

**FAMILY MEMBER VERSION**

**REQUEST FOR FAMILY MEDICAL LEAVE OF ABSENCE**

**Instructions to Employee:** Complete this form and request that your Supervisor and Administrator sign and return to the City Clerk's Office/Human Resources. Complete the top part of the Certification of Health Care Provider Form and ensure that your health care provider completes the balance of the form and returns it to the City Clerk's Office/Human Resources within 15 calendar days.

Employee's Name \_\_\_\_\_

Home Address \_\_\_\_\_

Employee Number \_\_\_\_\_ Department \_\_\_\_\_ Hire Date \_\_\_\_\_

Employees who have worked for the City of Ferndale at least 1,250 hours during the 12-month period immediately before the request for leave are eligible for leave. **A completed Medical Certification must be submitted to Human Resources prior to FMLA final approval.**

**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; or

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

Because of a qualifying exigency out of the fact that your spouse, child, or parent is on active duty status in support of contingency operation as a member of the National Guard or Reserves.

Because you are the spouse, child, parent, or next of kin of a covered servicemember with a serious injury or illness.

Date leave is to start: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date I expect to return to work \_\_\_\_/\_\_\_\_/\_\_\_\_

Type of Leave Requested:	Continuous Leave	Intermittent Leave
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I understand that healthcare benefits will continue during any approved FMLA leave. Health benefits must be maintained during any period of unpaid leave under the same conditions as if I continued to work. 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 FMLA 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. I understand that I may elect to continue life insurance and/or long-term disability coverage by paying the applicable monthly premium to the City during an unpaid leave.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

Supervisor's Signature \_\_\_\_\_ Date \_\_\_\_\_

Administrator's Signature \_\_\_\_\_ Date \_\_\_\_\_

HR Representative \_\_\_\_\_ Date \_\_\_\_\_

Approved \_\_\_\_\_

Denied \_\_\_\_\_

## **Family and Medical Leave Act (FMLA)**

The City of Ferndale will comply with all applicable requirements of the Family and Medical Leave Act (FMLA). The FMLA requires private employers with 50 or more employees and all public agencies, including state, local, and federal employers, and local education agencies (schools), to provide eligible employees up to 12 weeks of unpaid, job-protected leave in any 12-month period for certain family and medical reasons. The twelve (12) month period for determining leave entitlement is calculated from the first day of FMLA leave rolling forward twelve (12) months.

### **Employee Eligibility**

The FMLA defines eligible employees as employees who: (1) have worked for the City of Ferndale for at least 12 months; (2) have worked for the City of Ferndale for at least 1,250 hours in the previous 12 months; and (3) work at or report to a work site which has 50 or more employees or is within 75 miles of work sites that taken together have a total of 50 or more employees. Statutory maternity-related disability leave is not included in determining the amount of leave available under this policy.

### **Leave Entitlement**

Eligible employees may take leave for the following reasons:

- (1) to care for the employee's child upon birth or to care for a child upon the child's placement with the employee for adoption or foster care;
- (2) to care for a parent, spouse, or child with a serious or terminal health condition; or
- (3) when the employee is unable to work because of the employee's own serious health condition;
- (4) for periods of work-related injury or illness covered by worker's compensation;
- (5) for any "qualifying exigency", as defined by the United States Secretary of Labor, arising when the spouse, child, or parent of the employee is called to active duty or is on active duty;
- (6) to care for a service member who is a spouse, child, parent, or "next of kin" and who has suffered a serious injury or illness while on active duty. Eligible employees are eligible for up to twenty-six (26) workweeks of unpaid leave during a single 12-month period.

### **Serious health condition**

An employee who elects to take leave to care for a child, parent or spouse who has a serious health condition, or to attend to a personal serious health condition, will be required to take FMLA leave.

According to the FMLA, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves: (1) inpatient care (i.e., an overnight stay), including any period of incapacity or any subsequent treatment in connection with the inpatient care; or (2) "continuing treatment" by a health care provider. For further information on what is considered "continuing treatment," contact the City Clerk's Office/Human Resources.

