PINAL COUNTY POLICY AND PROCEDURE **7.40**

Subject: **FAMILY AND MEDICAL LEAVE**

Date: **October 18, 2012**

Pages: 1 of 10

Replaces Policy Dated: June 24, 2009

PURPOSE: To establish the means by which an employee may request a leave of absence under the provisions of the Family and Medical Leave Act ("FMLA"), and to identify the procedure for all Pinal County employees and Appointing Authorities to follow with respect to the approval and documentation of leaves of absence under FMLA.

STATEMENT OF POLICY: It is the policy of Pinal County to comply with the provisions of the Family Medical Leave Act of 1993 (29 U.S.C. § 2601 *et seq.*, 29 CFR § 825 *et seq.*) and the subsequent revisions (effective January 2009) and to provide eligible employees up to 12 weeks of leave (480 work hours), based on the employee's normally scheduled workweek, within a 12 month period for certain family, medical and military reasons and provide up to a total of 26 workweeks (1040 work hours) of leave during a 12 month period for certain family members or next of kin to care for a covered service member who suffered a serious injury or illness while on active military duty.

SCOPE: The following policy and procedure**s** shall apply to all Pinal County employees, including temporary employees and employees of elected officials**,** provided the employee has worked for Pinal County for at least 12 months, whether or not such time is continuous, and who has not had a continuous break in service of more than seven (7) years. At the time the leave is scheduled to begin, the employee must have worked a minimum of 1,250 hours during the 12 months preceding the date for the requested leave. When calculating the 1,250 hour requirement, the number of hours worked does not include vacation, sick leave, holidays, compensatory time off, any unpaid leave hours or layoff periods. Overtime, holiday hours worked and military hours worked are to be included in the calculation of work hours. In calculating the 12 month period, all employment prior to a continuous break in service of seven (7) years or more need not be counted. The determining factor is whether the time is considered work hours under the federal Fair Labor Standards Act ("FLSA" 29 CFR § 785).

DEFINITIONS:

CHILD, SON, and/or DAUGHTER refer to biological, adopted, or foster child, stepchild, legal ward, or child for whom an employee stands in *loco parentis* (commonly refers to a relationship in which a person has put him or herself in the situation of a parent by assuming and discharging the obligations of a parent to a child with whom he or she has no legal or biological connection) provided such child is either under age eighteen (18) or over age eighteen (18) if the child is incapable for self-care due to a mental or physical disability.

SPOUSE is defined in accordance with applicable state laws for the purpose of marriage, including common law marriage where recognized. Domestic partners and fiancés are not considered spouses.

PARENT means a biological or legally adoptive parent or an individual who stands, or stood, in *loco parentis* to an employee when the employee was a child. This term does not include parents of an employee's spouse (e.g. "in-law")

QUALIFIED HEALTH CARE PROVIDER refers to a doctor of medicine or osteopathy authorized to practice medicine or surgery (as appropriate) by the State in which the qualified health care provider practices. Other qualified health care providers may include dentists, podiatrists, nurses, psychologists, and other providers, as listed in the applicable FMLA regulations.

SERIOUS HEALTH CONDITION means an illness, injury, impairment, or physical or mental condition that involves inpatient care in a hospital, hospice, or residential medical care facility or continuing treatment by a health care provider.

NORMAL WORK SCHEDULE refers to the employee's normal work schedule at the time FMLA leave is requested, per Pinal County Policy 3.50 (as it now exists or as it may be subsequently amended).

CONTINUOUS LEAVE refers to work hours taken consecutively, or as a single block of time. For example, multiple uninterrupted, consecutive days off of work for a period lasting several days to the full 12 week (480 hour) entitlement.

INTERMITTENT LEAVE is taken when medically necessary and in separate blocks of time and may include leave periods for as short as a portion of one hour to more than several weeks. Examples of intermittent leave include leave taken on an occasional basis for medical appointments or leave taken several days at a time over a period of six months, such as for chemotherapy or a condition flare-up.

REDUCED LEAVE SCHEDULE is taken when medically necessary and is a leave schedule that reduces the usual number of hours per workweek or per workday of an employee.

HOSPITALIZATION and/or INPATIENT CARE requiring admission for an overnight stay in a hospital, hospice or residential medical care facility. It does not include visits to an emergency room (without hospital admission), urgent care or other similar clinics.

I. **TYPES OF PERMISSIBLE FMLA LEAVE:** An eligible employee shall request FMLA Leave for one or more of the following reasons:

A. Family Leave: The birth of a child and to care for the newborn child following the birth; or, the placement of a child with the employee through adoption or foster care. **Note:** the FMLA requires that Family Leave following the birth or placement of a child must be completed within 12 months after the date of the birth or placement of the child.

B. Medical Leave: To care for a Spouse, biological Parent (or an individual who stands, or stood, *in loco parentis)*, or a Son or Daughter *of the employee*, who has a Serious Health Condition.

C: Employee's Serious Health Condition: A health condition where the employee is unable to perform his/her essential job duties.

D. Military Caregiver Leave: An eligible employee who is the spouse, son, daughter, parent, or next of kin of a covered service member may take up to 26 workweeks of leave in a "single 12 month period" to care for the service member with a serious illness or injury incurred while on active military duty.

E. Qualifying Exigency Leave: An employee may take up to 12 workweeks of FMLA to handle certain non-medical exigencies arising from the fact that the employee's spouse, son, daughter, or parent in the National Guard or Air Force, Army, Navy, or Marine Reserve is on active duty or called to active duty status. There are eight qualifying exigencies that merit this type of leave:

(1) short-notice deployment;
(2) military events and related activities;
(3) childcare and school activities;
(4) financial and legal arrangements;
(5) counseling;
(6) rest and recuperation;
(7) post-deployment activities; or,
(8) additional activities not encompassed in the previous categories arising out of the covered military member's active duty, or call to active duty status, to which the employee and County agree.

