FAMILY & MEDICAL LEAVE ACT REQUEST AND DESIGNATION FORM

(TO BE USED FOR ADVANCE REQUESTS *OR* FOR DESIGNATING UNFORESEEN LEAVE AS FMLA.)

Employee Name_____ **Employee Number**_____ **Title:** _____

Department: _____ **Date:** _____

CHECK & COMPLETE APPROPRIATE SECTION(S) FOR THE PARTICULAR CIRCUMSTANCES INVOLVED.

NOTICE OF NEED FOR FAMILY OR MEDICAL LEAVE

☐ **ADVANCE REQUEST BY EMPLOYEE:**

I am requesting leave for family or medical reasons as described below, to commence _____ for an expected duration of _____ to be taken ☐ consecutively ☐ Intermittently. *(If intermittent, describe in space provided in next section.)*

_____ _____
Employee Signature Date Signed

☐ **UNFORESEEN NOTICE OF NEED FOR LEAVE RECEIVED BY EMPLOYER**:

On _____, ☐ you or ☐ your representative _____ notified us that you have an unforeseen need for family or medical leave to commence _____ for an expected duration of _____ to be taken ☐ consecutively ☐ Intermittently. ***(If intermittent, describe in space provided in next section.)***

_____ _____
Department Head or Authorized Designate Date Signed.

REASON FOR NEEDING LEAVE

Place ✓ in appropriate box and complete sections below.

☐ Birth of a child or placement of child with me for adoption or foster care. Expected Date of birth or placement _____. *(Employee must submit certified legal record of placement when available.)*

☐ A serious health condition affecting my ☐ spouse, ☐ child, ☐ parent, for which I am needed to provide care. *(Health Provider Certification Required)*

☐ A serious health condition that makes me unable to perform the essential functions of my job. *(Health Provider Certification Required)*

☐ A qualifying exigency arising out of the fact that my ☐ spouse, ☐ child, ☐ parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves. *(Qualifying Exigency Certification Required)*

☐ To care for ☐ spouse, ☐ child, ☐ parent or ☐ "next of kin" of a covered service member with a serious injury or illness as a result of service in the United States Military, the period of FMLA is 26 weeks of leave during a 12 month period. *(Caregiver Leave Certification Required)*

Note: If Intermittent Leave requested or being used, provide proposed intermittent or reduced schedule.

Note: Employees requiring intermittent leave or leave on a reduced leave schedule must attempt to schedule their leave so as not to disrupt the department's operations. In addition, the department head may assign an employee to an alternative position with equivalent pay and benefits that better accommodates the employee's intermittent or reduced leave schedule. (29 CFR § 825.117 The Family and Medical Leave Act of 1993 as published by the U. S. Department of Labor, Wage & Hour Division, April, 1995.)

EMPLOYER'S RESPONSE TO NOTICE OF NEED FOR FAMILY OR MEDICAL LEAVE

(To be completed by department head or authorized designate)

Your ☐ **Advance Request** ☐ **Unforeseen Notice** of need for family or medical leave as described above was received on _____

You are □ eligible □ not eligible for FMLA leave .

If eligible, the leave is being designated as FMLA leave and will be charged to your FMLA unpaid leave entitlement and any paid leave accrual for which you are eligible under the circumstance necessitating the leave.

Please read the following pages and the City FMLA Policy (Section 7-005 in Non-uniformed Employees' Policy Manual) for information on eligibility and other FMLA requirements. If you have any questions, please contact your department head or authorized designate or the Human Resources Department. Please sign the acknowledgement of receipt and return to your department head or authorized designate.

_____ _____
Department Head (or authorized designate) Signature Date Signed

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FMLA INFORMATION

Eligibility for FMLA Leave: You must have performed work for the City for a total of at least 12 months **and** have actually worked at least 1,250 hours during the twelve months preceding the commencement of the leave. Hours worked does not include time paid but not "worked", i.e., vacation, personal or sick leave, holidays, workers' compensation leave nor does it include unpaid leave of any kind, periods of layoff or overtime hours not actually worked.

