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:

Aimee Smith, Sr. HR Assistant at 404-728-6511

Traci Montgomery, HR Director at 404-728-6858

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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 Telephone

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FMLA Certification of Health Care Provider
Employee Serious Health Condition

SECTION I: For Completion by the EMPLOYEE: Please complete Section I 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. 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.
PRINT Your Name:

_____ **DATE:**_____
First **Middle** **Last**

SECTION II: For Completion by the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. 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**. Please be sure to sign the form on the second page.**

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. Will the patient need to have treatment visits at least twice per year due to the condition No Yes

6. Was medication, other than over-the-counter medication(s) prescribed? 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 treatments and expected duration of treatment:
_____

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

9. 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:
_____

10. 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):

PART B – / AMOUNT OF LEAVE NEEDED

1. 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? No Yes If so, estimate the beginning and ending dates for the period of incapacity: _____

2. Will the employee need to attend follow-up treatment appointments or work part-time or a reduced schedule because of the employee's medical condition? No Yes

A. If yes, is the treatments or the reduced schedule medically necessary? No __Yes

B. Estimate the treatment schedule, if any, including the dates of any scheduled appointments and the time required, including any recovery period: _____

_____

C. Estimate the part-time or reduced work schedule the employee needs, if any:
_____hours per day/shift;_____days per week; from:_____through:_____

3. 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

ADDITIONAL INFORMATION (identify question number with your answer):

Signature of Health Care Provider_____Date:_____

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

Note: It is the employee's responsibility to ensure that the health care provider fully completes this form.

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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

EMPLOYEE RIGHTS AND RESPONSIBILITIES
UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement
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 or daughter, or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements
Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember 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 that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

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 entitlement 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 entitlement. 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.