Sweeping Reforms to the Family and Medical Leave Act

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December 16, 2008
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Introduction

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Note: This presentation will focus on the changes made by the new regulations, but will not address regulations that are unique to the public sector or educational institutions.
PART ONE

CHANGES TO INDIVIDUAL REGULATIONS
PART ONE

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FMLA Notice Requirement

- All FMLA covered employers must post “in conspicuous places” an FMLA notice, even if the employer does not have any employees eligible to take FMLA leave. The notice must be readily available to be seen by employees and applicants.

- If the employer has any FMLA eligible employees, it must provide a notice to each employee by putting the notice in the handbook or other distributed literature about benefits or leave rights, or by giving a copy to each new employee upon hiring.

- In addition to the general FMLA notice, employers must also post a supplemental FMLA notice which speaks to the new military leave provisions.
FMLA Notice Requirement (2)

- Notices can be posted and distributed electronically.

- If a “significant portion” of the workforce is not literate in English, the notices must be in a language in which the employees are literate.

- The DOL has two form notices (one general notice and one regarding the new military leave provisions) which can be used by employers and will be posted at: www.dol.gov/esa/whd/fmla.*

*Note: As of the date of this presentation, the notices on the Department of Labor website are not the updated notices. It is our expectation that the updated notices will be available on or before the effective date of the new regulations, January 16, 2009.
Eligible Employees – 12 Months of Employment

- Employers must count periods of employment before a break in service unless the break was more than 7 years ago.

- **BUT**, you must count an employment period before a break in service more than 7 years ago if:
  - The break is because the employee was fulfilling National Guard or Reserve military service obligations; or
  - There was a written agreement confirming the employer’s intention to rehire the employee after the break.
Eligible Employees – 12 Months of Employment (2)

- If an employee is on an approved leave during which time the 12 month FMLA eligibility threshold is reached, the pre-12\textsuperscript{th} month leave time cannot be counted as FMLA leave.
Eligible Employees – 1,250 Hours

- Employer must credit an employee returning from military service with hours of work that would have been performed but for the military service.

- Employer can rely on employee’s pre-military service work schedule.
Eligible Employees
50 Employees Within 75 Miles

- The worksite of telecommuters, sales persons who generally work from their residence, etc., is the office to which they report and from which they get their assignments.

- The worksite of jointly employed persons (such as persons on-site working through a temporary placement agency) is the primary employer’s worksite (in this case, the temporary agency).

- But, if the person has physically worked at the secondary employer’s worksite for at least a year, the location of the secondary employer is the worksite.
Definition of Serious Health Condition

A “serious health condition” is still defined as an illness, injury, impairment or physical or mental condition that involves:

- Inpatient care (overnight stay in hospital including any period of incapacity or any subsequent treatment in connection with such inpatient care); or

- Continuing treatment by a health care provider, meaning:
  - Incapacity and Treatment
  - Pregnancy or Prenatal Care
  - Chronic Conditions
  - Permanent or Long Term Conditions
  - Conditions Requiring Multiple Treatments
Definition of Serious Health Condition - Incapacity and Treatment

- Incapacity must be more than 3 consecutive full calendar days (this is in the current definition).

- Treatment must be at least 2 times within 30 days of the first day of incapacity, unless there are extenuating circumstances.
  - Extenuating circumstances mean circumstances beyond employee’s control which prevents the follow up visit as planned by the health care provider.
  - The second visit must be because the health care provider determined that it was needed (i.e., not the employee).
Definition of Serious Health Condition - Incapacity and Treatment (2)

- Or, treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the health care provider’s supervision (this is in the current definition).

- In either case, the first (and perhaps only) in-person treatment must be within 7 days of the first day of incapacity.
Definition of Serious Health Condition – Chronic Conditions

- If the serious health condition is due to a chronic condition, the employee must make at least two visits per year for treatment by a health care provider.

- A chronic condition may cause episodic rather than a continuing period of incapacity.
Leave for
Pregnancy, Prenatal Care or Birth

- A husband can take leave to care for a pregnant spouse who is incapacitated, or to care for her during prenatal care or to care for her following birth if the spouse has a serious health condition. This leave is not available to the child’s father if he is not the husband.

- If the leave is to care for a newborn with a serious health condition, the father is eligible for this leave.
Leave to Care for a Disabled Adult Child

- When leave is sought to care for a son or daughter who is age 18 or older and is “incapable of self-care because of a mental or physical disability,” the disability must exist at the time that the leave commences.
Leave to Care for a Family Member

- An employee can be “needed to care for” a family member with a serious health condition even if there are other family members available to care for the family member.
Definition of Health Care Provider

- A licensed Physician’s Assistant is a health care provider (in addition to a doctor of medicine or osteopathy, definition of health care provider includes certain professions deemed to be “capable of providing health care services”).
Scheduling Planned Medical Appointments

- Employee must consult with employer.