Spouses employed by the same employer are jointly entitled to a combined leave of 12 workweeks of family leave to care for a parent who has a serious health condition. However, each spouse may take up to 12 workweeks of leave to care for a child or spouse with a serious health condition.

### **Birth, adoption, or foster care of children**

FMLA leave for birth or placement for adoption or foster care must conclude within 12 months of the birth or placement. In addition, spouses employed by the same employer are jointly entitled to a combined leave of 12 workweeks of family leave for the birth or placement of a child for adoption or foster care.

Leave due to maternity disability prior to or immediately following giving birth will not be counted toward the employee's annual FMLA entitlement but will count as Washington State medical disability leave.

### **Military caregiver leave**

An eligible employee who is the spouse, son, daughter, parent or next of kin of a covered service member who is recovering from a serious illness or injury sustained in the line of duty on active duty is entitled to up to 26 weeks of leave in a single 12-month period to care for the service member.

A recovering service member is defined as a member of the Armed Forces who suffered an injury or illness while on active duty that may render the person unable to perform the duties of the member's office, grade, rank or rating.

### **Active duty leave**

An eligible employee may take up to 12 weeks of leave because of "any qualifying exigency" arising out of the fact that the spouse, son, daughter, or parent of the employee is on active duty, or has been notified of an impending call to active duty status, in support of a contingency operation.

### **Intermittent or reduced work schedule leave**

In certain circumstances, eligible employees may take FMLA leave intermittently (for example, in blocks of time) or by reducing their work schedule. If FMLA leave is to care for a child after the birth or placement for adoption or foster care, employees may take their FMLA leave intermittently or on a reduced work schedule only with the City of Ferndale's permission. If the FMLA leave is because of the employee's serious illness or to care for a seriously ill family member, the employee may take the leave intermittently or on a reduced work schedule if it is medically necessary.

Following approval of intermittent leave by Human Resources, the employee must attempt to schedule his/her intermittent leave without disrupting the City's operations. The schedule must be coordinated with his/her Department Head or designee.

### **Notice and Certification**

Employees who want to take FMLA leave ordinarily must provide the City of Ferndale at least 30 days notice of the need for leave, if the need for leave is foreseeable. If the employee's need is not foreseeable, the employee should give as much notice as is practicable. When leave is needed to care for an immediate family member or for the employee's own illness and is for planned medical treatment, the employee must try to schedule treatment in order to prevent disruptions of the City of Ferndale's operations.

The request should be submitted to the Human Resources Department and the employee's immediate supervisor on the Request for Family Medical Leave Form.

In addition, employees who need leave for their own or a family member's serious health condition must provide medical certification from a health care provider of the serious health condition. The City of Ferndale also may require a second or third opinion (at the City of Ferndale's expense), periodic re-certifications of the serious health condition, and, when the leave is a result of the employee's own serious health condition, a fitness for duty report to

return to work.

The City of Ferndale may delay leave to employees who do not provide proper advance notice of the foreseeable need for leave. The City of Ferndale also may delay or deny approval of leave for lack of proper medical certification. Medical certification must include the following information:

- (1) The date on which the serious medical condition began; and
- (2) The probable duration of the condition; and
- (3) The physician's certification that the employee meets the definition of a serious health condition; and
- (4) That the employee is unable to work or perform the requirements of the job; or
- (5) That the employee is needed to care for a child, parent or spouse who meets the definition of a serious health condition including as estimate of the amount of time care is required; and
- (6) The dates on which medical treatment is expected to be given and the duration of treatment when applicable.

### **Benefits during FMLA Leave**

Employees taking leave under the FMLA are entitled to receive health benefits during the leave at the same level and terms of coverage as if they had been working throughout the leave. If applicable, arrangements will be made for employees to pay their share of health insurance premiums while on leave.

If an employee chooses not to return to work from FMLA leave, the City of Ferndale may be entitled to recover premiums it paid to maintain health coverage during the leave. If the employee does not return at the end of the FMLA period, his or her failure to return will be the COBRA qualifying event.

