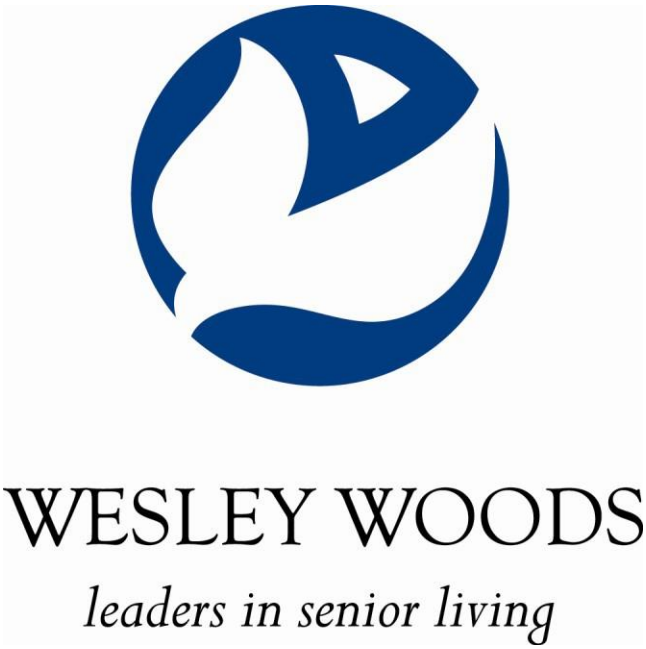

Family/Medical Leave of Absence
Employee Packet

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 the Human Resources office at 404-728-6511 or 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 Signature: _____ Date _____

Manager's Telephone _____

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Family and Medical Leave Act
Qualifying Exigency Certification for Military Family Leave

For Completion by the EMPLOYEE - INSTRUCTIONS to the EMPLOYEE: Please complete 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:

_____

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
First **Middle** **Last**
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:_____hour's _ day(s) per event.

PART C:

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:

I certify that the information I provided above is true and correct.
Signature of Employee:_____Date _____

Please 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_____ ○ Anticipated PPI rating_____	
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.