- Employee must make “a reasonable effort to schedule the treatment so as not to disrupt unduly the employer’s operations, subject to the approval of the health care provider.”

- Commentary says that this is a heightened obligation over the present regulation.
Increments of FMLA Leave

- Increments of FMLA time must be as small as the smallest increment used for other forms of leave, but not greater than one hour.

- However, an employer cannot charge an employee for more FMLA leave than the employee actually used.
Increments of FMLA Leave (2)

- If an employee normally would be required to work overtime but does not because of taking FMLA leave, the unworked overtime hours count as FMLA leave.

- If it is physically impossible for an employee on intermittent or reduced leave to commence or end work mid-shift (such as a flight attendant), the entire time that the employee is forced to be absent may be counted as FMLA leave.
Amount of FMLA Leave Used – Holidays

- When an employee is out a full week and there is a holiday during the week, the employee has taken one week of FMLA leave (this is the current rule).

- If the employee is out less than a full week, an employer may count the holiday as part of the FMLA leave only if the employee would otherwise have been scheduled to work and would have worked on the holiday.
Substitution of Paid Leave

- Contrary to the current regulations, all forms of paid leave are treated the same for purposes of the rules relating to substitution of paid leave for FMLA leave.

- Employees may substitute paid leave for FMLA leave (or, an employer may require substitution) but the substitution must conform to the employer’s normal leave policies (e.g., minimum increments, giving advance notice, etc.).

- If the employee does not comply with additional requirements of paid leave policies, employee would not be entitled to substitute paid leave BUT would still be entitled to unpaid FMLA leave.
Substitution of Paid Leave (2)

- If the employee wants to substitute paid leave and the minimum increment of the paid leave is larger than the amount of FMLA leave the employee needs, the employee must take the larger amount of leave and it will be charged against FMLA leave.

- Paid leave policies must not discriminate against use of FMLA leave.

- Employer cannot require substitution of paid leave if employee is getting short term disability or workers compensation benefits.
Health Insurance Premium Payments

- If an employee on FMLA leave loses coverage due to employee’s failure to pay premiums, when the employee returns from FMLA leave the employer must restore the employee (and spouse and dependents) to coverage he or she would have had but for the lapse due to failure to pay the premiums. No waiting periods or pre-existing condition exclusions are permitted.

- If an employer fails to restore health insurance as required, it may be liable for benefits lost, other actual monetary losses, and equitable relief.
Perfect Attendance and Similar Policies

- Bonuses that are dependent on a goal, such as perfect attendance, or hours worked, or products sold or manufactured, may be denied to those who took FMLA leave and as a result could not attain the goal.

- **But**, employer cannot deprive employee of these bonuses if it does not deprive others who used leave that did not qualify as FMLA leave.

- **And**, employer cannot count FMLA leave days as absences under a no-fault attendance policy.
Light Duty

- When an employee returns to work but is on light duty, the employee is not using FMLA leave.

- If an employee is unable to perform even just one function of the position, the employer cannot force the employee to take a light duty position.

- Employee’s right to job restoration is held in abeyance while on light duty or until expiration of applicable 12 month FMLA leave year.
FMLA Releases

- It is legal for an employee to sign a release waiving past FMLA claims without getting Department of Labor approval. The waiver can include a waiver of all claims based on facts known or unknown, asserted or not asserted.

- It is not legal to have an employee waive claims for possible future FMLA violations.
Joint Employer - Professional Employer Organizations

- Whether a PEO is a joint employer depends on the economic realities of the arrangement. If it merely performs administrative functions, it is not a joint employer.

- “Administrative functions” include: payroll, benefits, regulatory paperwork, and updating employment policies.

- If a PEO has the right to hire, fire, assign, or direct and control employees, it may be joint employer.
PART TWO

THE LEAVE PROCESS
PART TWO

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Employee Notice Requirement
Timing - Foreseeable Leave

- Employee must still give notice at least 30 days in advance, or as soon as practicable.

- As soon as practicable means “as soon as both possible and practical,” and usually means the day the employee learns of the need for the leave or the next business day.

- If employee does not provide at least 30 days’ notice, employee is obligated to explain why it was not practicable to give 30 days’ notice if employer asks.