The employee's use of FMLA leave will not result in the loss of any employment benefit that accrued prior to the start of the employee's leave. However, the employee must use any accrued paid sick leave during an unpaid FMLA leave taken because of the employee's own serious health condition or the serious health condition of a family member. The employee may use paid sick leave during FMLA leave taken to care for a newborn or newly placed child as discussed in Absence policy.

An employee is not entitled to seniority, holiday, vacation, personal or sick leave accruals during the period of unpaid leave unless an employee has been in a paid status for at least half of his or her scheduled hours in any pay period.

Employees may elect to continue additional life insurance and/or long-term disability coverage by paying the applicable monthly premiums to the City during an unpaid leave. Coverage ceases under FMLA when an employee's premium payment becomes delinquent.

### **Job Restoration after FMLA Leave**

A Fitness for Duty certificate signed by the consulting physician will be required prior to return from leave, unless 1) the employee is out for five or fewer consecutive days, or 2) when FMLA is required for a family member. The employee's practitioner shall complete the City's Fitness for Duty/Physician Or Practitioner Certification, and forward it to the Human Resources Department.

The City of Ferndale will reinstate an employee returning from FMLA leave to the same or equivalent position with equivalent pay, benefits, and other employment terms and conditions. However, an employee on FMLA leave does not have any greater right to reinstatement or to other benefits and conditions of employment than if the employee had been continuously employed during the FMLA leave period.

Except as otherwise provided by the applicable collective bargaining agreement, reinstatement is not available under the following conditions:

- 1) The employee takes another job while on leave;
- 2) The position was eliminated by a bona fide restructuring or RIF (reduction in force);
- 3) The employee fails to return from the FMLA leave at the authorized FMLA ending date without prior written approval;
- 4) Except for Worker's Compensation injuries or illnesses, if the leave continues beyond the 12-week period, reinstatement rights are at the discretion of the City.

### **Other Provisions**

The FMLA does not affect any federal or state law prohibiting discrimination, or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

Under an exception to the Fair Labor Standards Act in the FMLA regulations, hourly amounts may be deducted for unpaid leave from the salary of executive, administrative, and professional employees who are exempt from the minimum wage and overtime requirements of the Fair Labor Standards Act, and records of leave may be kept for those employees, without affecting the employee's exempt status. This special exception to the "salary basis" requirements for the FLSA's exemptions extends only to eligible employees' use of leave required by the FMLA.

### **Further Information**

For more information, employees may contact the City Clerk's Office/Human Resources

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

**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
<p>Indicate “yes” or “no” as to whether a serious health condition exists for the above named employee.</p> <p style="text-align: center;"> <input type="checkbox"/> Yes                      <input type="checkbox"/> No         </p> <p>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.</p> <p><input type="checkbox"/> (1) Hospital Care (<i>inpatient</i>)</p> <p><input type="checkbox"/> (2) Absence Plus Treatment (<i>Patient is unable to work or perform other regular daily activities for more than three consecutive calendar days and needs treatment</i>)</p> <p><input type="checkbox"/> (3) Pregnancy</p> <p><input type="checkbox"/> (4) Chronic Serious Health Condition (<i>i.e. asthma, diabetes, epilepsy, etc.</i>)</p> <p><input type="checkbox"/> (5) Permanent/Long-term Condition Requiring Supervision <i>(i.e., Alzheimer’s, severe stroke, terminal stages of disease)</i></p> <p><input type="checkbox"/> (6) Multiple Treatments (<i>i.e., cancer, severe arthritis, therapy, dialysis, etc.</i>)</p> <p><input type="checkbox"/> <b>Not a serious health condition</b></p>
<p>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.</p>   
<p>If condition is a “<b>chronic condition</b>” or <b>pregnancy</b>, state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity:</p> <p>___ Patient    <input type="checkbox"/> <i>is</i>    <input type="checkbox"/> <i>is not</i> presently incapacitated. (<i>check one</i>)</p> <p>___ <b>Duration</b> of episodes of incapacity = _____ (<i>hours or days, etc.</i>)</p> <p>___ <b>Frequency</b> of episodes of incapacity = _____ (<i>number of times per week or month, etc.</i>)</p>

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**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:

\_\_\_\_\_

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