II. **CALCULATION OF LEAVE:**

A. CALCULATION: An employee shall be allotted up to 12 weeks of unpaid leave for an FMLA-qualifying reason within a specified 12-month period of time (or 26 workweeks under Military Caregiver Leave). The specified 12-month period is determined on a rolling calendar year basis. To calculate the specified 12-month

period, the Appointing Authority must determine whether the employee has used any FMLA-approved leave during the preceding 12 months. If the employee has previously used some, but not all, of the 12-week allotment, the employee may be permitted to use the remainder of the allotment; however, the employee will only be permitted to use the allotment as long as the FMLA qualifying reason exists. (EXAMPLE: A covered employee requests 12 weeks of FMLA leave to begin June 1, 2012 for a permissible Medical Leave reason. The employee previously used six weeks of approved FMLA leave from July 11, 2011 through August 19, 2011 for a permissible Family Leave reason. Thus, the employee has six weeks of FMLA allotment remaining because the approved Family Leave used during the preceding 12 months counted towards the employee's FMLA allotment, however, the employee may utilize the remaining six-week allotment provided the new Medical Leave reason falls within FMLA qualifications.)

EXCEPTION: The only exception to the above is if both spouses are employed by Pinal County, the 12 weeks of "Family" Leave is limited to a combined total (between the spouses) of 12 weeks during the 12 months following the birth or placement of a child.

B. SICK LEAVE: Sick leave, in excess of three consecutive working days, will first be considered as time counted toward Family Medical Leave (FMLA). If the employee's return to work date is unknown and/or is not imminent, the employee is required to furnish written physician verification of illness in accordance with the provisions of FMLA. Human Resources will provide provisional acceptance of FMLA, pending receipt of the required Certification of Health Care Provider form.

Upon receipt of the required form, Human Resources will determine whether the illness/reason meets the FMLA requirements. Human Resources will notify the employee's supervisor. The supervisor is then required to determine whether the employee previously used portions of his/her FMLA entitlement. If hours were used as FMLA, the supervisor is to notify Human Resources of the employee's hours remaining under the FMLA entitlement. The employee will be notified in writing of remaining time he/she is entitled to by the supervisor.

In the event the illness/reason does not meet FMLA requirements, the time used will be considered as sick leave.

III. "**SERIOUS HEALTH CONDITION":** A "serious health condition" is defined as an illness, injury, impairment, or physical or mental condition involving one or more of the following conditions:

A. Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with, or consequent to, the inpatient care;

B. 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 either:

(1) treatment by a health care provider, a nurse or physician's assistant under the direct supervision of a health care provider, or a provider of health care services (e.g., a physical therapist) under orders of, or referral by, a care provider two or more times within 30 days with the first visit occurring within seven days;
or
(2) treatment by a health care provider on at least one occasion resulting in a regime of continuing treatment under the supervision of the health care provider;

C. Any period of incapacity due to pregnancy and pre-natal care;

D. Chronic conditions resulting in a period of incapacity or treatment for incapacity which requires:

(1) periodic visits (minimum of twice per year) for treatment by a health care provider, or a nurse, or physician's assistant under the 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 (e.g. asthma, diabetes, epilepsy, etc.)

E. Permanent or long-term condition: 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, severe stroke, or terminal stages of a disease.

F. Conditions requiring multiple treatments: Any period of absence to receive multiple treatments (including any necessary recovery period) by a health care provider or by a provider of health care services under the orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, a condition likely resulting 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).

G. Absences attributable to incapacity under paragraph (C) or (D) of this section qualify for FMLA leave even though the employee or the covered family member does not receive treatment from a health care provider during the absence, and even if the absence does not last more than three consecutive, full calendar days.

IV. **EMPLOYEE REQUESTS FOR FMLA LEAVE:** A leave of absence shall be counted toward an employee's FMLA allotment even if he or she does not specifically request FMLA leave, so long as the illness/reason for the leave qualifies under FMLA and the leave is properly documented by the supervisor.

A. Although the employee normally requests FMLA leave, Pinal County may be put on notice that the employee may need to be placed on FMLA leave due to attendance patterns:

1. Supervisors should be on notice when recurring absences or tardiness occur, especially if an employee has been absent longer than three consecutive business days;
2. Supervisors should not ask the employee the nature of the qualifying event;
3. Supervisors are responsible for notifying Human Resources of potential FMLA recurrences;
4. Supervisors shall not contact a health care provider or inpatient facility to request additional information. If additional or clarifying information is needed, the Supervisor must contact Human Resources;
5. Supervisors are responsible for protecting the privacy and confidentiality of their employee's medical conditions and circumstances as a result of an FMLA application and process.

B. To be assured of certain protections offered by FMLA during the leave of absence, the employee shall request FMLA leave.

1. An employee shall submit to the supervisor or Human Resources a **written** request for a leave of absence not less than 30 days prior to the requested start of the leave. Where an employee fails to give timely advance notice with no reasonable excuse, FMLA coverage may be delayed until 30 days after the date the employee provides notice.
2. If the reason for the leave could not have been foreseen 30 days in advance, the employee shall submit the written request for leave as soon as practicable after the need for leave is discovered.
3. If an employee is incapacitated, a family member or other responsible party shall submit the written request for leave on behalf of the employee.
4. An employee's request for a leave of absence must be made in writing, and include applicable documentation verifying the need for the leave. "Provisional" approval of leave will be granted, pending receipt of more complete documentation if original information is unavailable, incomplete, or inadequate.

V. **REQUIRED DOCUMENTATION:** Documentation required from an employee will depend upon whether the request is for "Family Leave," "Medical Leave," or Military FMLA [See Section I (D) and (E) above]. FMLA leave may be delayed or denied if an employee fails to comply with the employer's notice and procedural

requirements, barring unusual circumstances. Attachment “A” attached is the Pinal County Employee Request for Family Medical Leave (FMLA).