City FMLA Policy: *Section 7-005 in Non-uniformed Employee Handbook or Uniformed Employees' Contract* This notice and policy are intended to inform you of your rights and responsibilities under the FMLA and to advise you of the City's policy with regard to the administration of the FMLA. This policy was established pursuant to 29 CFR § 825 The Family and Medical Leave Act of 1993, as published by the U. S. Department of Labor, Wage & Hour Division, April, 1995.

Maximum Annual FMLA Entitlement: If you meet the eligibility requirements stated above, and provide the proper verification of need for leave, you have a right under the FMLA for up to 12 weeks of unpaid leave in a 12-month calendar year for reasons listed above, depending on need and/or the appropriate medical verification or 26 weeks of unpaid leave during a 12 month period for certain military requirements.

FMLA REQUIREMENTS

(To be completed by department head (or designate). *Place ✓ in appropriate box below before providing to employee.)*

1. **You will be required** to furnish certification from the treating physician or medical provider verifying a serious medical condition affecting you or an eligible immediate family member. You must provide such required certification no later than ***15 days after your receipt of this notice*** or the commencement of your FMLA leave may be delayed until the certification is submitted. If it will not be possible to provide it within the 15 day limit, you must explain the reasons why and provide it as soon as possible under the circumstances. The Department of Labor's Wage & Hour FMLA Health Care Provider Form WH-380, dated March 1995 or later should be used when at all possible. If one is not included with this notice, you may obtain one in your department or from the Human Resources Department***. All treating physician or medical provider statements must be signed personally by the treating physician and the original must be presented to your supervisor. Photocopies, stamped signatures, or signatures of any person other than the treating physician or medical provider are not acceptable.***

2. **You will be required** to furnish medical recertifications relating to a serious health condition at the end of the initial period of medical certification if you are unable to return to work at the scheduled time as stated in the initial medical certification and every 30 days thereafter as long as the absences are consecutive and continuing. If the circumstances of your leave change and you are able to return to work earlier than the date indicated on this form, **you** ☐ **will** ☐ **will not be** required to notify us at least two work days prior to the date you intend to report for work. ***For chronic conditions necessitating only intermittent absences, recertifications may be required periodically as provided by §825.308 of the FMLA regulations. Such medical recertifications shall be furnished within fifteen days of notification of requirement.***

3. You ☐ **will** ☐ **will not be** required to present a job-related health provider's fitness-for-duty medical certification prior to being restored to duty. Such certification must be on a form approved by the City. If not received, your return to work may be delayed until certification is provided. Contact your department or the Human Resources Department to obtain proper job-related forms prior to final visit to doctor.

4. The City shall substitute all paid leave accumulations for ***which you are eligible according to current City policy*** for the particular circumstances necessitating the need for leave until no paid leave remains or your FMLA entitlement ends, whichever occurs first. If eligible paid leave is exhausted before the end of your unpaid FMLA entitlement, the remainder of the FMLA leave will be unpaid. *See Non Uniformed Employee Handbook or Uniformed Employees' Contract (if applicable) for existing city rules on eligibility for and limitations on, eligibility to use paid leave benefit accruals. Refer any questions to your supervisor or department head.*

5. You ☐ **are** ☐ **are not** a "key employee" as described in §825.218 of the FMLA Regulations. If you are a "key employee," restoration to employment may be denied following FMLA leave because such restoration will cause substantial and grievous economic injury to the City.

6. It ☐ **has** ☐ **has not been** determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic harm to the City.

Health insurance Information

1. Your health benefits must be maintained during any period of **unpaid** leave under the same conditions as if you continued to work, and you must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from leave. If you do not return to work following FMLA leave for a reason other than: (1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave: or (2) other circumstances beyond your control, you may be required to reimburse the City for its share of health insurance premiums paid on your behalf during your FMLA leave.

