INSTRUCTIONS FOR REQUESTING FMLA LEAVE AND RETURNING TO WORK

TO REQUEST FMLA LEAVE OF ABSENCE:

1. Complete and sign the *Request for Family Medical Leave of Absence* form **(FORM 1)** and request that your Supervisor and Administrator sign and return to the City Clerk's Office/Human Resources.

2. Complete the top part of the *Certification of Healthcare Provider* form **(FORM 2)** and have your health care provider complete the balance of the form and return it to Human Resources within 15 calendar days. **A completed Medical Certification must be submitted prior to FMLA final approval. Please Note:** If this is a worker's compensation claim, your physician does not need to complete the Certification of Health Care Provider Form. Your time will automatically be designated as FMLA.

Once the request is completed and the Medical Certification is received by Human Resources, notice of approval or denial will be sent to you, your Supervisor and Administrator.

PRIOR TO YOUR RETURN WHEN LEAVE IS FOR OWN HEALTH CONDITION:

1. As an employee on FMLA leave due to your own serious health condition, your healthcare provider must release you to return to work. Please present the *Fitness for Duty to Return from Leave Certification* form **(FORM 3)** to your provider, along with your job description, and return the completed form to Human Resources. **We must receive this form prior to your return.**

2. If your provider indicates that you need to return in a modified or light duty capacity, the *Fitness for Duty to Return from Leave Certification* form **(FORM 3)** needs to be turned in prior to your return in order to determine if your department can accommodate any restrictions.*

3. If you are unable to return as originally scheduled, please contact Human Resources for information about the possibility of extending your leave of absence.

*Important: If your department is able to accommodate you and you return to work in a modified or light duty capacity, a new *Fitness for Duty to Return from Leave Certification* form **(FORM 3)** must be completed if:

- Your restrictions change at any time during your modified or light duty, or
- To release you to full, unrestricted duty.

Any additional questions can be directed to: Susan Duncan
City Clerk
685-2354
susanduncan@cityofferndale.org

REQUEST FOR FAMILY MEDICAL LEAVE OF ABSENCE – EMPLOYEE
FORM 1

Employees who have worked for the City of Ferndale for at least 12 months, including at least 1,250 hours during the 12-month period immediately before the request for leave, are eligible for leave. FMLA provides for twelve total weeks of protected leave. In cases of intermittent leave, regular full-time employees receive a total of 480 hours. The hourly conversion for Police may be different depending on the actual shift schedule worked. Please contact Human Resources for clarification.

Name:		Employee Number:
Address:	City:	Zip:
Department:	Hire Date:	

FMLA reason for requesting leave (check one):

_____ The birth of a 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 for your job.
_____ Workers' Compensation injury/illness – Contact Human Resources.

Date leave is to start: _____/_____/_____Date I expect to return to work:_____/_____/_____

Type of Leave Requested:	Continuous Leave	Intermittent Leave

I understand that benefits will continue during any approved FMLA leave. If I 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 me to additional leave; or (2) other circumstances beyond my control, I may be required to reimburse the City for the City's share of health insurance premiums paid on my behalf during my FMLA leave. I understand that it is my responsibility to pay my portion of applicable health benefits to continue healthcare coverage. Failure to pay my applicable portion of any of the health premium will result in loss of coverage and the City's obligation to maintain such coverage ceases under FMLA when my premium becomes delinquent.

A *Fitness for Duty to Return from Leave Certification* form signed by your health care provider will be <u>required</u> prior to return from leave unless you are out five or fewer consecutive days, or when FMLA is required for a family member.

Please sign below and have your supervisor and department administrator sign then return to Human Resources.

Employee Signature _____ Date _____

Supervisor's Signature _____ Date _____

Administrator's Signature _____ Date _____

HR Representative _____ Date _____

FMLA LEAVE REQUEST – CERTIFICATION OF HEALTHCARE PROVIDER
EMPLOYEE REQUEST
FORM 2

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1. TO BE COMPLETED BY **EMPLOYEE**

Employee Name:	
Department:	Division:
Employee Signature:	Date:

2. TO BE COMPLETED BY **HEALTHCARE PROVIDER**

Designation of Serious Health Condition

Indicate "yes" or "no" as to whether a serious health condition exists for the above named employee.

☐ Yes ☐ No

Under FMLA a "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves one or more of the categories below. Does the employee's condition qualify under any of the categories described? (See definitions on page 3.) If so, please check the applicable category.

☐ (1) Hospital Care *(inpatient)*

☐ (2) Absence Plus Treatment *(Patient is unable to work or perform other regular daily activities for more than three consecutive calendar days and needs treatment)*

☐ (3) Pregnancy

☐ (4) Chronic Serious Health Condition *(i.e. asthma, diabetes, epilepsy, etc.)*

☐ (5) Permanent/Long-term Condition Requiring Supervision

(i.e., Alzheimer's, severe stroke, terminal stages of disease)

☐ (6) Multiple Treatments *(i.e., cancer, severe arthritis, therapy, dialysis, etc.)*

☐ **Not a serious health condition**

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.