A. Family Leave. If the leave is due to a "serious health condition" of a family member Human Resources shall request the completion of a "Certification of Health Care Provider" form within 15 calendar days of the date of Human Resources' request. Attachment “B” is the Pinal County Certification of Health Care Provider. (The Certification of Health Care Provider form is the only acceptable form to obtain information from the employee's health care provider.) In the event a medical emergency or other unforeseeable event, the employee shall contact his/her supervisor as soon as practicable to request an extension and provide documentation five business days after the leave commences.

B. If the request for leave is due to the anticipated birth of a child (and sufficient documentation has not already been provided by the employee), Human Resources shall request from the employee completed documentation from the employee's Health Care Provider demonstrating the anticipated or actual date of birth. If the leave is due to the placement of a child through adoption or foster care, Human Resources shall request a copy of a letter from the adoption or foster care agency placing the child in the parent's care and/or custody or similar document demonstrating the date of placement.

C. Medical Leave. If the leave is due to an employee's "serious health condition" Human Resources shall request the completion of a "Certification of Health Care Provider" form within 15 calendar days of the date of Human Resources' request. Attachment “B” is the Pinal County Certification of Health Care Provider. (The Certification of Health Care Provider form is the only acceptable form to obtain information from the employee's health care provider.) In the event a medical emergency or other unforeseeable event, the employee shall contact his/her supervisor as soon as practicable to request an extension and provide documentation five business days after the leave commences.

D. Military – Qualifying Exigency Leave. Pinal County will require the employee to provide a completed Certification of Qualifying Exigency for Military Family Leave Form (Attachment ”C”) and a copy of the covered military member's active duty order and/or other documentation issued by the military which indicates that the covered military member is on active duty or a call to active duty in support of contingency operations and the dates of the active duty service. This certification must be provided within 15 calendar days after the notice of need to for the leave. Failure to provide certification may result in a denial of Military Qualifying Exigency Leave

E. Military – Serious Injury or Illness for Covered Service Member. Pinal County requires certification from an employee requesting leave to care for a covered service member with a serious injury or illness. The certification must be provided on a Certification for Serious Injury or Illness of Covered Service Member -for Military Family Leave Form (Attachment ”D”) within 15 calendar days after notice of need for the leave. The certification must be made by an authorized health care provider for the covered service member, which may include any of the following: a Department of Defense (DOD) health care provider, a Department of Veteran's Affairs (VA) health care provider, a DOD TRICARE network authorized health care provider, or a DOD non-network TRICARE health care provider. Failure to timely provide the certification may result in the delay of or denial of leave.

F. Documentation of Relationships. Pinal County will also require an employee to provide confirmation of a covered family relationship, i.e. spouse, parent, child, and next-of-kin.

G. In circumstances where the requested medical leave extends over a period of time, the employee may be required to secure recertification from his/her health care provider. Such requests for recertification are at the employee's own expense and shall not be more frequent than every six months unless:

    1. The employee requests an extension of the leave;
    2. Circumstances described by the original certification have changed significantly (e.g., the duration of the illness and the nature of the illness or complications);

3. Pinal County received information or notices trends in attendance that casts doubt upon the continuing validity of the most recent certifications.

H. Second and Third Medical Opinions
Pinal County HR may require an employee requesting leave for the employee's own serious health condition to obtain a second medical opinion. Such evaluation shall be conducted by a qualified health care provider selected and paid for by the employee's department. Should the second opinion differ from the opinion of the employee's health care provider, Pinal County may order and pay for a third medical opinion. The health care provider selected shall be mutually agreed upon by Pinal County and the employee. The third opinion shall be final and binding.

I. FITNESS FOR DUTY

Fitness for Duty reports (Attachment "E") will be required upon an employee's return to work following leave taken for the employee's own serious health condition for which FMLA was taken The employee shall pay for the cost for the fitness for duty certification. The report must certify that the employee is able to return to work and must specifically address the employee's ability to perform the essential functions of the position. Failure to provide a Fitness for Duty report may result an inability to reinstate an employee to his or her position.

Fitness for Duty Reports (Attachment "E") are **not** needed to return to work for the birth of a child, but are needed for return to work in the event of a serious health condition due to a complication from pregnancy.

VI. **REQUESTS FOR INTERMITTENT OR REDUCED SCHEDULED LEAVE:** Approval of an employee's request for leave on an intermittent or reduced schedule (rather than on a consecutive day basis) depends on whether the request is for "Family Leave" or "Medical Leave."

A. If the request is for "Family Leave," Human Resources may, but is not required to, permit the employee to take leave on an intermittent or reduced schedule basis (including absences of less than a full day); however, Human Resource's determination that leave will not be approved on an intermittent or reduced scheduled basis, does not mean that Human Resources may deny an otherwise qualifying leave request.

B. If the request is for "Medical Leave," Human Resources must approve leave on an intermittent or reduced schedule basis if the use of intermittent or reduced schedule leave is determined to be "medically necessary" by an appropriate Health Care Provider. An employee shall only be entitled to a reduced leave schedule when such leave will not disrupt the employer's operations and only with the Appointing Authority's approval. Approval is within the discretion of the Appointing Authority and must be obtained prior to the beginning of FMLA leave. .

C. An employee's request for intermittent or reduced schedule leave must be made in the same manner and within the same time restrictions as a request for FMLA leave on a consecutive day basis

D. An employee using intermittent FMLA for appointments which do not require a full ay of leave, such as physical therapy or lab work, is only entitled to the time necessary and <u>not</u> a full day of leave. For example, an employee may use FMLA only for the duration of the medical appointment and time required to and from the appointment location.

VII. **USE OF PAID SICK AND VACATION LEAVE DURING FMLA LEAVE AND HOLIDAY BENEFITS:**

A. All available and appropriate paid vacation and sick leave must be exhausted as part of the 12 week FMLA leave allotment. An employee may also use any available compensatory time balances during the leave. All remaining time during the FMLA leave will be treated as an approved leave of absence without pay.

