Attachment #1

CITY OF STOCKTON
LEAVE REQUEST FORM

Employee Name: _____

Position: _____

Department: _____

Type of Leave Requested	Date and Time Requested
☐ Annual Leave	Date(s): _____
☐ Bereavement	Time: # of days:____ # of hours:____
☐ Compensatory (Comp) Time	
☐ Family Sick Leave (Less than 3 days)	
☐ Family Medical Leave (FMLA) / California Family Rights Act (CFRA) **Check appropriate box**:	
☐ Birth of child or to care for a newborn	☐ Baby bonding
☐ Placement of a child due to adoption or foster care	☐ Employee's serious health condition
☐ Military Leave (Circle one): Qualifying exigency Care for military member	☐ Serious health condition of (**Circle one**): Child, parent, spouse or domestic partner
☐ Jury Duty	
☐ Leave without Pay (LWOP)	
☐ Military Leave	
☐ Pregnancy Disability Leave (in conjunction with FMLA/CFRA)	
☐ Sick Leave	

Employee Signature: _____ Date: _____

Supervisors Signature: _____ Date: _____

Attachment #2

City of Stockton
Notice of Eligibility and Rights & Responsibilities
Family and Medical Leave Act (FMLA) / California Family Rights Act (CFRA)

DATE:

Employee:

Supervisor:

PART A – NOTICE OF ELIGIBILITY

On_____, you informed us that you needed leave starting_____ due to:

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

☐ Your own serious health condition

☐ Need to care for your: ☐ spouse/registered domestic partner; ☐child; ☐ parent due to serious health condition.

☐ A qualifying exigency due to your ☐ spouse; ☐son or daughter; ☐ parent being on active duty or called to active duty status in support of a contingency operation in a foreign country as a member of the Regular Armed Forces, National Guard or Reserves.

☐ Caring for a covered servicemember with a serious injury or illness and you are the ☐ spouse/registered domestic partner; ☐son or daughter; ☐ parent; ☐ next of kin of this military member.

This Notice is to inform you that you:

☐ Are eligible for FMLA/CFRA leave (See Part B below for Rights and Responsibilities)

☐ Are **not** eligible for FMLA/CFRA leave, because:
- ☐ 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 _____ month(s) towards this requirement.
- ☐ You have not met the FMLA's 1,250-hours-worked requirement.
- ☐ You have exhausted all of your FMLA/CFRA leave in the applicable 12-month period.

If you have any questions, contact your immediate supervisor or Human Resources.

CITY OF STOCKTON

PART B – RIGHTS AND RESPONSIBILITIES FOR TAKING FMLA LEAVE

As explained in Part A, you meet the eligibility requirements for taking FMLA/CFRA leave and still have FMLA/CFRA leave available in the applicable rolling 12-month period. **In order for us to determine whether your absence qualifies as FMLA/CFRA leave, you must return the following information to us by:_____.**

☐ A medical certification (completed by your health care provider) to support your request for FMLA/CFRA leave if your leave request is in excess of 3 days. (Please see attached form). Failure to provide a complete and sufficient medical certification 15 calendar days from the date of this notice may result in a denial of or delay in the processing of your FMLA/CFRA leave request.

☐ Sufficient documentation to establish the required relationship between you and your family member.

☐ Other information needed: _____

☐ No other information is needed

If your leave <u>does qualify</u> as FMLA/CFRA, you will have the following <u>responsibilities</u>:

- You will be required to use your available paid leave accruals (sick, vacation, compensatory time) during your FMLA/CFRA absences. This means that you will receive paid leave and the leave will also be considered protected FMLA leave and counted against your FMLA/CFRA leave benefit. (See FMLA Policy & Procedures, "Required Use of Paid Accruals".)

- If your FMLA/CFRA leave is due to your own medical condition, and your leave request is for an excess of 3 days, you will be required to submit appropriate medical documentation from the appropriate health care provider before you can return to work.

- If you pay a portion of your health benefits or participate in the City's Section 125 plan, these expenses will continue to be deducted directly from your paycheck. However, if you are in a leave without pay status while on FMLA/CFRA, you must make arrangements to continue to pay your premium payments. Please contact the Human Resources Office to make these arrangements.

If your leave <u>does qualify</u> as FMLA/CFRA leave you will have the following <u>rights:</u>

- You have a right under the FMLA/CFRA for up to 12 weeks of unpaid leave in a 12-month period. The 12-month period is measured forward from the date of your first FMLA/CFRA leave usage.