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

___Patient ☐ *is* ☐ *is not* presently incapacitated. *(check one)*

___**Duration** of episodes of incapacity = _____*(hours or days, etc.)*

___**Frequency** of episodes of incapacity = _____*(number of times per week or month, etc.)*

Continued on Back

Duration of Incapacity and Treatments	
Approximate date condition began:	Probable duration of condition:

Schedule of Treatment

Please state the nature of the treatment and period of time covered:

_____

_____

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

_____

_____

By other provider of health services:

_____

_____

Employee Work Status

Due to the medical conditions identified, it is medically necessary for employee to:

☐ Take a consecutive leave starting on:_____and returning to work on:_____

☐ Take intermittent leave according to the following schedule:

_____

_____

☐ Work less than employee's normal schedule of hours per day or days per week according to the following schedule:

_____

☐ Yes	☐ No	During the period of incapacity, is the employee able to perform work of any kind?
☐ Yes	☐ No	Is the employee able to perform the essential functions of the employee's position? *(Answer after reviewing job description describing essential functions of the employee's position, or, if none provided, after discussing with employee.)* If yes, elaborate:

Physician Information	
Name of Health Care Provider (please print)	Type of Practice
Signature of Health Care Provider	Date
Address	Telephone Number

Please Return to:

City of Ferndale - Human Resources
P.O. Box 936
Ferndale, WA 98248
360-384-1163 (Fax)

Description of Serious Health Condition

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 of or subsequent treatment in connection with, or consequent to such inpatient care.

2. Absence Plus Treatment

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

a) Treatment 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

b) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment 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:

a) 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;

b) Continues over an extended period of time (including recurring episodes of a single underlying condition); and

c) May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

5. Permanent/Long-term Conditions Requiring Supervision

A period of incapacity, 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 states 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 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).

Definitions: **Incapacity** for purposes of FMLA is defined to mean inability to work, attend school or perform other regular activities due to the serious health condition. **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. 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.

FITNESS FOR DUTY TO RETURN FROM LEAVE CERTIFICATION

FORM 3

City of Ferndale Employee: As an employee on Family and Medical Leave due to your own serious medical condition, your healthcare provider must release you to return to work. Please present this form along with your job description to have your provider complete this form. Submit completed form to Human Resources prior to your return.

Supervisor: If this form is turned in to you, please return completed Fitness for Duty form to Human Resources.

A EMPLOYEE INFORMATION

Employee Name: _____

Employee's Job Title: _____

Date Leave Began: _____

B HEALTH CARE PROVIDER

As a condition of return to work, the employee is required to have a medical examination. This form should be completed by you, as his/her health care provider, before the employee is allowed to resume his/her job duties.

1. Date of medical examination: _____
2. Date employee may return from leave: _____
3. Please indicate with a check mark the status of the employee's release for duty

   ☐ Full, unrestricted duty. (Skip question 4 and proceed to Section C)

   ☐ Modified duty (Complete question 4)

   ☐ Not released for any type of duty (Go to Section C)

4. If you are releasing the employee to modified duty, please complete the following:
   a. Estimated date that employee will be able to return to full, unrestricted duty:

   _____

   b. Date of your next medical evaluation of the employee:

   _____

This is a 2-sided document.

Please be sure to indicate the exact work restrictions that will apply to the employee at this time on the chart on the back of this form.

C	MODIFIED WORK DUTY			
Indicate the exact work restrictions which apply to the employee at this time on the chart below:				
PHYSICAL LIMITATIONS		**FULL RESTRICTIONS**	**PARTIAL RESTRICTIONS**	**NO RESTRICTIONS**
Sedentary-Lifting 0 to 10 pounds				
Light-Lifting 10 to 20 pounds				
Moderate-Lifting 20 to 50 pounds				
Heavy-Lifting 50 to 100 pounds				
Pulling/Pushing, carrying				
Reaching or working above shoulder				
Walking	hours			
Standing	hours			
Sitting	hours			
Stooping	hours			
Kneeling	hours			
Repeated bending	hours			
Climbing	hours			
Operating a motor vehicle, crane, tractor, etc.				
Exposure Limitations (Specify)				
Number of hours able to work per day				

CERTIFICATION

I hereby certify that the foregoing facts are true and correct and executed under penalty of perjury in

_____, Washington, this_____day

of_____, 20___.

_____ _____

Signature of Treating Physician or Practitioner Date

_____ _____

Print Name of Treating Physician or Practitioner Phone Number