Documentation of the amount of FMLA leave used by an employee is the supervisor's responsibility. If any portion of the FMLA leave is to be without pay, the supervisor must submit a completed Employee Status Change Form placing the employee on an unpaid status.

(NOTE: This also means if an employee transfers from one supervisor to another, all records documenting the employee's FMLA use must also be transferred.)

B. A Timesheet documenting the appropriate paid and unpaid leave usage must be submitted each payroll period for each employee designated on approved FMLA leave. The employee and/or supervisor are responsible for coding the time sheet with the correct FMLA codes according to the accrual balances of the employee. If a full day of FMLA leave has been taken, a full day must be accounted for on the timesheet. This process includes amending any timesheets submitted prior to the final approval of the FMLA leave.

C. Once all accrued sick leave, compensatory time, and vacation leave bank balances have been exhausted, the employee will be placed on leave without pay for the remaining FMLA entitlement, unless the employee is eligible to receive compensation under another employee benefit program (i.e. donated leave), as long as the FMLA is for the **employee's own serious health condition** and as per Pinal County Policy 7.70 (as it now exists or may subsequently be amended).

D. If an employee needs less than a full week of FMLA leave (intermittent leave) and a holiday falls within that partial week, the holiday hours will not be counted against the employee's FMLA entitlement, provided the employee would not have been required to report for work that day. If a holiday occurs within a full week of FMLA leave (continuous leave), the employee will be charged with a full week against his or her FMLA entitlement.

E. If an employee is on approved continuous FMLA leave, the employee will not participate in work and/or work-related activities. For exempt employees, upon request of the employee and upon receipt of the healthcare provider's certification allowing such activity, the supervisor may request the FMLA status be changed from "continuous" to "intermittent". Any request to work from home must be approved by the Assistant County Manager with a copy of the approval sent to Human Resources. The employee must be paid for time worked.

F. Outside or supplemental employment: Pinal County prohibits outside employment while an employee is on a paid or unpaid leave of absence where benefits may be maintained. Pinal County's employment policies continue to apply to an employee on FMLA leave in the same manner as they would apply to an employee who continues to work, or is absent while on some other form of leave.

G. An employee may not flex his/her work hours for FMLA. In order for leave to be covered under FMLA, leave time must be coded as FMLA on the employee's timesheet.

VIII. WORKERS' COMPENSATION AND ADA COORDINATION

A. An FMLA Leave Request form must be submitted to Human Resources for an employee on **approved** ICA/Workers' Compensation. If it is determined by Human Resources to be an FMLA qualifying event, payment to the employee should be 66 2/3% of the average monthly wage as calculated by the Industrial Commission of Arizona and paid by Workers' Compensation, and 33 1/3% from the employee's compensatory time or leave bank. Sick leave is to be used first, followed by compensatory time, and run concurrently with FMLA. Annual leave time and vacation leave banks are then to be exhausted and run concurrently with FMLA. It is the supervisor's responsibility to notify Human Resources upon the employee's return to work**.**

B. Qualified individuals with disabilities covered under the ADA Amendments Act (ADAAA) must also meet the FMLA qualification requirements of at least 12 months of total employment and at least 1250 hours worked in

the prior 12 months to be eligible for FMLA leave. Some FMLA serious health conditions, such as most cancers, heart disease and serious strokes, would likely be ADAAA disabilities.

IX. **CONTINUATION OF BENEFITS:** During the period of FMLA leave, the employee's health insurance coverage will remain at the same level and under the same conditions that coverage would have been provided if the employee continuously remained on the job. The employee's share of any health insurance premium will continue to be the employee's responsibility. In the case of unpaid leave, the employee should contact the Pinal County Compensation and Benefits Manager or designee to make arrangements for payment of any benefits that would normally have been paid through payroll deduction.

Employees taking FMLA leave are responsible for payment of the employee portion of his/her insurance premiums. Failure to make timely payments may result in the discontinuation of health and/or dental insurance coverage for the duration of the unpaid FMLA leave.

In accordance with other leave without pay policies, the accrual of sick and annual leave hours shall cease during a period of leave without pay pursuant to Pinal County Policies and Procedures.

X. **EMPLOYMENT UPON RETURN TO WORK:** An employee returning from an approved FMLA leave must be restored to a position equivalent to that which he/she held prior to the leave and must be restored to the position at the same rate of pay and level of benefits held prior to the leave. The supervisor may hire an individual in a temporary status to replace the employee on FMLA leave, subject to fiscal considerations.

XI. **RECORDS AND CONFIDENTIALITY**: The Human Resources Department shall maintain the following records detailing FMLA leaves of absence:

A. Documentation of the employee's request for Family or Medical Leave;

B. Documentation showing the date the employee's verbal and written request(s) was received;

C. Documentation of approval or denial of FMLA leaves, including start date, and anticipated return date, for any approved leave;

D. Dates FMLA leave was taken, including dates and hours taken, if leave was taken in increments of less than one full day;

E. Employee medical certification records; (NOTE: Retention of all medical information must comply with the ADAAA's confidentiality requirements. All employee medical information that contains specific information regarding an employee's current diagnosis, prognosis, medical condition, or medical history must be maintained in a separate, sealed and locked file, apart from general personnel files, with controlled access. Barring extraordinary circumstances, only immediate supervisors will be informed regarding an employee's restrictions related to his/her Essential Functions and/or necessary accommodations);

F. Documentation regarding any dispute between the employee and the supervisor regarding the designation of leave as FMLA;

H. Any written documentation indicating an employee has been offered FMLA leave and chooses not to take it, and/or terminates as an alternative to FMLA leave; and

I. The supervisor shall retain time sheets and other related payroll, benefits, and earning records.

XII. **PROCEDURE FOR AN EMPLOYEE TO APPLY FOR FMLA LEAVE**

A. The employee notifies his/her immediate supervisor or Human Resources Director or his/her designee of his/her need for FMLA leave. When Human Resources receives employee notification, Human Resources must notify the employee's supervisor of the FMLA request. When the supervisor is the person receiving employee notification, he/she must notify Human Resources.

