Family/Medical Leave of Absence
Employee Packet

Instruction Sheet
FMLA Fact Sheet
Request Form
Certification of Healthcare Provider Form
Return to Work Status Form

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Instructions for Completing FMLA Paperwork

1. *Complete the "Leave of Absence Request Form" and return to your supervisor for their signature.*

2. *Have your doctor fill out the "Certification for Health Care Provider Form" and fax completed form to Human Resources at 404-728-6214.*

3. *When time to return, have your doctor complete the "Return to Work Status Form" and fax completed form to Human Resources at 404-728-6214. You will not be allowed to return to work without this form.*

If you have any questions about FMLA please contact,
Human Resources at 404-728-6511.

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Leave of Absence Request Form

Employee's Name:	Employee ID:
Manager's Name:	Department:
Dates of Leave Requested From:	To:

Contact Information:

Home Address: _____

Email Address: _____

Phone Number: _____

SELECT Box for Type of Leave of Absence:

☐ FMLA - Medical -- Due to employee's own serious health condition.

☐ FMLA - Family -- Birth of a child, care for the newborn child; or placement of a child with the employee for adoption or foster care.

☐ FMLA - Family -- To care for an immediate family member with a serious health condition (spouse, same-sex domestic partner, child, or employee's parent). NOTE: The term spouse as set forth above may include an employee's same-sex domestic partner to the extent that this individual is otherwise covered by our benefits policy. Definition of a child is 18 years or younger, or a child with a physical or mental disability that renders him/her incapable of self-care

☐ FMLA - Military Caregiver - To care for spouse, same-sex domestic partner, child, parent or nearest blood relative who has incurred a serious illness or injury while on active duty.

☐ FMLA-Military/Qualifying Exigency-Due to a "qualifying exigency" for a spouse, same-sex domestic partner, child, or parent who is on armed forces active duty, or has been notified of an impending call or order to active duty.

☐ Are you requesting an Intermittent FMLA or a reduced work schedule FMLA? ☐ No ☐ Yes

☐ Medical Non FMLA Leave of Absence - select if Not-FMLA eligible and absence due to employee's own serious health condition.

☐ Educational Leave of Absence - attach appropriate educational document; 1 year maximum

☐ Military Leave of Absence - Attach copy of military orders

☐ Personal Leave of Absence - Attach written request with reason for leave.

Each type of leave is subject to the standard policies regarding that particular type of leave, including whether such leave is paid or unpaid leave.

I certify that the above information is true and correct to the best of my knowledge. I understand that any misrepresentation concerning the above facts can result in dismissal.

Employee's Signature: _____ Date _____

Manager's Signature: Date _____

Manager's Telephone

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FMLA Certification of Health Care Provider for Family Member Serious Health Condition

SECTION I: For Completion by the EMPLOYEE: Complete Section I before giving this form to your family member's 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. Your response is required to obtain or retain the benefit of FMLA protections. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. Your employer must give you at least 15 calendar days to return this form to your employer.

PRINT Your Name:

_____ **DATE:**_____

First Middle Last

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

Employee Signature:_____ **Date**_____

SECTION II: For Completion by 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 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 page 3.

PART A: MEDICAL FACTS:

1. Approximate date condition commenced: _____
2. Probable duration of condition: _____
3. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
   ___No___Yes If so, dates of admission_____
4. Date(s) you treated the patient for condition: _____
5. Was medication, other than over-the-counter medication, prescribed?____No___Yes

PART A: MEDICAL FACTS continued:

6. Will the patient need to have treatment visits at least twice per year due to the condition?____No____Yes

7. 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:

8. Is the medical condition pregnancy?____No____Yes. If so, expected delivery date: _____

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

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

1. 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:

2. 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:

3. Will the patient require care on an intermittent or reduced schedule basis? __No Yes Estimate hours of care needed on intermittent basis, if any:
   _____hour(s) per day;_____days per week from_____through _____

4. 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 o f 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:

Signature of Provider_____**Date** _____ **Print Provider's name:** _____
_____ **Business address:** _____
_____ **Type of practice / Medical specialty:**
_____
Telephone: (_____)_____**Fax :(_____)** _____

RETURN TO: Wesley Woods Senior Living Human Resources, 1817 Clifton Road, Atlanta, GA. 30329
Confidential Fax: (404) 728-6214 Telephone: (404) 728-6511

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Return to Work Status Form

Employee/Patient:_____ Date: _____
S-S-N:_____ Date of Injury: _____
Department:_____ Supervisor: _____

WORK STATUS	○ Unable to work_____ ○ Returned to regular duty_____ ○ Return to work on_____with restrictions as below: Follow up appointment_____ ○ Projected date of MMI_ ○ A	
BACK	○Sitting job only. ○No lifting greater than_____lbs. ○No pushing/pulling greater than___lbs. ○No prolonged sitting/standing/walking for more than_____minutes.	○ Alternate sitting/standing every _____min/hr. ○ No prolonged/repeated bending/twisting at waist ○ No prolonged/repeated kneeling/squatting. ○ No climbing ladders/stairs
NECK	○ No constant neck flexion.	○ No overhead reaching.
EXTREMETIES: UPPER	○ No use of L R Arm / Finger / Thumb / Hand / Wrist ○ No repetitive bending or twisting of L R Arm ○ No repetitive bending or twisting of L R Elbow ○ No repetitive bending or twisting of L R Wrist ○ No repetitive bending or twisting of L R Hand ○ No/ limited reaching above Shoulder level	
LOWER	○ Sitting job with foot/leg elevated. ○ Alternate sitting/ standing, may walk short distances. ○ May walk/ stand up to_____hours per day. ○ No squatting/ kneeling/ climbing.	
OTHER	○ No overtime. ○ Employee limited to_____hours per day. ○ No driving.	○ No use of hazardous machinery. ○ No unprotected heights. Other: _____

Physician Name _____ Phone: _____
(Please Print)

Please fax completed form to: Human Resources: Fax: 404-728-6214 • Phone: 404-728-6511