- Military Leave Only:
  You have a right under the FMLA for up to 26 weeks of unpaid leave in a rolling 12-month period to care for a military member with a serious injury or illness. This rolling 12-month period commenced on _____.

- Your health benefits must be maintained during any period of FMLA unpaid leave. However, you will still be responsible for any premiums you would normally pay while working.

- Unless you are determined to be a "key employee", you will 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 benefit, you do not have return rights under FMLA.)

- If you do not return to work following FMLA period 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 military member's serious injury or illness which would entitle you to FMLA leave; or 3) other circumstances beyond your control, you will be required to reimburse the City for any health expenses paid on your or your family member's behalf.

Upon receipt of the information specified above, you will be inform, within 5 business days, whether your leave will be designated as FMLA/CFRA leave and count towards your FMLA/CFRA leave benefit. If you have any questions, please contact: Human Resources Department-Benefits Section at 937-8865 or 937-7325.

By signing below, I certify that the above noted employee has met the FMLA's 12-month length of service requirement **<u>and</u>** has met the minimum 1,250-hours-worked requirement. I also certify that the above-noted employee has **<u>not</u>** exhausted all his/her FMLA/CFRA leave in the applicable 12-month period.

_____

Supervisor Name and Title

_____

Supervisor Signature Date

cc: Human Resources—Benefits Section

CITY OF STOCKTON

Attachment #3

EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Benefit

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son/daughter, parent, with a serious health condition; or
- For a serious health condition that makes the employee unable to perform their job.

Military Family Leave Benefits

Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the Regular Armed Forces, National Guard or Reserves in support of a contingency operation to a foreign country may use their 12-week leave benefit to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, caring for a parent who is incapable of self-care, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave benefit that permits eligible employees to take up to 26 weeks of leave to care for a military member during a single 12-month period. A military member is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty or that existed before the beginning of the member's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces that may render the military member medically unfit to perform his or her duties for which the military member is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list. Covered veterans who are undergoing medical treatment, recuperation, or therapy for a serious injury or illness qualify as well.

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave benefit in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities
Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave benefit. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers
FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement
An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.

Attachment #4

City of Stockton
Designation Notice
Family and Medical Leave Act

Leave covered under the Family and Medical Leave Act (FMLA) must be designated as FMLA-protected and the City of Stockton must inform the employee of the amount of leave that is counted against the employee's FMLA leave benefit. In order to determine whether leave is covered under FMLA, the City will require that the leave be supported by a medical certificate.

DATE (Notice Sent):	
TO (Employee):	

On_____, you notified us of your need to take family medical leave. This is to inform you that:

☐ **Your FMLA leave request is approved and 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 benefit:

- ☐ Provided there is no deviation from your anticipated leave schedule, the following number of hours, days, or weeks will be counted against your leave benefit: _____.
- ☐ The leave you will need is currently unknown or unscheduled; therefore, it is not possible to provide the specific hours, days, or weeks that will be counted against your FMLA benefit at this time.
- ☐ You will be required to present a Return to Work Certificate to be restored to employment. If the certificate is not received timely, your return to work may be delayed until the certificate is provided.

Please be advised that you are required to use paid leave during your FMLA leave.

If you normally pay a portion of the premiums for your health insurance or other benefits, such as voluntary products under the Section 125 plan, these payments will continue during the period of FMLA leave. Arrangements for payment have been discussed with you and it is agreed that you will make premium payments as follows:_____

_____

☐ **Additional information is needed to determine if your FMLA leave request can be approved.**

☐ The medical certification you provided is not complete or sufficient enough to determine whether the FMLA applies to your leave request. You must provide the following information no later than _____(provide at least 7 calendar days)

_____

_____

(Specify information needed to make the 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 because:**

☐ FMLA does not apply to your leave request

☐ You have exhausted your FMLA leave benefit for this rolling 12-month period

---

Supervisor Name:_____

Supervisor Signature:_____Date:_____

cc: Department Payroll
Human Resources-Benefits Section

CITY OF STOCKTON

Attachment #5

City of Stockton
Employee Health Care Provider's Certification Form

Section I: To be Completed by the Employee

INSTRUCTIONS TO THE EMPLOYEE: Please complete Section I before giving this form to your medical provider. 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. Failure to provide this medical certification within **15 calendar** days from the date you requested FMLA/CFRA, may result in a denial of or delay in the processing of your FMLA/CFRA request.

_____
Employee's Name (First, Middle, Last) – Please print

_____
Employee's Job Title

Section II: To be Completed by the Health Care Provider

INSTRUCTIONS TO THE HEALTH CARE PROVIDER: Your patient has requested leave under the Family and Medical Leave Act (FMLA) / California Family Rights Act (CFRA) for a serious health condition. Please 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/CFRA coverage. Limit your responses to the condition for which the employee is seeking leave.

1. Provider's name: (Please print)_____
2. Provider's address:_____
3. Provider's phone #:_(_____)_____Fax #:___(_____)_____
4. Type of practice / Medical specialty: _____
6. License Number:_____

CITY OF STOCKTON

MEDICAL FACTS

1. Approximate date on which health condition began: _____

2. Probable duration of condition: _____

3. **The serious health condition to which you are treating the patient for.** (Please note that the following are **not** normally considered serious health conditions: Common cold or flu, upset stomach, headache-excluding migraines, earache, routine dental problem, or treatments that involve only over-the-counter medicines, bed rest, exercise, and other activities that can be done without visiting a health care provider):

   ☐ Inpatient care during an overnight hospital stay, hospice, or residential health care facility; Date of Admission:_____

   ☐ Prenatal care;

   ☐ Pregnancy (leave taken for disability due to pregnancy, childbirth, or related medical conditions); Expected delivery date:_____

   ☐ Chronic conditions (e.g., asthma, diabetes, epilepsy, etc.) that (1) require periodic visits (at least twice a year) for treatment, (2) continue for a long time, and (3) may cause episodic rather than a continuing period of incapacity;

   ☐ Permanent or long-term conditions that require continuing supervision, with or without active treatment (such as Alzheimer's, severe strokes, terminal stages of a disease);

   ☐ Multiple treatments for either (1) restorative surgery after an injury, or (2) conditions likely to result in three day's incapacity if not treated (including chemotherapy, physical therapy for severe arthritis, and dialysis); or

☐ Incapacity for more than three consecutive days during which the patient is either (1) treated two or more times, or (2) treated and referred to a nurse, physician's assistant, physical therapist, or nurse practitioner for further treatment; or (3) treated and prescribed a course of prescription medication or therapy requiring special equipment to resolve or alleviate the health condition;

☐ None of the above. Patient does not have a serious health condition as defined by the FMLA.

4. Date(s) you treated the patient for condition:

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

   □ Yes □ No

6. Was the patient referred to other health care provider(s) for evaluation or treatment (e.g. physical therapist)? □ Yes □ No

   If "Yes", state the nature of such treatment and expected duration of treatment:

   _____

7. Based on the employee's description of his/her job functions, is the employee unable to perform any of his/her job functions due to the condition:

   ☐ Yes ☐ No. If "Yes", identify the job functions the employee is unable to perform:

   _____

   _____

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

☐ Yes ☐ No

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

Complete the following <u>ONLY</u> if the employee requires intermittent leave or a reduced work schedule:

6. Will the employee require follow-up treatment appointments or be off work on an intermittent basis or on a reduced schedule because of his/her medical condition?

   ☐ Yes ☐ No

   If "Yes", are the treatments or the reduced number of hours of work medically necessary?

   ☐Yes ☐ No

   Please estimate the intermittent leave or reduced work schedule the employee needs:

   _____ hour(s) per day; _____days per week

   from_____through _____

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

   ☐Yes ☐ No

   Is it medically necessary for the employee to be absent from work during the flare-ups?

   ☐ Yes ☐ No
   If "Yes", 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) and
   Duration: _____hours or _____day(s) per episode

Health Care Provider's Signature: _____Date:_____

Attachment #6

City of Stockton
Family Member's Health Care Provider's Certification Form

Section I: To be Completed by the Employee

INSTRUCTIONS TO THE EMPLOYEE: Please complete Section I before giving this form to your family member or his/her medical provider. 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 care for a covered family member with a serious health condition. Failure to provide this medical certification within **15 calendar** days from the date you requested FMLA/CFRA, may result in a denial of or delay in the processing of your FMLA request.

_____
Employee's Name (First, Middle, Last) – Please print

_____
Name of family member for whom you will provide care (First, Middle, Last) – Please print

Relationship of family member to you:_____

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

Describe the care you will provide to your family member and the estimated amount of leave time needed to provide care:_____

_____

_____
Employee Signature Date:

Section II: To be Completed by the Health Care Provider

INSTRUCTIONS TO THE HEALTH CARE PROVIDER: The employee listed above has requested leave under the Family and Medical Leave Act (FMLA) / California Family Rights Act (CFRA) to care for your patient. Please 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/CFRA coverage. Please be sure to sign the form on the last page.

1. Provider's name: (Please print)_____

2. Provider's address:_____

3. Provider's phone number: ( ) Fax number: ( )

4. Type of practice / Medical specialty: _____

5. License number:_____

MEDICAL FACTS

1. Approximate date on which health condition began: _____

2. Probable duration of condition: _____

3. **The serious health condition to which you are treating the patient for.** (Please note that the following are **not** normally considered serious health conditions: Common cold or flu, upset stomach, headache-excluding migraines, earache, routine dental problem, or treatments that involve only over-the-counter medicines, bed rest, exercise, and other activities that can be done without visiting a health care provider):

   ☐ Inpatient care during an overnight stay in a hospital, hospice, or residential health care facility; or was the patient expected to have an overnight stay?
   Date of Admission:_____

   ☐ Prenatal care;

   ☐ Pregnancy (leave taken for disability due to pregnancy, childbirth, or related medical conditions); Expected delivery date:_____

   ☐ Chronic conditions (e.g., asthma, diabetes, epilepsy, etc.) that (1) require periodic visits (at least twice a year) for treatment, (2) continue for a long time, and (3) may cause episodic rather than a continuing period of incapacity;

   ☐ Permanent or long-term conditions that require continuing supervision, with or without active treatment (such as Alzheimer's, severe strokes, terminal stages of a disease);

   ☐ Multiple treatments for either (1) restorative surgery after an injury, or (2) conditions likely to result in three day's incapacity if not treated (including chemotherapy, physical therapy for severe arthritis, and dialysis);

☐ Incapacity for more than three consecutive days during which the patient is either (1) treated two or more times, or (2) treated and referred to a nurse, physician's assistant, physical therapist, or nurse practitioner for further treatment; or (3) treated and prescribed a course of prescription medication or therapy requiring special equipment to resolve or alleviate the health condition;

☐ None of the above categories apply. Patient does not have a serious health condition as defined by FMLA.

4. Date(s) you treated the patient for condition:

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

   □ Yes □ No

6. Was the patient referred to other health care provider(s) for evaluation or treatment (e.g. physical therapist)? □ Yes □ No

   If "Yes", state the nature of such treatment and expected duration of treatment:

   _____

AMOUNT OF CARE NEEDED

7. Will the patient be incapacitated 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 the period of incapacity: _____ _____

8. Will the patient require follow-up treatments including any time for recovery?

   ☐ Yes ☐ No

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

   _____

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

If "Yes", explain the care needed by the patient and why it is medically necessary for the employee to take time off from work to provide this care:_____

_____

Complete the following <u>ONLY</u> if employee requires intermittent leave or reduced schedule to care for your patient:

10. Will the patient require follow-up treatment appointments because of his/her medical condition? ☐ Yes ☐ No

    If "Yes", please estimate the hours the patient needs care on an intermittent basis:

    _____ Hour(s) per day; _____days per week from_____ through _____

11. Will the condition cause episodic flare-ups preventing the patient from participating in normal daily activities?

    ☐ Yes ☐ No

    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) and

    Duration: _____hours or ___day(s) per episode

    Does the patient require care during these flare-ups? ☐ Yes ☐ No

    If "Yes", explain the care needed by the patient and why it is medically necessary for the employee to take time off from work to provide this care:_____

    _____

Health Care Provider's Signature: _____Date:_____

CITY OF STOCKTON

Attachment #7

U.S. Department of Labor
Wage and Hour Division
OMB Control Number: 1235-0003
Expires: 2/282/15

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

SECTION I: For Completion by the EMPLOYER

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

Employer name: _____

Contact Information: _____

SECTION II: For Completion by the EMPLOYEE

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

Your Name: _____
First Middle Last

Name of military member on active duty or call to active duty in support of a contingency operation:

_____
First Middle Last

Relationship of military member to you: _____

Period of military member's covered active duty: _____

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

___ A copy of the military member's covered active duty orders is attached.
___ Other documentation from the military certifying that the military member is on covered active duty (or has been notified of an impending call to active duty) is attached.
___ I have previously provided my employer with sufficient written documentation confirming the military member's covered active duty or call to active duty status.

CITY OF STOCKTON

PART A: QUALIFYING REASON FOR LEAVE

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

_____

_____

_____

_____

2. A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes any available written documentation which supports the need for leave; such documentation may include a copy of a meeting announcement for informational briefings sponsored by the military; a document confirming the military member's R&R leave; a document confirming an appointment with a third party, such as a counselor or school official, or staff at a care facility; or a copy of a bill for services for the handling of legal or financial affairs. Available written documentation supporting this request for leave is attached.
__ Yes __ No __ None Available

PART B: AMOUNT OF LEAVE NEEDED

1. Approximate date exigency commenced: _____

   Probable duration of exigency: _____

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

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

   _____.

3. Will you need to be absent from work periodically to address this qualifying exigency? ___ Yes ___No

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

   _____

   _____

   _____

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

   Frequency: _____ times per _____ week(s) _____ month(s)
   Duration: _____ hours ___ day(s) per event.

PART C:

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

Name of Individual: _____ Title: _____

Organization: _____

Address: _____

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

Email: _____

Describe nature of meeting: _____

_____

_____

_____

_____

_____

_____

PART D:

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

_____ _____

Signature of Employee Date

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

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

CITY OF STOCKTON

Attachment #8

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

U.S. Department of Labor
Wage and Hour Division
OMB Control Number: 1235-0003
Expires: 2/28/2015

Notice to the EMPLOYER

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

SECTION I: For completion by the EMPLOYEE and/or the CURRENT SERVICEMEMBER for whom the Employee is Requesting Leave.

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

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

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

A complete and sufficient certification to support a request for FMLA leave due to a current servicemember's serious injury or illness includes written documentation confirming the servicemember's injury/illness was incurred in the line of duty on active duty or if not, that the current servicemember's injury or illness existed before the beginning of the servicemember's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces, and that the current service member is undergoing treatment for such injury or illness by a health care provider listed above.

Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the servicemember's condition for which the employee is seeking leave.

SECTION I: For completion by the EMPLOEE and/or the CURRENT SERVICEMEMBER for whom the Employee is Requesting Leave:

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

Part A: EMPLOYEE INFORMATION

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

_____

Name of Employee Requesting Leave to Care for Current Servicemember:

_____

First Middle Last

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

_____

First Middle Last

Relationship of Employee to Current Servicemember:
☐ Spouse ☐ Parent ☐ Son ☐ Daughter ☐ Next of Kin

Part B: SERVICEMEMBER INFORMATION

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

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

_____

Is the servicemember assigned to a military medical treatment facility as an outpatient or to a unit established for the purpose of providing command and control of 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 CServicemember on the Temporary Disability Retired List (TDRL)?
_____ Yes ____ No

Part C: CARE TO BE PROVIDED TO THE SERVICEMEMBER

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

_____

_____

SECTION II: For completion by a United States Department of Defense ("DOD") Health Care Provider or a Health Care Provider who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; (3) a DOD non-network TRICARE authorized private health care provider; or (4) a health care provider as defined in 29 CFR 825.125. If you are unable to make certain of the military-related determinations contained below in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator). (Please ensure that Section I above has been completed before completing this section. Please be sure to sign the form on the last page.)

Part A: HEALTH CARE PROVIDER INFORMATION
Health Care Provider's Name and Business Address:

_____

Type of Practice/Medical Specialty: _____

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

_____

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

PART B: MEDICAL STATUS

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

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

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

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

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

(2) Is the current Servicemember being treated for a condition which was incurred or aggravated by service in the line of duty on active duty in the Armed Forces? ___Yes ___No

(3) Approximate date condition commenced: _____

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

(5) Is the Servicemember undergoing medical treatment, recuperation, or therapy?
___Yes ___No

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

PART C: COVERED SERVICEMBMER'S NEED FOR CARE BY FAMILY MEMBER

(1) Will the servicemember need care for a single continuous period of time, including any time for treatment and recovery? ___Yes ___No

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

(2) Will the servicemember require periodic follow-up treatment appointments? ___Yes ___No

If yes, estimate the treatment schedule: _____

(3) Is there a medical necessity for the servicemember to have periodic care for these follow-up treatment appointments? ___Yes ___No

(4) Is there a medical necessity for the servicemember to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups or medical condition)?
___Yes ___No

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

_____

_____

Signature of Health Care Provider: _____ Date: _____

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Attachment #9