

APPENDIX B

EMPLOYER/EMPLOYEE REQUEST FOR FMLA/CFRA LEAVE

Employee Name:	Date of Request:
Department: Transportation/FAX	Division: Operations
Position Title:	Hire Date:

EMPLOYER requests Family/Medical Leave for the following reason (check one):

EMPLOYEE requests Family/Medical Leave for the following reason (check one):

- A. The birth of a child and/or in order to care for such child.
- B. The placement of a child for adoption or foster care.
- C. In order to care for an immediate family member because such family member has a serious health condition.
- D. Care for an adult child who is incapable of self care (A child is "incapable of self care" if he/she requires active assistance or supervision to provide daily self care in three or more of the activities of daily living or instrumental activities of daily living, such as caring for grooming and hygiene, bathing, dressing and eating, cooking, cleaning, shopping, taking public transportation, paying bills, maintaining a residence, using telephones and directories, etc.)
- E. Employee's own serious health condition that renders the employee unable to perform the functions of his/her position.
- F. To assist a child, spouse, or parent who is a member of the National Guard or reserves with a "qualifying exigency" related to active duty or a call of active duty status in support of a contingency operation.
- G. To care for a child, spouse, parent or "next of kin" service member of the United States Armed Forces who has a serious injury or illness incurred in the line of duty while on active duty (up to 26 weeks of leave).

Method of Leave Requested

- A. Consecutive Leave
- B. Intermittent or Reduced Leave Schedule (Specify schedule below)

Date leave is to begin: _____ Expected duration of leave: _____

Date: _____

Employee's Signature: _____
(Not required if request is submitted by Department)

Department Representative Signature: _____

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Physician or Practitioner Medical Certification Employee/Family Member Serious Health Condition

1. Employee's Name: _____

2. Patient's Name: _____

3. Does the employee's child, parent, spouse, or domestic partner have an illness, injury, impairment, or physical or mental condition which constitutes a "serious health condition" qualifying under any of the categories described? (A "serious health condition" is described on the attached sheet) If so, please check the applicable category:

(1) ____ (2) ____ (3) ____ (4) ____ (5) ____ (6) ____ or None of the above ____.

4. Date the medical condition or need for treatment commenced: _____

5. Probable duration of medical condition or need for treatment: _____

6. If the certification is for the serious health condition of the EMPLOYEE, please answer the following:

Yes No

 Is the employee able to perform work of any kind?
(If "No" then skip the next question)

 Is the employee unable to perform any one or more of the essential functions of the employee's position? (Answer after reviewing statement from employer of essential functions of employee's position, or if none provided, after discussing with employee.)

7. If the certification is for the care of the employee's FAMILY MEMBER, please answer the following:

Yes No

 Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation?

 After review of the employee's signed statement (See Item 10 below), does the condition warrant the participation of the employee? (This participation may include psychological comfort and/or arranging for third-party care for the family member)

8. Estimate the period of time care needed or during which the employee's presence would be beneficial:

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9. Please answer the following question only if the employee is asking for intermittent leave or a reduced work schedule:

Yes* No

Is it medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal work schedule in order to deal with the serious health condition of the employee or family member?

*If you answered YES please indicate the estimated number of doctor's visits, and/or estimated duration of medical treatment, either by the health care practitioner or another provider of health services, upon referral from the health care provider.

ITEM 10 IS TO BE COMPLETED BY THE EMPLOYEE NEEDING FAMILY LEAVE

***TO BE PROVIDED TO THE HEALTH CARE PROVIDER UNDER SEPARATE COVER

10. When family care leave is needed to care for a seriously ill family member, the employee shall state the care he or she will provide and estimate the time period during which this care will be provided, including a schedule if leave is to be taken intermittently or on a reduced leave schedule:

11. Signature of Health Care Provider:

_____ Date: _____

12. Employee Signature:

_____ Date: _____

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Physician or Practitioner Medical Certification Employee/Family Member Serious Health Condition

Definitions: 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 or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

- a) A period of incapacity of more than three consecutive, full calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:
- b) Treatment two or more times within 30 days of the first day of incapacity, unless extenuating circumstances exist, by a health care provider, by a nurse, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or
- c) 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. The in-person treatment visit must take place within seven days of the first day of incapacity.

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 (defined as at least twice a year) for treatment by a health care provider, or by a nurse;
- (b) Continues over an extended period of time (including recurring episodes of a single underlying condition); and
- (c) May cause episodic rather than 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 stages of a disease.

6. Multiple Treatments (Non-Chronic Conditions)

Any period of absence to receive multiple treatments (including any period of recovery therefore) by a healthcare 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 or more than three full consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).



EMPLOYEE CONTACT INFORMATION SHEET

Employee Name:		Employee ID #:	
Position Title:		Division:	
Street Address:			Unit #:
City:	State:	Zip:	
Phone Number:		Alternate Phone:	