215-0181
Expires : 08-31-07

To: _____
(Employee's Name)

From: _____
(Name of Appropriate Employer Representative)

Subject: REQUEST FOR FAMILY/MEDICAL LEAVE

On _____ , you notified us of your need to take family/medical leave due to:
(Date)

O The birth of a child, or the placement of a child with you for adoption or foster care; or

O A serious health condition that makes you unable to perform the essential functions for your job: or

O A serious health condition affecting your O spouse, O child, O parent, for which you are needed to provide care.

You notified us that you need this leave beginning on _____ and that you expect
(Date)
leave to continue until on or about _____ .
(Date)

Except as explained below, you have a right under the FMLA for up to 12 weeks of unpaid leave in a 12-month period for the reasons listed above. Also, your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work, and 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 leave. 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; or (2) 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.

This is to inform you that: *(check appropriate boxes; explain where indicated)*

1. You are O eligible O not eligible for leave under the FMLA.

2. The requested leave O will O will not be counted against your annual FMLA leave entitlement.

3. You O will O will not be required to furnish medical certification of a serious health condition. If required, you must furnish certification by _____ *(insert date)* (must be at least 15 days after you are notified of this requirement), or we may delay the commencement of your leave until the certification is submitted.

4. You may elect to substitute accrued paid leave for unpaid FMLA leave. We O will O will not require that you substitute accrued paid leave for unpaid FMLA leave. If paid leave will be used, the following conditions will apply: *(Explain)*

5. (a) If you normally pay a portion of the premiums for your health insurance, these payments will continue during the period of FMLA leave. Arrangements for payment have been discussed with you, and it is agreed that you will make premium payments as follows: *(Set forth dates, e.g., the 10th of each month, or pay periods, etc. that specifically cover the agreement with the employee.)*

(b) 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. We O will O will not pay your share of health insurance premiums while you are on leave.

(c) We O will O will not do the same with other benefits (*e.g.*, life insurance, disability insurance, etc.) while you are on FMLA leave. If we do pay your premiums for other benefits, when you return from leave you O will O will not be expected to reimburse us for the payments made on your behalf.

6. You O will O will not be required to present a fitness-for-duty certificate prior to being restored to employment. If such certification is required but not received, your return to work may be delayed until certification is provided.

7. (a) You O are O are not a "key employee" as described in § 825.217 of the FMLA regulations. If you are 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 as discussed in § 825.218.

(b) We O have O have not determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic harm to *us. (Explain (a) and/or (b) below. See §825.219 of the FMLA regulations.)*

8. While on leave, you O will O will not be required to furnish us with periodic reports every _____ _____ *(indicate interval of periodic reports, as appropriate for the particular leave situation)* of your status and intent to return to work *(see § 825.309 of the FMLA regulations).* 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 O will O will not be required to notify us at least two work days prior to the date you intend to report to work.

9. You O will O will not be required to furnish recertification relating to a serious health condition. *(Explain below. if necessary, including the interval between certifications* as *prescribed in §825.308 of the FMLA regulations.)*

This optional use form may be used to satisfy mandatory employer requirements to provide employees taking FMLA leave with Written notice detailing spectfic expectations and obligations of the employee and explaining any consequences of a failure to meet these obligations. (29 CFR 825.301(b).)

Note: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

Public Burden Statement

We estimate that it will take an average of 5 minutes 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 of information, including suggestions for reducing this burden. send them to the Administrator, Wage and Hour Division, Department of Labor, Room S-3502. 200 Constitution Avenue, N.W., Washington. D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THE OFFICE SHOWN ABOVE.

Certification of Health Care Provider
(Family and Medical Leave Act of 1993)

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division

*(When completed, this form goes to the employee, **Not to the Department of Labor**.)*

OMB No.: 1215-0181
Expires: 08-31-2007

1. Employee's Name

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

3. Page 4 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.

(1)_____ (2) _____ (3) _____ (4)_____(5) _____ (6) _____ , or 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 these categories:

5. a. State the approximate **date** the condition commenced, and the probable duration of the condition (and also the probable duration of the patient's present **incapacity**[2] if different):

b. Will it be necessary for the employee to take 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** (condition #4) or **pregnancy**, state whether the patient is presently incapacitated[2] and the likely duration and frequency of **episodes of incapacity**[2]:

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

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

Form E

Form WH-380
Revised December 1999

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 estimated dates of treatment if known, and period required for recovery if any:

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?

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?