B. Human Resources will verify if the employee meets the minimum requirements for FMLA eligibility (e.g. 12 months of service and 1,250 work hour requirement).

C. Upon receipt of the FMLA request, Human Resources shall send the employee, via email or certified mail, a Pinal County FMLA packet. Human Resources will also complete and forward a status change form to the main Human Resources office building designating an employee is on provisional FMLA leave. The FMLA packet consists of the following documents:

1. Letter notifying the employee the request for FMLA leave has been received
2. FMLA Notice of Rights
3. Medical Certification for a Personal Medical Condition or the Medical Certification for Family Medical Condition
4. Short Term Disability Policy
5. FMLA Leave Request Form

D. The employee must return the completed packet to Human Resources. Incomplete requests for leave will not be processed if information is missing. It is the employee's responsibility to ensure all forms are complete and returned to Human Resources within the timelines outlined in the provisional letter.

E. Human Resources will review the documentation presented by the employee to ensure–the information is complete, considering the following factors:

1. the documents are signed;
2. by a medical provider;
3. the documentation contains the dates of the onset of the serious health condition;
4. the medical provider has expressed the need for leave;
5. the documentation provides a start date and duration for the leave;
6. the information provided is clear and unambiguous

F. If the certification is incomplete, Human Resources shall advise the employee, in writing, of the information needed to complete the review process. The employee shall be given an additional 7 calendar days to remedy any deficiencies. The written notice provided to the employee will provide the anticipated consequences if he/she fails to comply (i.e. FMLA protection will not be granted). Human Resources staff may contact the Health Care Provider directly for clarification, if documentation is insufficient or incomplete and the employee has not remedied the deficiencies within the allotted time period. The clarification inquiry is to understand the handwriting on the medical certification or to understand the meaning of a response. Human Resources staff will not request additional information beyond that contained on the medical certification.

G. Where appropriate, Human Resources staff will confer with the Employee Relations Manager, Compensation and Benefits Manager, Occupational Nurse, and Legal Counsel

H. When Human Resources receives the completed application, the following factors will be considered when deciding employee qualification for FMLA:

1. The employee is a Pinal County employee;
2. The employee has worked for Pinal County for at least one year and has worked 1,250 hours during the 12 months preceding the date for the requested leave; and,
3. The employee's request for leave adheres to at least one of the conditions determined in the **"TYPES OF PERMISSIBLE FMLA LEAVE"** section above.

I. Human Resources shall notify the employee in writing whether the leave has been approved or denied using the Pinal County Notice of Approval or Denial forms no later than five working days after receipt of the completed FMLA packet or certification (whichever comes later).

The Pinal County Notice forms include the following information:

1. The date Human Resources was notified of the FMLA request.
2. Whether the leave request is for a serious health condition of the employee; family leave; birth/adoption of child; or Military FMLA.
3. Beginning and approximate FMLA ending dates.
4. Whether intermittent leave was approved (employee shall coordinate his/her schedule with his/her supervisor).
5. Whether FMLA leave was approved or denied.
6. Whether the employee may be required to submit recertification.
7. Whether the employee is required to present a physician's work release.
8. Whether the employee will need to pay for benefits (employees not receiving a paycheck will need to contact Human Resources to make arrangements for payments, otherwise the payments will continue to be deducted from the employee's pay).
9. If the reason for leave is medically related, the Certification of Health Care Provider form must be included.
10. Basic summary of FMLA policy.
11. The possibility that benefits may be terminated once FMLA leave is terminated or the employee failed to pay the employee portion of premium benefits.

J. Human Resources may request recertification every thirty days (see **REQUIRED DOCUMENTATION** section (F) above). For certifications specifying a minimum period of incapacity of more than thirty days, Human Resources must wait to request a recertification until the specified period has passed, except that in all cases, Human Resources may request recertification every six months in connection with an absence by the employee. If the employee is asked to recertify, he/she will have 15 calendar days to submit an updated medical certification from his/her Health Care Provider.

K. The employee shall notify his/her supervisor of a return to work date. The supervisor is responsible for communicating this information to Human Resources by completing an Employee Status Change form, returning the employee to active status.

L. The complete FMLA packet, including any correspondence, will be sent to Human Resources for storage in the employee's medical file.

ATTACHMENT “A”

Pinal County Employee Request for Family Medical Leave (FMLA)

PINAL • COUNTY
Wide open opportunity

Employee Name:	**Employee SSN or ID#:**	**Date of Request:**
Current Mailing Address:	**City:** **State:**	**Zip Code:**
Work Phone:	☐ **Send non-confidential forms by email to:**	
Home Phone:	☐ **Work E-mail:**_____	
Cell Phone:	☐ **Home E-Mail:**_____	
Department Name:	**Work Days and Hours:**	
Supervisors Full Name:	**Supervisor Phone:**	

Reason for Leave:

☐ Birth of my child and/or to care for the newborn child. Estimated delivery date: _____
☐ Placement of a child with me for adoption or foster care. Estimated placement date:_____
☐ To care for a family member with a serious health condition
- ☐ Child Name:_____ DOB:_____
- ☐ Spouse Name:_____
  Is spouse a Pinal County employee? ☐ Yes ☐ No If yes, what department:_____
- ☐ Parent (s) Name(s):_____

☐ My own serious health condition
- ☐ Admitted to Hospital (Hospital Name:_____)
- ☐ Attended at least 2 doctor's visits (Doctor Name_____)

☐ Qualifying Exigency
☐ To care for a covered service member (Name:_____)

Anticipated Dates of Leave: **I am requesting FMLA leave as follows:**

☐ Continuous leave from:_____to_____

☐ Intermittent / Reduced work schedule from:_____to_____

Please note that actual leave dates will be based on information in medical certification, proof of birth, and proof of adoption or placement of child for foster care or military orders.