- Verbal notice is acceptable.
Employee Notice Requirement
Timing - Unforeseeable Leave

- Notice must be given “as soon as practicable,” which generally should be consistent with the employer’s usual policies.
Employee Notice Requirement – Content of Notice

- Employee must provide sufficient information to enable the employer to determine that the leave might be FMLA qualifying leave, but employer is still obligated to inquire if it appears that the reason may be FMLA-qualifying.

- For unforeseeable leave, employee saying that he or she is “sick” is not enough information to put employer on notice.

- Employee must respond to employer’s reasonable inquiries for information to determine if leave is potentially FMLA qualifying leave.

- If reason for leave is same as for a previously granted FMLA leave, employee must specify reason or specify that employee is requesting FMLA leave.
Employee Notice Requirement - Obligation to Comply With Employer Policies

- Employees can be required to comply with employer’s customary policies regarding requesting leave.

- But, employer policies must not be any more strict than FMLA regulations and must not discriminate against employee who takes FMLA leave.

- Call in procedures: Employer can require that employee contact a specific individual. Absent unusual circumstances, such as inability of employee to reach the person, employee can be denied FMLA leave for failure to contact specific individual.

- Employer may waive some requirements of its policies but it should be consistent.
Effect of Failure to Comply with Employer Policies

- For employer to impose any sanctions, it must be able to show that employee had actual notice of requirements. Complying with general FMLA notice requirements (poster, handbook) is sufficient.

- Employer may delay or deny leave for failure of employee to give proper notice absent unusual circumstances, but cannot delay or deny foreseeable leave if employee gave 30 days’ notice even when employee knew of need for leave more than 30 days.
Employer Response: Eligibility Notice

- Notice tells employee if eligible or not for FMLA leave (12 months; 1,250 hours; 50 employees).

- Employer must notify employee of his/her eligibility to take FMLA leave within 5 business days of employee’s request or of employer’s learning that leave may be covered by FMLA, unless there are extenuating circumstances.

- The notice can be oral or in writing but should be mailed to the employee if the leave has already started.

- If the employee is not eligible for FMLA leave, the eligibility notice must specify at least one reason why the employee is not eligible.
Employer Response:
Eligibility Notice (2)

- If a “significant portion” of the workforce is not literate in English, the notice must be in a language in which the employees are literate.

- The DOL has provided a form that can be used for this purpose. We expect that it will be available electronically on the DOL website on or after the effective date of the new regulations, January 16, 2009. A copy of the form is attached in the Appendix at p. 77-79.

- Subsequent request for leave in 12 month period for different reason:
  - New notice not needed if eligibility has not changed.
  - New notice needed if employee is no longer eligible for FMLA leave.

- All absences for the same qualifying reason are considered a single leave and employee eligibility does not change during the 12 month period.
Employer Response:
Rights and Responsibilities Notice

- Must be provided to employee each time an eligibility notice is required.

- Certain minimum information must be provided, but employer can add more.

- If information on rights and responsibilities notice changes later, a new notice must be given within 5 business days of the change.

- Notice can be delivered electronically.

- The DOL notice of eligibility form referenced in the previous slide includes this notice of rights and responsibilities and can be used for this purpose.
Employer Response: Rights and Responsibilities Notice (2)

- If an employer does not use the DOL form, notice must contain specific expectations and obligations and consequences of failure to meet obligations, including, at a minimum (when appropriate):
  - That the leave may be designated and counted against employee’s FMLA leave entitlement;
  - The applicable 12 month period;
  - Any requirements for certifications (e.g., medical – for serious health condition);
  - Employee’s right to substitute paid leave;
  - How employee is to pay health insurance premiums and the consequences of failure to make premium payments;
Employer Response: Rights and Responsibilities Notice (3)

- Continued (Rights and Responsibilities Notice form requirements):
  - If the employee is a “key employee”;
  - Employee’s right to maintenance of benefits when on leave and right to be restored to an equivalent position upon return from leave;
  - Employee’s liability for payment of health insurance premiums if employee fails to return to work;
  - Any requirements for paid leave and inform the employee that he/she is still eligible for FMLA leave if the employee does not substitute paid leave.
Medical Certifications (1)

- Employer should make a request for certification within 5 business days after the employee requests leave; usually done via rights and responsibilities notice.

- Employee must provide certification within 15 calendar days (employer can give more time if it wants) unless it is not practicable to do so despite employee’s diligent efforts.

- DOL has provided certification forms for employee’s own serious health condition and for the serious health condition of family member. We expect that they will be electronically available on the DOL website on or after the effective date of the new regulations, January 16, 2009. Copies of the forms are attached in the Appendix at pp. 80-82 (Employee’s Serious Health Condition) and 83-86 (Family Member’s Serious Health Condition).
Medical Certifications (2)

- Employee must provide a “complete and sufficient certification” or must provide the employer with authorization for the health care provider to release certification to the employer, but in all events it is the employee’s responsibility to provide the employer with a “complete and sufficient certification.”