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

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

Type of Practice

Address

Telephone Number

Date

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

State 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 less than a full schedule:

Employee Signature

Date

Form E

A **"Serious Health Condition"** means an illness, injury impairment, or physical or mental condition that involves one of the following:

1. Hospital Care

   Inpatient care (*i.e.*, an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity[2] or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

   (a) A period of incapacity[2] of **more than three consecutive calendar days** (including any subsequent treatment or period of incapacity[2] relating to the same condition), that also involves:

   (1) **Treatment**[3] **two or more times** by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (*e.g.*, physical therapist) under orders of, or on referral by, a health care provider; or

   (2) **Treatment** by a health care provider on **at least one occasion** which results in a **regimen of continuing treatment**[4] under the supervision of the health care provider.

3. Pregnancy

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

4. Chronic Conditions Requiring Treatments

   A **chronic condition** which:

   (1) Requires **periodic visits** 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[2] (*e.g.*, asthma, diabetes, epilepsy, etc.).

5. Permanent/Long-term Conditions Requiring Supervision

   A period of **Incapacity**[2] 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, a severe stroke, or the terminal stages of a disease.

6. 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**[2] **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), and kidney disease (dialysis).

This optional form may be used by employees to satisfy a mandatory requirement to furnish a medical certification (when requested) from a health care provider, including second or third opinions and recertification (29 CFR 825.306).

Note: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

[3] 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.

[4] 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.

Public Burden Statement

We estimate that it will take an average of 20 minutes 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 of information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, Department of Labor, Room S-3502, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE; IT GOES TO THE EMPLOYEE. **Form E**

*U.S. GPO: 2000-461-954/25505

CITY OF HOUSTON - FAMILY AND MEDICAL LEAVE
STATEMENT OF FAMILY RELATIONSHIP

If you are requesting FMLA leave to care for a spouse, child or parent with a serious health condition, or for the birth, adoption or foster care placement of a child and/or to care for the child within 12 months of the birth or placement, you must complete the appropriate section of this form, sign and date on the reverse side, and submit the form to your supervisor. Pursuant to the Family and Medical Leave Act of 1993, the City may require supporting documentation.

_____ _____/_____/_____ _____
Employee Name (first, mi, last) Social Security No. Employee No.

_____ (____ _)_____-_____
Home Address City State Zip Code Home Phone No.

SPOUSE: A husband or wife as defined or recognized under state law. The State of Texas recognizes a common law marriage, but does not recognize a domestic partnership.

CHILD: A biological, adopted, or foster care son or daughter; a stepson or stepdaughter, a legal ward, or the son or daughter of an employee standing ***in loco parentis****, and who is either under age 18, or is age 18 or older and incapable of self-care because of mental or physical disability.

PARENT: A biological mother or father, or an individual who stands or stood ***in loco parentis**** to an employee when the employee was a child. The term does not include a parent-in-law.

* Persons who are ***in loco parentis*** include those with day-to-day responsibilities to care for and financially support a child, or, in the case of an employee, who had such responsibility for the employee when the employee was a child. A biological or legal relationship is not necessary.

Part I

☐ The employee's request for FMLA leave pertains to the employee's spouse. Complete (a) or (b).

(a) Spouse's Name (last, first, mi) _____
(b) If the relationship is by common-law marriage, read and complete the following statement.

I, the undersigned, am married, but the marriage exists without there having been a ceremonial marriage or recorded license. I understand that under the laws of Texas, such a marriage is valid only if (1) neither of us has a prior legal impediment or bar to marriage, such as a previous marriage which has not been terminated; (2) both of us do, in fact, intend to be husband and wife; (3) we have lived together as husband and wife; and, (4) we hold ourselves out to the public as husband and wife. The following information is given under oath:

Spouse's Name (last, first, mi) _____

Date when parties commenced a relationship as husband and wife _____/_____/_____.

List the names, addresses and telephone numbers of at least two persons who are unrelated to either you or your spouse and who will confirm that they consider you to be husband and wife. The City is authorized to contact the named persons for such confirmation.

_____ (_____)_____-_____
Name Address City State Zip Code Phone No.

_____ (_____)_____-_____
Name Address City State Zip Code Phone No.

Form F

Part II

☐ The employee's request for FMLA leave **(pertains to the employee's child)**. Complete (a) or (b).

(a) Child's Name (Last, First, MI) _____

Date of Birth: _____/_____/_____ Place of Birth: _____

(b) If the relationship with the person is ***in loco parentis***, read and complete the following statement:

I, the undersigned, have an ***in loco parentis*** relationship with the person named in **Part II** above.

Explanation of ***in loco parentis*** relationship: _____

_____

_____

_____

Part III

☐ The employee's request for FMLA leave pertains to the **(employee's parent)** (not parent-in-law). Complete (a) or (b).

(a) Parent's Name (last, first, mi) _____

(b) If the relationship with the person is ***in loco parentis***, read and complete the following statement:

I, the undersigned, have an ***in loco parentis*** relationship with the person named in **Part III** above.

Explanation of ***in loco parentis*** relationship: _____

_____

_____

_____

I certify that the information provided above is true and correct. I understand that if I provide false or misleading information, I may be denied FMLA leave and related benefits and receive discipline up to and including indefinite suspension.

_____ _____/_____/_____

Employee's Signature Date

Form F

CITY OF HOUSTON - FAMILY AND MEDICAL LEAVE DETERMINATION

_____ _____/_____/_____ _____

Employee Name (first, mi, last) Social Security No. Employee No.

You recently requested Family and Medical Leave or notified us of the need for such leave beginning on or about _____/_____/_____ due to:

☐ the birth of your child, or the placement of a child with you for adoption or foster care

☐ a serious health condition that makes you unable to perform the essential functions of your job

☐ a serious health condition affecting your ☐ ***spouse*** ☐ ***child*** ☐ ***parent*** for whom you are needed to provide care

This is to notify you that the Family and Medical Leave is:

☐ **APPROVED**

☐ **Delayed pending receipt of supporting documentation. Employee must submit the following by _____ (failure to timely submit requested documentation will result in continued delay of FMLA leave):**

- ☐ **Completed Certification of Health Care Provider, WH-380**
- ☐ **Completed Statement of Family Relationship Form**
- ☐ **Second medical opinion**
- ☐ **Third medical opinion**
- ☐ **Other, must specify _____**

☐ **DISAPPROVED DUE TO THE FOLLOWING:**

- ☐ **Ineligible employee**
- ☐ **Reason for leave is non-FMLA qualifying**
- ☐ **Exhausted FMLA leave for the current benefit year**
- ☐ **Other, must specify _____**

_____ _____/_____/_____

Department Coordinator (PRINT ONLY) Date

_____ _____/_____/_____

Department Coordinator's Signature Date

Form G

REVISED P.D. FORM 206
NOVEMBER 17, 1982

CITY OF HOUSTON
Leave Authorization Request

FORM DATA - FILL IN APPROPRIATE INFORMATION				
EMPLOYEE NAME	Last Name	First Name	Middle Initial	EMPLOYEE NUMBER
DEPARTMENT		DIVISION		
Public Works & Engineering				
DATE SUBMITTED	PREPARED BY	DATE OF LAST REQUEST		REASON
		———		———

ACTION DATA - FILL IN APPROPRIATE INFORMATION												
ACTION		BEGIN				END			NUMBER OF WORK DAYS			HRS
	VACATION								DAYS ———	HOLIDAY ———		
	⇒ **Leave pursuant to the Family and Medical Leave**											
	SICK LEAVE								———			
	SICK LEAVE EXTENSION								*SECT 12-169, PAR F.1 CIVIL SERVICE CODE OF ORDINANCE			
	ABSENT								———			
	FLOATING HOLIDAY								———			
	DEATH IN FAMILY								———			
	COMP. TIME								———			
	JURY DUTY								*ATTACH SUMMONS			
	MILITARY LEAVE								*ATTACH ORDERS			
	OTHER (EXPLAIN BELOW)								———			
⇒ **Leave pursuant to the Family and Medical Leave**												

SIGNATURE DATA - FILL IN APPROPRIATE INFORMATION			
EMPLOYEE ▶		DATE	
SUPERVISOR ▶		DATE	
APPROVING ▶		DATE	

*Supporting document(s) **must** accompany this form

TYPE OF ABSENCE—CHECK ONE: ☐ ***SCHEDULED*** ☐ ***UNSCHEDULED***

MEDICAL PROVIDED—CHECK ONE: ☐ ***YES*** ☐ ***NO***

OTHER NECESSARY DOCUMENTATION (JURY DUTY, FUNERAL, etc.) PROVIDED—CHECK ONE: ☐ ***YES*** ☐ ***NO***

Form H

CITY OF HOUSTON - FAMILY AND MEDICAL LEAVE
EMPLOYEE AUTHORIZATION FOR CLARIFICATION/AUTHENTICATION OF MEDICAL CERTIFICATION

I, _____, authorize the City of Houston's health care representative to communicate with the health care provider named below for purposes of clarifying and/or verifying the authenticity of the FMLA medical certification dated _____/_____/_____, as specifically authorized under § 825.307 (a) of the Department of Labor Final Rule on the Family and Medical Leave Act of 1993. I understand that no additional information other than that indicated on the medical certification will be requested by the City's health care representative or given by my health care provider, and that my health care provider will only clarify and/or authenticate the medical certification.

_____ _____/_____/_____
Employee's Signature Date

Health Care Provider's Name: _____
(Please Print)

Telephone Number: (_____)_____-_____

Fax Number: (_____)_____-_____

Form I

CITY OF HOUSTON - FAMILY AND MEDICAL LEAVE
FITNESS FOR DUTY CERTIFICATION

_____ _____/_____/_____ _____
Employee Name (first, mi, last) Social Security No. Employee No.

_____
Employee Address City State Zip Code

_____
Job Title

INSTRUCTIONS TO HEALTH CARE PROVIDER

The above individual desires to return to work after a Family and Medical Leave for his/her own serious health condition. Please complete and sign this form.

Is the employee ready to return to work duties?

CHECK ONE

☐ Regular duty with no restrictions _____/_____/_____
Return to work date

☐ Duty with the following restrictions

_____/_____/_____ until _____/_____/_____
Return to work date Date restrictions end

_____

_____

☐ No duty; the employee is not yet released to return to work.

_____ _____/_____/_____
Health Care Provider's Signature Date

_____
Health Care Provider's Name (please print)

_____
Health Care Provider's Area of Specialty

_____
Address City State Zip Code

(_____)_____-_____ (_____)_____-_____
Telephone Number Fax Number

Form J

CITY OF HOUSTON - FAMILY AND MEDICAL LEAVE
SCHEDULE FOR REDUCED/INTERMITTENT LEAVE

_____ _____/_____/_____ _____
Employee Name (first, mi, last) Social Security No. Employee No.

_____
Employee Address City State Zip Code

SECTION I - EMPLOYEE'S CURRENT SCHEDULE

SHIFT Begins _____ am/pm Off-days _____

Ends _____ am/pm _____

Describe in detail if non-standard shift:

_____

_____

SECTION I I - REDUCED/INTERMITTENT LEAVE SCHEDULE

NOTE: Attach a completed Certification of Health Care Provider, Form WH-380, explaining the medical necessity for the reduced schedule or intermittent leave.

The employee's current work schedule will be changed during the applicable FMLA period to a:

☐ Reduced leave schedule from _____/_____/_____ to _____/_____/_____. Describe schedule in detail:

_____

_____

☐ Intermittent leave schedule from _____/_____/_____ to _____/_____/_____. Describe schedule in detail, including hours/days during which FMLA leave will be utilized.

_____

_____

The employee and the Department have mutually agreed on Section II that allows reduced/intermittent leave during the applicable FMLA leave period.

_____ _____/_____/_____
Employee's Signature Date

_____ _____/_____/_____
Supervisor/Department Coordinator Signature Date

Form K

CITY OF HOUSTON - FAMILY AND MEDICAL LEAVE
HEALTH BENEFITS CONTINUATION BIWEEKLY PREMIUM SCHEDULE
(PRINT OR TYPE ONLY)

Name: _____ _____-_____-_____
Last First MI. Social Security Number

_____ (_____)_____-_____
Address City St. Zip Code Home Phone Number

_____ _____ _____/_____/_____
Employee Number Department Name Date of Last City Payroll Check Received

CONTINUED GROUP HEALTH PLAN INSURANCE COVERAGE

(Note: Workers' Compensation does not pay for benefits while an employee is out on injury.)

I acknowledge that while I am on FMLA, I am responsible for my share of the premium payment for my group health plan coverage and the premiums for continuation of any other benefit(s) I wish to maintain. I understand that failure to make this payment within thirty (30) days of the due date will result in termination of health plan and other coverage retroactive to the date for which my last premium was paid. If coverage is terminated due to non-payment or untimely premium payment, I understand that my health plan and other coverage will be restored without requalification upon my return to work and my completion of enrollment forms on the same terms as prior to my leave.

SECTION I - ELECTION

I am paying for the period of _____, and I agree to pay for my benefits below (check applicable boxes):

Please use chart on the reverse of this form to calculate your Basic Life Insurance Premium of one times your annual salary.

(BIWEEKLY PREMIUMS)	MEDICAL PREMIUM	DENTAL PREMIUM	BASIC LIFE PREMIUM	TOTAL PREMIUM
HEALTH MAINTENANCE ORGANIZATION				
Employee only	{___} $ 15.65	{___} $ 4.33 DMO		
(Medical Tobacco Rate)	{___} $ 28.15	{___} $ 12.50 INDEMNITY	$ _____	$ _____
Employee + One Dependent	{___} $ 86.00	{___} $ 9.32 DMO		
(Medical Tobacco Rate)	{___} $ 98.50	{___} $ 28.90 INDEMNITY	$ _____	$ _____
Employee + Two or More Dep.	{___} $ 105.59	{___} $ 13.20 DMO		
(Medical Tobacco Rate)	{___} $ 118.09	{___} $ 39.41 INDEMNITY	$ _____	$ _____
PREFERRED PROVIDER ORGANIZATION				
Employee only	{___} $ 92.77	{___} $ 4.33 DMO		
(Medical Tobacco Rate)	{___} $ 105.27	{___} $ 12.50 INDEMNITY	$ _____	$ _____
Employee + One Dependent	{___} $ 271.92	{___} $ 9.32 DMO		
(Medical Tobacco Rate)	{___} $ 284.42	{___} $ 28.90 INDEMNITY	$ _____	$ _____
Employee + Two or More Dep.	{___} $ 350.07	{___} $ 13.20 DMO		
(Medical Tobacco Rate)	{___} $ 362.57	{___} $ 39.41 INDEMNITY	$ _____	$ _____

Voluntary Life Insurance with Standard and/or Met Life should also be included in the total premium amount. Enter your biweekly premium here: Met Life $_____ Standard $ _____. (Premiums are located on your check stub.)

TOTAL AMOUNT ENCLOSED: $_____

SECTION II - ELECTION

☐ I elect **NOT** to continue my group health plan coverage or any other benefit coverage while on unpaid FMLA.

Premiums must be paid by **CASHIERS CHECK OR MONEY ORDER ONLY**. Payment will be made payable to: **City of Houston Health Benefits**. Premium payments must be in the **Human Resources Department, Benefits Division, LWOP Section, 611 Walker, 4th Fl., Houston, TX 77002,** by the first (1st) and fifteenth (15th) of the month. A copy of this form must be attached to your payment. (Monthly payments can also be made.)

I have reviewed and understand my responsibilities regarding my portion of the premium payments for group health plan insurance coverage and other benefits coverage while I am on Family Medical Leave.

Signature: _____ Date: _____/_____/_____

BASIC LIFE INSURANCE

FORMULA FOR CALCULATING BASIC LIFE PREMIUM

STEP 1.)

Enter your biweekly base pay and multiply it by twenty-six (26) to arrive at your annual salary. Take your annual salary amount and round it to the nearest thousand (example: Annual salary $22,550.55 = nearest thousand is $23,000). Divide nearest amount by one thousand to arrive at value amount (*).

_____	x 26 =	_____	=	_____	÷ 1,000 =	(*) _____
Biweekly Base Pay		1 Times Annual Salary		Round Salary to nearest Thousand		Value Amount

STEP 2.)

Carry value amount to this space (*) and multiply by sixteen cents (.16). This is your total monthly Basic Life Premium. Divide your total monthly basic life premium by two (2). This is your Basic Life Biweekly Premium. ***(Place this amount on Basic Life column on reverse side.)***

(*) _____	x .108 =	_____	÷ 2 =	_____
Value Amount		Total Monthly Basic Life Premium		Basic Life Biweekly Premium

Please carry Basic Life Biweekly Premium to the reverse side of this form for calculation with your other benefits.

<u>Other Benefits Coverage: AFLAC (American Family Life Assurance Company)</u>

Your AFLAC supplemental insurance policy (ies) may also be maintained by:

- Informing your Department that you wish to continue premiums for AFLAC.
- Making premium payments for each policy that you may have.
- Payments for AFLAC will be made along with your benefits payment.

Payments will be made payable to AFLAC by a separate money order or cashier check. One money order or cashier check may be used to pay for all AFLAC policies. Payments for AFLAC will be made with your medical, dental, and life insurance payment.

If you have questions or need any assistance regarding your benefits or calculating your premiums, please contact the Benefits Office at (713) 837-9400.

Form L