I understand and acknowledge that, by submitting this request for FMLA:

- *I am not approved for FMLA leave until I receive a Designation Notice of Approval from HR.*
- *Pinal County requires me to use all available sick, compensatory, and vacation leave concurrently with FMLA leave until exhausted as per policy 7.40*
- *I am required to furnish medical certification of a serious health condition and/or the need for me to provide care for a family member and that this certification must be submitted to HR within 15 calendar days.*
- *HR may obtain clarifying information from the health care provider regarding my request for FMLA.*
- *I will be required to provide proof of birth, adoption, placement of a foster child, or military orders as applicable.*

Employee Signature:	**Date:**

You will receive a Notice of Eligibility and Rights & Responsibilities from HR with information about your eligibility and rights under FMLA. If your leave is approved, you will receive a Designation Notice of Approval with details of the leave. Please address any questions concerning FMLA to HR at (520) 866-6231 or by secure fax at (520) 866-6401.

Human Resources-FMLA Use Only

Date Request Received:	**Date Medical Certification Received:**	**Date Short-Term Disability Application Received:**

Employee has worked:
- ☐ **at least 12 months for Pinal County** _____
- ☐ **at least 1,250 hours in the 12-month period immediately preceding the start of the leave**_____
- ☐ **has employee taken FMLA prior to this occurrence**
  - ☐ **Yes (if yes and if leave was taken within the last 12 months list the specific dates)**_____
  - ☐ **No**_____

Employee is ☐ **Eligible** ☐ **Not eligible for FMLA**	**Condition** ☐ **Qualifies** ☐ **Does not qualify for FMLA**	
FMLA is ☐ **Approved** ☐ **Denied** **Effective Date of FMLA:**	**HR Signature:**	**HR-MGR Signature:**

ATTACHMENT “B”

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

U.S. Department of Labor
Wage and Hour Division

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.

OMB Control Number: 1235-0003
Expires: 5/31/2018

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: _____

_____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your family member or his/her medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a covered family member with a serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Your name: _____
First Middle Last

Name of family member for whom you will provide care:_____
First Middle Last

Relationship of family member to you: _____

If family member is your son or daughter, date of birth:_____

Describe care you will provide to your family member and estimate leave needed to provide care:

_____

_____

_____

_____ ____ _____
Employee Signature Date

CONTINUED ON NEXT PAGE

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the patient needs leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e). Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address:_____

Type of practice / Medical specialty: _____

Telephone: (_____)_____ Fax:(_____)_____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

Probable duration of condition: _____

s the ent admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
___No ___Yes. If so, dates of admission: _____

Date(s) you treated the patient for condition: _____

Was medication, other than over-the-counter medication, prescribed? ___No ___Yes.

Will the patient need to have treatment visits at least twice per year due to the condition? ___No ____ Yes

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
____ No ____Yes. If so, state the nature of such treatments and expected duration of treatment:

_____

_____

2. Is the medical condition pregnancy? ___No ___Yes. If so, expected delivery date: _____

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

_____

_____

_____

_____

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ___No ___Yes.

   Estimate the beginning and ending dates for the period of incapacity: _____

   During this time, will the patient need care? __ No __ Yes.

   Explain the care needed by the patient and why such care is medically necessary:

   _____

   _____

   _____

   _____

   _____

5. Will the patient require follow-up treatments, including any time for recovery? ___No ___Yes.

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   _____

   Explain the care needed by the patient, and why such care is medically necessary: _____

   _____

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? __ No __ Yes.

   Estimate the hours the patient needs care on an intermittent basis, if any:

   _____ hour(s) per day; _____ days per week from _____ through _____

   Explain the care needed by the patient, and why such care is medically necessary:

   _____

   _____

   _____

   _____

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ____No ____Yes.

   Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

   Frequency: _____ times per _____ week(s) _____ month(s)

   Duration: _____ hours or ___ day(s) per episode

   Does the patient need care during these flare-ups? ____ No ____ Yes.

   Explain the care needed by the patient, and why such care is medically necessary: _____

   _____

   _____

   _____

   _____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Health Care Provider **Date**

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents 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 information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210.
DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.

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

U.S. Department of Labor
Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 5/31/2018

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: _____

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

Employee's essential job functions: _____

_____

Check if job description is attached: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: _____
First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b). Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____)_____ Fax:(_____)_____

 CONTINUED ON NEXT PAGE

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

   Mark below as applicable:
   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
   ___No ___Yes. If so, dates of admission:

   _____

   Date(s) you treated the patient for condition:

   _____

   Will the patient need to have treatment visits at least twice per year due to the condition? ___No ___ Yes.

   Was medication, other than over-the-counter medication, prescribed? ___No ___Yes.

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
   ____No ____Yes. If so, state the nature of such treatments and expected duration of treatment:

   _____

2. Is the medical condition pregnancy? ___No ___Yes. If so, expected delivery date: _____

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

   Is the employee unable to perform any of his/her job functions due to the condition: ____ No ____ Yes.

   If so, identify the job functions the employee is unable to perform:

   _____

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

   _____

   _____

   _____

   _____

   _____

   _____

   _____

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___No ___Yes.

   If so, estimate the beginning and ending dates for the period of incapacity: _____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ___No ___Yes.

   If so, are the treatments or the reduced number of hours of work medically necessary? ___No ___Yes.

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   _____

   Estimate the part-time or reduced work schedule the employee needs, if any:

   _____ hour(s) per day; _____ days per week from _____ through _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ____No ____Yes.

   Is it medically necessary for the employee to be absent from work during the flare-ups? ____ No ____Yes. If so, explain:

   _____

   _____

   Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency : _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or ___ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

Signature of Health Care Provider **Date**

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents 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 information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**

ATTACHMENT “C”

Certification of Qualifying Exigency For Military Family Leave (Family and Medical Leave Act)

U.S. Department of Labor

Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 5/31/2018

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a qualifying exigency to submit a certification. Please complete Section I before giving this form to your employee. Your response is voluntary, and while you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 CFR 825.309.