- If certification is incomplete or insufficient, employer must notify employee in writing of what additional information is needed.

- Certification is incomplete if an entry is blank and is insufficient if information is “vague, ambiguous, or non-responsive.”
Medical Certifications (3)

- Employer must give the employee at least 7 calendar days to cure any deficiency in the certification unless that is not practicable despite the employee’s diligent efforts.

- Employer may deny FMLA leave if the deficiencies in the certification are not corrected in the resubmitted certification, or there is no resubmitted certification.

- Employer must follow HIPAA Privacy Rule if certification contains individually-identifiable information created or held by a HIPAA covered health care provider.

- Employer can request a certification annually if the need for leave lasts beyond a single leave year.
Authentication or Clarification of Medical Certification

- Employer may contact health care provider for authentication (i.e., verifying that the health care provider completed and signed the certification) or clarification (i.e., understanding the handwriting or understanding the meaning of a response) **but only after giving employee a chance to clarify**.

- Employee must authorize employer to contact health care provider or must provide the clarification requested by the employer, but employee authorization not needed for authentication.

- Employer health care provider, human resources professional, leave administrator, or manager, **but not employee’s supervisor**, may contact employee’s health care provider.
Employer Response: Designation Notice

- When employer has enough information to know whether leave is for an FMLA qualifying reason (e.g., after getting a medical certification), it must notify the employee within 5 business days.

- Employer must notify employee whether employee has FMLA time available and whether leave does or does not qualify as FMLA leave.

- Notice must in writing.

- Notice must be given again, within 5 business days, if information changes, such as when the employee runs out of FMLA leave.

- The DOL has provided a form that can be used for this purpose. We expect that it will be electronically available on the DOL website on or after the effective date of the new regulations, January 16, 2009. A copy of the form is attached in the Appendix at pp. 87-88. However, if you are denying FMLA leave a simple written notice is sufficient.
Employer Response: Designation Notice (2)

- If you do not use the DOL form, you must state the following:

  - Whether you will require a fitness for return to work certification and, if so, you must inform employee of essential functions if you want the fitness-for-duty certification to address employee’s ability to perform essential functions.

  - Whether you will require, or the employee requested, that paid leave be substituted for unpaid leave.

  - How much FMLA time the employee will use if it is possible to make that determination. This can be done orally, but must be confirmed in writing no later than the next payday.

    - If it is not possible, employer must tell employee upon employee’s request, but not more often than once every 30 days.
Recertification

- Employer can ask for a recertification once every 30 days but only in connection with absence by employee.

- However, if original certification indicated that the duration of the condition will be more than 30 days and the leave involves absence of the employee, employer must wait until minimum duration has expired (but employer can always ask every 6 months).

- Employer does not have to wait 30 days if:
  - employee asks for an extension of leave; or
  - if circumstances in original certification have changed significantly (e.g., medical condition seems worse, or employee has pattern of taking unscheduled FMLA leave in conjunction with other days off); or
  - if employer “receives information that casts doubt upon the continuing validity of the certification.”
Fitness for Duty Certification

- If an employee uses intermittent leave and the employer has reasonable safety concerns, the employer may require a fitness for duty certification up to once every 30 days.

- Insistence on a fitness-for-duty certification must follow a uniform policy.

- Employer is entitled to a certification, rather than the current “simple statement” from the health care provider.

- Employer **must** provide a list of essential functions at the time of providing the designation notice if employer wants the fitness for duty certification to address employee’s ability to perform the essential functions of employee’s position.
Disagreement About Whether Leave Qualifies As FMLA Leave

- If there is a disagreement as to whether the leave is FMLA qualifying, it should be resolved through employer-employee discussions which should be documented.
Employer Failure to Follow 3 Notice Requirements

- Employer failure to follow the notice requirements could be deemed to be unlawful interference with, restraint, or denial of the exercise of an employee’s FMLA rights, but the employee would have to prove actual harm to the employee.

- The employer can retroactively designate leave as FMLA leave so long as the employee does not suffer harm as a result.
Nothing in the FMLA regulations prevents an employer from following appropriate procedures for requesting information in connection with the Americans with Disabilities Act.
PART THREE

MILITARY-RELATED LEAVES
### PART THREE

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Military Caregiver Leave

- Military Caregiver Leave - Care for a “covered service member” with a serious injury or illness incurred in the line of duty.