2. During any period of **unpaid** FMLA leave, payment of health insurance premiums and other payroll deducted payments must be made by you.

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3. You have a minimum 30-day grace period in which to make premium payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse, or, at our option, we may pay your share of the premiums during FMLA leave, and recover these payments from you upon your return to work. If you do not return to work, the City will consider any amount paid on your behalf for any health or other insurance premiums as an indebtedness owed by you and will collect such indebtedness by whatever legal means necessary. (Only applies when all or part of leave will be unpaid). The City will pay your share of health insurance premiums while you are on leave. (Only applies when all or part of leave will be unpaid). The City will do the same with other benefits (e.g., life insurance, disability insurance, etc.) while you are on FMLA leave. If the City does pay your premiums for other benefits, when you return from leave you will be expected to reimburse the City for the payments made on your behalf. (Only applies when all or part of leave will be unpaid).

If you are currently ineligible for paid leave benefits and all or part of your FMLA entitlement is or will be unpaid during the period of leave, arrangements for payment of health insurance premiums and other usual payroll deductible items by you have been discussed with you and it is agreed that you will make premium payments as follows:

(Note to Department Head, or designate: the arrangements must be approved by the Finance Department before finalizing. Set forth dates, e.g. the 10th of each month, or pay periods, etc. that specifically cover the agreement with the employee.)

Dates Payments to be made: _____ Amount of Payments: _____ How Payments to be made:_____

EMPLOYEE ACKNOWLEDGEMENT AND RECEIPT (If serving in person)

Note to Department Head (or designate): If unable to provide to employee in person, send to employee's residence via Certified Mail, Return Receipt Requested. The signed, green return-receipt card will serve as a receipt for the notice and policy. When signed green receipt card is received back from post office, forward it to Human Resources to file with original of this FMLA Designation Form.

I acknowledge receipt of this Notice of FMLA leave designation and a copy of the City's Family and Medical Leave Act Policy. I understand that pursuant to the Family and Medical Leave Act, any and all accrued paid leave benefits that I am eligible to use for the particular circumstances occasioning the need for FMLA leave will be substituted for unpaid FMLA leave within the eligibility qualifications, and limitations for use of such paid leave as described in existing City policy or contract. Any such paid leave shall be substituted until exhausted or the need for FMLA leave ceases, whichever comes first. I understand that if paid leave for which I am eligible becomes exhausted prior to the end of my FMLA leave, the remainder of the FMLA leave will then be unpaid, and I will be responsible for payment of health and other optional insurance premiums which I normally make by payroll deduction. I understand that there is a 30-day grace period in which to make premium payments and agree to make such payments as agreed to above. I acknowledge that at the City's option, it may pay these premiums for me, but when I return from unpaid leave I will be expected to reimburse the City for any payments made on my behalf. Until reimbursed, the City will consider such payments made on my behalf as an indebtedness to be recovered by payroll deduction upon my return to work or, if I do not return to work, to be deducted from any pension fund refund (per City ordinance), or from such final wages as are allowable pursuant to the Fair Labor Standards Act limitations. I understand that I am to report my status periodically to my supervisor as required in No. 4 above, and that if I am unable to return to work at the end of my initial health provider certification, I must present a health provider recertification at that time and every 30 days thereafter as long as the absences are consecutive and continuing, unless my leave is due to a chronic condition necessitating only intermittent absences, in which case health provider recertifications may be required periodically within fifteen days of being requested. I understand that I must attempt to schedule any intermittent leave so as not to disrupt the department's operations. In addition, the department head may assign me to an alternative position with equivalent pay and benefits that better accommodates my intermittent or reduced leave schedule. I understand that no paid leave benefits or City pension contributions accrue during any period of unpaid leave.

Signed: _____ Date: _____
Employee

Witness:_____ Date: _____

COPY AND DISTRIBUTE: Original to H.R. Department; 1 Copy to Employee