Employer name: _____

Contact Information: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II fully and completely. The FMLA permits an employer to require that you submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a qualifying exigency. Several questions in this section seek a response as to the frequency or duration of the qualifying exigency. Be as specific as you can; terms such as "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Your response is required to obtain a benefit. 29 CFR 825.310. While you are not required to provide this information, failure to do so may result in a denial of your request for FMLA leave. Your employer must give you at least 15 calendar days to return this form to your employer.

Your Name: _____
First Middle Last

Name of military member on covered active duty or call to covered active duty status:

_____
First Middle Last

Relationship of military member to you: _____

Period of military member's covered active duty: _____

A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes written documentation confirming a military member's covered active duty or call to covered active duty status. Please check one of the following and attach the indicated document to support that the military member is on covered active duty or call to covered active duty status.

☐ A copy of the military member's covered active duty orders is attached.

☐ Other documentation from the military certifying that the military member is on covered active duty (or has been notified of an impending call to covered active duty) is attached.

☐ I have previously provided my employer with sufficient written documentation confirming the military member's covered active duty or call to covered active duty status.

PART A: QUALIFYING REASON FOR LEAVE

1. Describe the reason you are requesting FMLA leave due to a qualifying exigency (including the specific reason you are requesting leave):

_____

_____

_____

_____

2. A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes any available written documentation which supports the need for leave; such documentation may include a copy of a meeting announcement for informational briefings sponsored by the military; a document confirming the military member's Rest and Recuperation leave; a document confirming an appointment with a third party, such as a counselor or school official, or staff at a care facility; or a copy of a bill for services for the handling of legal or financial affairs. Available written documentation supporting this request for leave is attached.

Yes ☐ No ☐ None Available ☐

PART B: AMOUNT OF LEAVE NEEDED

1. Approximate date exigency commenced: _____

Probable duration of exigency: _____

2. Will you need to be absent from work for a single continuous period of time due to the qualifying exigency?

Yes☐ No☐

If so, estimate the beginning and ending dates for the period of absence:

_____

3. Will you need to be absent from work periodically to address this qualifying exigency? Yes☐ No☐

Estimate schedule of leave, including the dates of any scheduled meetings or appointments:

_____

_____

_____

Estimate the frequency and duration of each appointment, meeting, or leave event, including any travel time (i.e., 1 deployment-related meeting every month lasting 4 hours):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours ___ day(s) per event.

PART C:

If leave is requested to meet with a third party (such as to arrange for childcare or parental care, to attend counseling, to attend meetings with school, childcare or parental care providers, to make financial or legal arrangements, to act as the military member's representative before a federal, state, or local agency for purposes of obtaining, arranging or appealing military service benefits, or to attend any event sponsored by the military or military service organizations), a complete and sufficient certification includes the name, address, and appropriate contact information of the individual or entity with whom you are meeting (i.e., either the telephone or fax number or email address of the individual or entity). This information may be used by your employer to verify that the information contained on this form is accurate.

Name of Individual: _____ Title: _____

Organization: _____

Address: _____

Telephone: (_____) _____ Fax: (_____) _____

Email: _____

Describe nature of meeting: _____

_____

_____

_____

_____

_____

_____

_____

PART D:

I certify that the information I provided above is true and correct.

Signature of Employee _____ Date _____

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. 2616; 29 CFR 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents 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 information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution AV, NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE EMPLOYER.**

ATTACHMENT “D”

Certification for Serious Injury or Illness of a Current Servicemember - -for Military Family Leave (Family and Medical Leave Act)

U.S. Department of Labor

Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 5/31/2018

Notice to the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a serious injury or illness of a current servicemember to submit a certification providing sufficient facts to support the request for leave. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 CFR 825.310. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees or employees' family members created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 CFR 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 CFR 1635.9, if the Genetic Information Nondiscrimination Act applies.

SECTION I: For Completion by the EMPLOYEE and/or the CURRENT SERVICEMEMBER for whom the Employee Is Requesting Leave

INSTRUCTIONS to the EMPLOYEE or CURRENT SERVICEMEMBER: Please complete Section I before having Section II completed. The FMLA permits an employer to require that an employee submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a serious injury or illness of a servicemember. If requested by the employer, your response is required to obtain or retain the benefit of FMLA-protected leave. 29 U.S.C. 2613, 2614(c)(3). Failure to do so may result in a denial of an employee's FMLA request. 29 CFR 825.310(f). The employer must give an employee at least 15 calendar days to return this form to the employer.

SECTION II: For Completion by a UNITED STATES DEPARTMENT OF DEFENSE ("DOD") HEALTH CARE PROVIDER or a HEALTH CARE PROVIDER who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; (3) a DOD non-network TRICARE authorized private health care provider; or (4) a health care provider as defined in 29 CFR 825.125

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed on Page 2 has requested leave under the FMLA to care for a family member who is a current member of the Regular Armed Forces, the National Guard, or the Reserves who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list for a serious injury or illness. For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty in the Armed Forces or that existed before the beginning of the member's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces that may render the servicemember medically unfit to perform the duties of his or her office, grade, rank, or rating.

A complete and sufficient certification to support a request for FMLA leave due to a current servicemember's serious injury or illness includes written documentation confirming that the servicemember's injury or illness was incurred in the line of duty on active duty or if not, that the current servicemember's injury or illness existed before the beginning of the servicemember's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces, and that the current servicemember is undergoing treatment for such injury or illness by a health care provider listed above. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the servicemember's condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 CFR 1635.3(f), or genetic services, as defined in 29 CFR 1635.3(e).

SECTION I: For Completion by the EMPLOYEE and/or the CURRENT SERVICEMEMBER for whom the Employee Is Requesting Leave:

(This section must be completed first before any of the below sections can be completed by a health care provider.)