- Provides up to six months leave during a 12-month period to care for a servicemember with “serious injury or illness” incurred in the line of duty while on active duty.

- Covers more extended family members than other forms of FMLA leave (spouse, son or daughter of any age, parent, next of kin).
Military Caregiver Leave – Definition of a Covered Servicemember

- A **current** member of Armed Forces, including National Guard or Reserves, or member who is on the temporary disability retired list and:
  - has a serious illness or injury incurred in the line of duty on active duty for which s/he is undergoing medical treatment, recuperation or therapy, OR
  - is otherwise in outpatient status or otherwise on temporary disability list.

- **Not** former members or members on permanent disability retired list.
Military Caregiver Leave – Son or Daughter

- Applies to the covered servicemember’s “biological, adopted, or foster child, step child, legal ward, or a child for whom the servicemember stood *in loco parentis*, and who is of *any age*.”
Military Caregiver Leave – Parent of a Covered Servicemember

- Applies to “the covered servicemember’s biological, adoptive, step or foster father or mother, or any individual who stood in loco parentis to the covered servicemember.”

- Does not include parents-in-law.
Military Caregiver Leave – Definition of “Next of Kin”

- Means nearest blood relative, other than the covered servicemember’s spouse, parent, son, daughter, in the following order of priority:
  - blood relatives granted legal custody of servicemember
  - brothers/sisters
  - grandparents
  - aunts/uncles
  - first cousins

*unless* servicemember has designated in writing another blood relative for purposes of military caregiver leave under FMLA.
Military Caregiver Leave – Amount of Leave Allowed

- When military caregiver leave taken, total FMLA leave for the “single 12-month period” (beginning when FMLA caregiver leave begins) cannot exceed 26 weeks.

- Example: Employee may take 16 weeks of FMLA caregiver leave + 10 weeks FMLA leave for other reason, but could not take 26 weeks FMLA caregiver leave + 10 weeks other FMLA leave.

- The 12-month period in which an eligible employee may take military caregiver leave must be calculated on a going forward basis starting with the first day leave is taken.
Military Caregiver Leave – Employer Designation

- If leave qualifies for military caregiver leave and regular FMLA leave for serious health condition, employer must designate as military caregiver leave in the first instance.

- Employer cannot count toward entitlement for both forms of FMLA leave.
Military Caregiver Leave – Spouses

- Spouses working for same employer are limited to combined total of 26 weeks during the “single 12-month period” to care for a covered servicemember with a serious illness or injury.

- Similar to limitation when, for example, spouses take leave following birth or adoption of healthy child.
Military Caregiver Leave – Certification

- Certification for leave taken to care for covered servicemember.
  - Designates Health Care Providers who may complete certification
  - Outlines information required
  - Allows employers to request certain additional information from the employee or covered servicemember (e.g., address, relationship, branch, rank, unit assignment, treatment facility or unit, description of care, etc.)
Military Caregiver Leave – Certification (2)

Certification cont’d.

DOL has provided Optional Form WH-385 that can be used for this purpose. We expect that it will be electronically available on the DOL website on or after the effective date of the new regulations, January 16, 2009. A copy of the form is attached in the Appendix at pp 89-92.

In lieu of Form WH-385, employer must accept as sufficient “invitational travel order” (“ITO”) or “invitational travel authorization” (“ITA”) issued to family member to join servicemember at bedside.

Employer may seek authentication or clarification.

Second and third opinions are not permitted.
Qualifying Exigency Leave – Who Is Entitled to Leave

- Qualifying exigencies – Leave available to eligible employees with a covered military service member serving in the National Guard or Reserves to use for “any qualifying exigency.”

- Family (spouse, child or parent) of a National Guard or Reserves member can use 12-week FMLA entitlement for qualifying exigencies arising out of the fact that the member is on active duty or called to active duty in support of a contingency operation.
“Qualifying exigencies” include:

- short-notice deployment;
- military events and related activities;
- child care and school activities;
- financial and legal arrangements;
- counseling;
- rest and recuperation (up to 5 days for each instance);
- post-deployment activities; and
- any other activities agreed to by employer & employee (including agreement on timing and duration of such leave.)
Qualifying Exigency Leave – Active Duty or Call to Active Duty Status

- The term “active duty or a call to active duty status” means duty under a federal call or order to active duty (as opposed to a state call) in support of a contingency operation.

- Such active duty or call/order to active duty is only made to members of the National Guard or Reserves or retired members of the Regular Armed Forces or Reserves.

- An employee may **not** take exigency leave if the servicemember is a member of the Regular Armed Forces.
Qualifying Exigency Leave – Employee Notice

- For foreseeable, qualifying exigency leave, employee must provide notice as soon as practicable, *regardless of how far in advance the leave is foreseeable.*
Qualifying Exigency Leave – Certification

- Two types of certification, both of which must be provided by employee to employer within 15 days, absent unusual circumstances.

  - First certification confirms that the covered military member is a member of the National Guard or Reserves who is on active duty or called to active duty to support a contingency operation or has just returned from such duty.

  - May require copy of active duty orders or other documentation from military indicating dates.
Qualifying Exigency Leave – Certification (2)

- In the second certification employer may require:
  - Statement signed by employee describing the exigency;
  - Available documentation (e.g., meeting flyer, document confirming appointment, bill for financial/legal services handled);
  - Approximate date qualifying exigency commenced or will commence;
    - If request for a single period of time, the beginning and end dates of absence;
    - If request for intermittent or reduced schedule basis, an estimate of the frequency and duration of such exigency; and
  - If exigency involves meeting with third party, contact information for that party and brief description of purpose of meeting.
Qualifying Exigency Leave – Certification (3)

- Certification

  - DOL has provided Optional Form WH-384 that can be used for this purpose. We expect that it will be electronically available on the DOL website on or after the effective date of the new regulations, January 16, 2009. A copy of the form is attached in the Appendix at pp. 93-95.

  - If certification complete, employer may not request additional information.
Qualifying Exigency Leave – Employer Verification

- Verification:

  - If exigency involves meeting with third party, may contact to verify meeting or appointment schedule and nature of meeting; may not request additional information.

  - May contact unit of DOD to request verification that covered military member is on active duty (or called to active duty); may not request additional information.

  - Employee’s permission is not required.
Note: The *forms* contained herein are current updated forms, which were provided as attachments to the new regulations themselves. They are not yet available online but we expect that these too will be available on the DOL website on or around January 16, 2009.
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77-79. Notice of Eligibility and Rights and Responsibilities

80-82. Certification of Health Care Provider for Employee’s Serious Health Condition

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89-92. Certification for Serious Injury or Illness of Covered Servicemember for Military Family Leave

93-95. Certification for Qualifying Exigency for Military Family Leave
NOTICE OF ELIGIBILITY AND RIGHTS & RESPONSIBILITIES  
(Family and Medical Leave-Act)

PART A - NOTICE OF ELIGIBILITY

TO:  
__________________________________________
Employee

FROM:  
__________________________________________
Employer Representative

DATE:  
__________________________________________

On __________________ you informed us that you needed leave beginning on ____________ for:

____ The birth of a child, or placement of a child with you for adoption or foster care;

____ Your own serious health condition;

____ Because you are needed to care for your _____ spouse; _____ child; _____ parent due to his/her serious health condition.

____ Because of a qualifying exigency arising out of the fact that your_____ spouse; _____ son or daughter; _____ 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.

____ Because you are the _____ spouse; son or daughter; _____ parent; _____ next of kin of a covered servicemember with a serious injury or illness.

This Notice is to inform you that you:

____ Are eligible for FMLA leave (See Part B below for Rights and Responsibilities)

____ Are not eligible for FMLA leave, because (only one reason need be checked, although you may not be eligible for other reasons):

____ You have not met the FMLA's 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately _____ months towards this requirement.

____ You have not met the FMLA's 1,250-hours-worked requirement.

____ You do not work and/or report to a site with 50 or more employees within 75-miles.

If you have any questions, contact __________________________ or view the FMLA poster located in __________________________.

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PART B - RIGHTS AND RESPONSIBILITIES FOR TAKING FMLA LEAVE

As explained in Part A, you meet the eligibility requirements for taking FMLA leave and still have FMLA leave available in the applicable 12-month period. **However, in order for us to determine whether your absence qualifies as FMLA leave, you must return the following information to us by ___**. (If a certification is requested, employers must allow at least 15 calendar days from receipt of this notice; additional time maybe required in some circumstances.) If sufficient information is not provided in a timely manner, your leave may be denied.

- Sufficient certification to support your request for FMLA leave. A certification form that sets forth the information necessary to support your request __ is, __ is not enclosed.
- Sufficient documentation to establish the required relationship between you and your family member.
- Other information needed: ___________________________ ___________________________ ___________________________

- No additional information requested.

**If your leave does qualify** as FMLA leave you will have the following **responsibilities** while on FMLA leave (only checked blanks apply):

- Contact __________________ at __________________ to make arrangements to continue to make your share of the premium payments on your health insurance to maintain health benefits while you are on leave. You have a minimum 30-day (or, indicate longer period, if applicable) 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.

- You will be required to use your available paid __ sick, __ vacation, and/or __ other leave during your FMLA absence. This means that you will receive your paid leave and the leave will also be considered protected FMLA leave and counted against your FMLA leave entitlement.

- Due to your status within the company, you are considered a "key employee" as defined in the FMLA. As a "key employee," restoration to employment may be denied following FMLA leave on the grounds that such restoration will cause substantial and grievous economic injury to us. We ____ have, ____ have not determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic harm to us.

- While on leave you will be required to furnish us with periodic reports of your status and intent to return to work every ___.
  (Indicate interval of periodic reports, as appropriate for the particular leave situation).
If the circumstances of your leave change, and you are able to return to work earlier than the date indicated on the reverse side of this form, you will be required to notify us at least two workdays prior to the date you intend to report for work.

If your leave does qualify as FMLA leave you will have the following rights while on FMLA leave:

- You have a right under the FMLA for up to 12 weeks of unpaid leave in a 12-month period calculated as:
  - the calendar year (January - December).
  - a fixed leave year based on ________________.
  - the 12-month period measured forward from the date of your first FMLA leave usage.
  - a "rolling" 12-month period measured backward from the date of any FMLA leave usage.

- You have a right under the FMLA for up to 26 weeks of unpaid leave in a single 12-month period to care for a covered servicemember with a serious injury or illness. This single 12-month period commenced on ________________.

- Your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work.

- 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 FMLA-protected leave. (If your leave extends beyond the end of your FMLA entitlement, you do not have return rights under FMLA.)

- 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; 2) the continuation, recurrence, or onset of a covered servicemember's serious injury or illness which would entitle you to FMLA leave; or 3) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave.

- If we have not informed you above that you must use accrued paid leave while taking your unpaid FMLA leave entitlement, you have the right to have _____ sick, _____ vacation, and/or _____ other leave run concurrently with your unpaid leave entitlement, provided you meet any applicable requirements of the leave policy. Applicable conditions related to the substitution of paid leave are referenced or set forth below. If you do not meet the requirements for taking paid leave, you remain entitled to take unpaid FMLA leave.

  For a copy of conditions applicable to sick/vacation/other leave usage please refer to _______ available at: ________________________________.

  Applicable conditions for use of paid leave: ________________________________________________
  ________________________________________________
  ________________________________________________

Once we obtain the information from you as specified above, we will inform you, within 5 business days, whether your leave will be designated as FMLA leave and count towards your FMLA leave entitlement. If you have any questions, please do not hesitate to contact: _________________________________.

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CERTIFICATION OF HEALTH CARE PROVIDER FOR
EMPLOYEE’S SERIOUS HEALTH CONDITION
(Family and Medical Leave Act)

SECTION I: For Completion by the EMPLOYER

Employer name: _______________________________________________________

Contact Information: ___________________________________________________

Employee’s job title: ____________________________________________________

Regular Work Schedule: _________________________________________________

Employee’s essential job functions: _______________________________________

Check if job description 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 protection. 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

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 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 employee is seeking leave. 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:

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:

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. 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):

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

- 2 -
PART B: AMOUNT OF CARE NEEDED

5. Will the employee 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: __________________________

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

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

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH ADDITIONAL ANSWER

   __________________________

   __________________________

   __________________________

Signature of Health Care Provider __________________________ Date __________________________
CERTIFICATION OF HEALTH CARE PROVIDER FOR
FAMILY MEMBER'S SERIOUS HEALTH CONDITION
(Family and Medical Leave Act)

SECTION I: For Completion by the EMPLOYER

Employer name: ____________________________________________________________

Contact Information: _______________________________________________________

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 protection. 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 ________________________
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. 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:

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:

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):


- 2 -
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:
   ________________________________
   ________________________________
   ________________________________
   ________________________________
   ________________________________
   ________________________________
   ________________________________
   ________________________________

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 ____________
DESIGNATION NOTICE
(Family and Medical Leave Act)

TO: ____________________________________________________________

Employee

FROM: __________________________________________________________

Employer Representative

DATE: __________________________________________________________

We have reviewed your request for leave under the FMLA and any supporting documentation that you have provided. We received your most recent information on ________________________ and decided:

Your FMLA leave request is approved. All leave taken for this reason will be designated as FMLA leave.

The FMLA requires that you notify us as soon as practicable if dates of scheduled leave change or are extended, or were initially unknown. Based on the information you have provided to date, we are providing the following information about the amount of time that will be counted against your leave entitlement:

Provided there is no deviation from your anticipated leave schedule, the following number of hours, days, or weeks will be counted against your leave-entitlement: ________________________

Because the leave you will need will be unscheduled, it is not possible to provide the hours, days, or weeks that will be counted against your FMLA entitlement at this time. You have the right to request this information once in a 30-day period (if leave was taken in the 30-day period).

Please be advised (check if applicable):

You have requested to use paid leave during your FMLA leave. Any paid leave taken for this reason will count against your FMLA leave entitlement.

We are requiring you to substitute or use paid leave during your FMLA leave.

You will be required to present a fitness-for-duty certificate to be restored to employment. If such certification is not timely received, your return to work may be delayed until certification is provided. A list of the essential functions of your position ___ is ___ is not attached. If attached, the fitness-for-duty certification must address your ability to perform these functions.
Additional information is needed to determine if your FMLA leave request can be approved:

The certification you have provided is not complete and sufficient to determine whether the FMLA applies to your leave request. You must provide the following information no later than ________ (Provide at least seven calendar days), unless it is not practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied.

(Specify information needed to make certification complete and sufficient)

We are exercising our right to have you obtain a second or third opinion medical certification at our expense, and we will provide further details at a later time.

Your FMLA Leave request is Not Approved.

The FMLA does not apply to your leave request.

You have exhausted your FMLA leave entitlement in the applicable 12-month period.
CERTIFICATION FOR SERIOUS INJURY OR ILLNESS OF COVERED
SERVICEMEMBER — FOR MILITARY FAMILY LEAVE
(Family and Medical Leave Act)

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

INSTRUCTIONS to the EMPLOYEE or COVERED 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 covered 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 C.F.R. § 825.310(f). The employer must give an employee at
least 15 calendar days to return this form to the employer.

PART A – EMPLOYEE INFORMATION

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

Name of Employee Requesting Leave to Care for Covered Servicemember:

First    Middle    Last

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

First    Middle    Last

Relationship of Employee to Covered Servicemember Requesting Leave to Care:
☐ Spouse ☐ Parent ☐ Son ☐ Daughter ☐ Next of Kin

PART B – COVERED SERVICEMEMBER INFORMATION

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

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

Is the covered 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 Covered Servicemember on the Temporary Disability Retired List (TDRL)?
Yes  No

**PART C – CARE TO BE PROVIDED TO THE COVERED SERVICEMEMBER**

Describe the Care to Be Provided to the Covered 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; or (3) a DOD non-network TRICARE authorized private health care provider**

**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 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 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 covered servicemember's serious injury or illness includes written documentation confirming that the covered servicemember's injury or illness was incurred in the line of duty on active duty and that the covered 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 condition for which the employee is seeking leave.

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; or (4) a DOD non-network TRICARE authorized private health care provider:

________________________________________________________________________

Telephone: ( )_________ Fax: ( )_________ Email:______________________________

PART B – MEDICAL STATUS

(1) Covered 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 or an employer-provided form seeking the same information.)

(2) Was the condition for which the Covered Service member is being treated incurred in 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 covered servicemember undergoing medical treatment, recuperation, or therapy?

_____ Yes _____ No. If yes, please describe medical treatment, recuperation or therapy:

________________________________________________________________________
PART C – COVERED SERVICEMEMBER’S NEED FOR CARE BY FAMILY MEMBER

(1) Will the covered 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 covered servicemember require periodic follow-up treatment appointments?
_____ Yes _____ No If yes, estimate the treatment schedule:________________________

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

(4) Is there a medical necessity for the covered 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: ____________
CERTIFICATION OF QUALIFYING EXIGENCY FOR MILITARY FAMILY LEAVE
(Family and Medical Leave Act)

SECTION I: For Completion by the EMPLOYER

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 C.F.R. § 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 covered military member on active duty or call to active duty status in support of a contingency operation:

First    Middle    Last

Relationship of covered military member to you:

Period of covered military member's active duty:

A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes written documentation confirming a covered military member's active duty or call to active duty status in support of a contingency operation. Please check one of the following:

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

____ Other documentation from the military certifying that the covered military member is on active duty (or has been notified of an impending call to active duty) in support of a contingency operation is attached.

____ I have previously provided my employer with sufficient written documentation confirming the covered military member's active duty or call to active duty status in support of a contingency operation.
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 an appointment with a counselor or school official, 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? ___ No ___ Yes.

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? ___ No ___ Yes.

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 – THIRD PARTIES

If leave is requested to meet with a third party (such as to arrange for childcare, to attend counseling, to attend meetings with school or childcare providers, to make financial or legal arrangements, to act as the covered 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 – SIGNATURE

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

Signature of Employee ___________________________ Date ___________________________