Part A: EMPLOYEE INFORMATION

Name and Address of Employer (this is the employer of the employee requesting leave to care for the current servicemember):

_____

Name of Employee Requesting Leave to Care for the Current Servicemember:

_____
First Middle Last

Name of the Current Servicemember (for whom employee is requesting leave to care):

_____
First Middle Last

Relationship of Employee to the Current Servicemember:

Spouse☐ Parent ☐ Son ☐ Daughter ☐ Next of Kin ☐

Part B: SERVICEMEMBER INFORMATION

(1) Is the Servicemember a Current Member of the Regular Armed Forces, the National Guard or Reserves?
Yes☐ No☐

If yes, please provide the servicemember's military branch, rank and unit currently assigned to:

_____

Is the servicemember assigned to a military medical treatment facility as an outpatient or to a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients (such as a medical hold or warrior transition unit)?
Yes☐ No☐

If yes, please provide the name of the medical treatment facility or unit:

_____

(2) Is the Servicemember on the Temporary Disability Retired List (TDRL)?
Yes☐ No☐

Part C: CARE TO BE PROVIDED TO THE SERVICEMEMBER

Describe the Care to Be Provided to the Current Servicemember and an Estimate of the Leave Needed to Provide the Care:

_____

_____

SECTION II: For Completion by a United States Department of Defense ("DOD") Health Care Provider or a Health Care Provider who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; (3) a DOD non-network TRICARE authorized private health care provider; or (4) a health care provider as defined in 29 CFR 825.125. If you are unable to make certain of the military-related determinations contained below in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator).

(Please ensure that Section I above has been completed before completing this section. Please be sure to sign the form on the last page.)

Part A: HEALTH CARE PROVIDER INFORMATION

Health Care Provider's Name and Business Address:

_____

Type of Practice/Medical Specialty: _____

Please state whether you are either: (1) a DOD health care provider; (2) a VA health care provider; (3) a DOD TRICARE network authorized private health care provider; (4) a DOD non-network TRICARE authorized private health care provider, or (5) a health care provider as defined in 29 CFR 825.125:

_____

Telephone: ( ) _____ Fax: ( ) _____ Email: _____

PART B: MEDICAL STATUS

(1) The current Servicemember's medical condition is classified as (Check One of the Appropriate Boxes):

☐ **(VSI) Very Seriously Ill/Injured** – Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

☐ **(SI) Seriously Ill/Injured** – Illness/injury is of such severity that there is cause for immediate concern, but there is no imminent danger to life. Family members are requested at bedside. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

☐ **OTHER Ill/Injured** – a serious injury or illness that may render the servicemember medically unfit to perform the duties of the member's office, grade, rank, or rating.

☐ **NONE OF THE ABOVE** (Note to Employee: If this box is checked, you may still be eligible to take leave to care for a covered family member with a "serious health condition" under § 825.113 of the FMLA. If such leave is requested, you may be required to complete DOL FORM WH-380-F or an employer-provided form seeking the same information.)

(2) Is the current Servicemember being treated for a condition which was incurred or aggravated by service in the line of duty on active duty in the Armed Forces? Yes☐ No☐

(3) Approximate date condition commenced: _____

(4) Probable duration of condition and/or need for care: _____

(5) Is the servicemember undergoing medical treatment, recuperation, or therapy for this condition? Yes☐ No☐

If yes, please describe medical treatment, recuperation or therapy:

_____

PART C: SERVICEMEMBER'S NEED FOR CARE BY FAMILY MEMBER

(1) Will the servicemember need care for a single continuous period of time, including any time for treatment and recovery? Yes☐ No☐

If yes, estimate the beginning and ending dates for this period of time: _____

(2) Will the servicemember require periodic follow-up treatment appointments? Yes☐ No☐

If yes, estimate the treatment schedule: _____

(3) Is there a medical necessity for the servicemember to have periodic care for these follow-up treatment appointments? Yes☐ No☐

(4) Is there a medical necessity for the servicemember to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)?
Yes☐ No☐

If yes, please estimate the frequency and duration of the periodic care:

_____

_____

Signature of Health Care Provider: _____ Date: _____

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years, in accordance with 29 U.S.C. 2616; 29 CFR 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents 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 information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution AV, NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE PATIENT.**

ATTACHMENT “E”

Pinal County Employee
Return To Work Report

PINAL • COUNTY
Wide open opportunity

Have this form completed by your health care provider and fax to HR (secure fax # 520-866-6401) prior to or upon your return to work. Pinal County HR will require this form in order for you to return to your regular position after continuous FMLA leave. Please contact HR at 520-866-6231 with any questions.

EMPLOYEE INFORMATION
AND INFORMED CONSENT FOR DISCLOSURE OF HEALTH CARE INFORMATION

Employee's Name: Phone:

Address, City, State, Zip:

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize the health care provider identified below to release and disclose to Pinal County such health care records and information concerning my current medical condition as is necessary to determine my fitness for employment and/or eligibility for any employer-provided benefit. This authorization shall be valid for two (2) years from the date shown below, unless revoked by me in writing at an earlier date. Although I understand that I may revoke this authorization in writing at any time, I also understand that any such revocation may have an adverse effect on the receipt of employer-provided benefits.

Employee Signature: Date:

STATEMENT OF HEALTH CARE PROVIDER

Has patient reached the end of his or her healing period? ☐ Yes ☐ No

Is patient able to perform all essential functions of his/her regular job? ☐ Yes ☐ No

Is patient able to work his/her normal work schedule? ☐ Yes ☐ No

If not please identify the number of hours per day and the number of hours per week that the patient can work, and the expected return duration of the period for the reduced schedule:

Is patient able to return to work without endangering him/herself or others? ☐ Yes ☐ No

Date patient can return to work without restrictions? _____ With restrictions? _____

(Date) (Date)

Restrictions:

Provider Signature: Date:

HEALTH CARE PROVIDER INFORMATION

Provider Name:

Address:

City, State, Zip Code:

Telephone:	Field of Specialty:	License No: