FAMILY AND MEDICAL CARE LEAVE FORMS APPENDIX

1. Family & Medical Leave Departmental Checklist
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8. Fitness For Duty To Return From Leave Certification
9. Family Leave Tracking Form
10. Combined Federal Family And Medical Leave Act Of 1993 (FMLA) AND California Family Rights Act (CFRA) Notices

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SANTA BARBARA COUNTY
✓ FAMILY & MEDICAL LEAVE DEPARTMENTAL CHECKLIST

When you know an employee will be absent from work for **more than one week** due to a qualifying family or medical leave reason, regardless of whether employee has applied for a leave of absence, the following forms should be used as indicated:

1. Medical (work or non-work-related), or Maternity Leaves: Department to provide employee with the following:

   ⇒ Employee Request For Family/Medical Leave
   ⇒ Physician or Practitioner Medical Certification - Employee's Serious Health Condition
   ⇒ Permission to Contact Personal Health Care Provider
   ⇒ SDI Application Packet, if applicable
   ⇒ Fitness for Duty to Return From Leave Certification, if applicable
   ⇒ Any departmental policy or procedures to be followed

2. For Family Leave to bond with newborn or adopted child, department to provide:

   ⇒ Employee Request For Family/Medical Leave
   ⇒ Any departmental policy or procedures to be followed

3. For Family Leave to take care of seriously ill child, parent or spouse, department to provide:

   ⇒ Employee Request For Family/Medical Leave
   ⇒ Physician or Practitioner Medical Certification - Family Member Serious Health Condition
   ⇒ Any departmental policy or procedures to be followed

In all cases, department to respond to leave request with either:

⇒ Departmental Response To Employee Request For Family Or Medical Care Leave -
⇒ Notice That Employee's Requested Leave Will Run Against Family Medical Leave Entitlement

FORM DESCRIPTIONS

❒ **Employee Request For Family/Medical Leave** - Employee to submit 30 days in advance of leave or as soon as possible, in case of emergency. Department to supply request form to employee when it has determined that employee's requested leave qualifies under County policy. Used in place of PA-165 or Request for Unpaid Leave of Absence form. Qualifying employee must have worked at least 1,250 hours during last 12 months (use FLSA standards). This would exclude employees whose average workweek is less than 24 hours per week.

❒ **Permission to Contact Personal Health Care Provider** - Employee to complete and return this form to Department to allow department to contact health care provider to determine seriousness of condition (not diagnosis), length of leave necessary, any work accommodations required and other work related needs.

Family & Medical Leave Departmental Checklist, continued

❒ **Physician or Practitioner Medical Certification - Employee's Serious Health Condition** - Employee to submit with request for any family or medical leave for employee's own illness/injury/pregnancy. See policy for situations when second and third certification may be necessary. Be sure to complete **Physical Requirements Checklist** to let physician know physical requirements of the position.

❒ **Physician or Practitioner Medical Certification - Family Member Serious Health Condition** - Employee to submit with request for leave for care of child, parent, spouse. See policy for situations when second and third certification may be necessary

❒ **Departmental Response To Employee Request For Family Or Medical Care Leave** - Department to send to employee to approve/deny requested family leave and to require medical certification if not already received.

❒ **Notice That Employee's Requested Leave Will Run Against Family Medical Leave Entitlement** - Department to send to employee to notify them that requested leave will be counted against 12 week maximum leave in a 12 month period. *This includes work absences due to work related (workers' compensation) or non-work related causes including disability retirement application period.* <u>This form or the prior departmental response form is essential to start the 12 week leave clock for legal purposes; it does not affect use of paid leave</u>. Please note: Employees in "safety classifications" cannot be placed on family leave if they are receiving disability pay in lieu of workers' compensation temporary disability payments under provisions of California Labor Code Section 4850.

❒ **Personnel Change Form** (not included) - Use this form to place employee on either "P" status (employee using paid leave balances) or "L" status (no paid balances to be used) while on leave. Employee can be started in "P" status then changed to "L" when balances are exhausted. (Employees in "L" status for over 30 days will need to have their anniversary date changed when they return from leave.) Indicate reason code of either maternity, work or non-work related illness/accident or family leave as indicated in policy. <u>Please note: California does not recognize pregnancy disability as qualifying for family leave, therefore, use *maternity* code for period of pregnancy disability (up to 4 months with physician's certificate) and *family leave* for bonding period (up to 3 months) after pregnancy disability</u>. You will need to track family leave separately to determine if 12 weeks has been used in last 12 months. *Family leave* code is also used for care of seriously ill family member and for employee's own serious illness.

❒ **Family Leave Tracking Form** - Use this form to track the amount of family leave taken to see if employee has already used their maximum 12 weeks entitlement during the last 12 months. If they have, this does not mean that they cannot continue on a leave of absence, only that their leave time is not subject to required federal or state leave entitlements. Place form in employee departmental personnel file and track all future family leave taken. This would include all medical leave that qualifies for family leave under serious illness definition for themselves or care of family members as well as *family* leave, but in either case employee must have been notified that they were using family leave. <u>The initial period of pregnancy disability does not count towards family leave usage under California Family Rights Act.</u>

❒ **Fitness For Duty To Return From Leave Certification** - If the department requires a fitness for duty certification prior to returning to work, this form should be used. You can indicate on the Physical Requirements Checklist which duties are departmental requirements.

❒ **Department Posting of State and Federal Family Leave Notice -** This is an ongoing obligation of each department to post family leave availability. Attached to the Family Leave Policy is a combined state/federal notice that can be reprinted and posted.

EMPLOYEE REQUEST FOR FAMILY/MEDICAL LEAVE

(application shall be made 30 days in advance unless emergency exists)

Employee Name: ___________________________ Date of Request: __________________________________

Department: ________________________ Position Title: _____________________ Hire Date: ________________________

I request a Family/Medical Leave for the following reason (check one):

________ A. The birth of a child and/or in order to care for such child.

Child's name: _________________________________ Expected Birthdate: ________________________

________ B. The placement of a child for adoption or foster care.

Child's name: _________________________________ Expected Birthdate: ________________________

For A or B, is your spouse a County employee? Yes _____ No _____

If so, will he/she be requesting family leave? Yes _____ No _____

Name of spouse: ______________________ Department: ____

________ C. Employee's own serious health condition that makes the employee unable to perform the functions of his/her position **(Must also submit "Physician Certification" within 15 calendar days and "Permission to Contact Personal Health Care Provider" forms)**

________ D. In order to care for an immediate family member because such family member has a serious health condition. Check one: CHILD SPOUSE PARENT **(Must submit "Physician Certification" within 15 calendar days)**

METHOD OF LEAVE REQUESTED

_______ A. Consecutive Leave

_______ B. Intermittent or Reduced Leave Schedule (Specify Requested Schedule Below)

____

____

____

Date leave is to begin: _____________________________ Expected Duration of Leave: ______________________________

Please be sure to contact the Personnel Department, Employee Benefits Division (568-2814/2818) to arrange for payment of your insurance premiums while you are on a leave of absence.

Employee Request For Family/Medical Leave, continued

If you do not return to work after your leave is over, the County has the right to recover its share of health plan premiums for the entire leave period, unless you do not return because of the continuation, recurrence or onset of a serious health condition for you or your family member which would entitle you to leave, or because of circumstances beyond your control. Santa Barbara County shall have the right to recover premiums through deduction from any sums due to you (e.g. unpaid wages, vacation pay, etc.).

I understand that a failure to return to work at the end of my approved leave of absence may be treated as a resignation unless an extension has been agreed upon and approved by my department head.

Employee Signature: ______________________________________ Date: ____________________________________

Leave is: Approved Denied ____

Department Head / Supervisor Signature

Please Note: Send copies to Personnel, Employee Benefits Division & the County Retirement Office.

PERMISSION TO CONTACT PERSONAL HEALTH CARE PROVIDER

I hereby give my permission for representatives of the County of Santa Barbara ________________________ Department to contact my physician for information about my functional abilities, my functional limitations, and any work restrictions; and to receive information about my serious health condition. I understand my permission applies until I notify my employer in writing of its withdrawal; but in any event expires in one year and that I have a right to receive a copy of this authorization.

My physician is: Dr. ____

Phone: (_____) ____________________________________

Address: ____

____

____

I understand this information will be treated confidentially and released only to:

a. supervisors and managers who need to be informed about necessary restrictions on my work and necessary accommodations,
b. first aid and safety personnel, if my disability might require emergency treatment or if any specific procedures are needed in a fire or other evacuation,
c. insurance companies which require a medical examination to provide health or life insurance through my employer for me,
d. government officials investigating compliance with the ADA and other federal and state laws prohibiting discrimination of the basis of disability,
e. State Workers' Compensation offices or "second injury" funds, to comply with State Workers' Compensation laws,
f. an outside health care provider contracted by my employer who will contact my health care providers for clarification of medical certifications, and
g. human resources personnel who are considering my requests for leave, reinstatement, placement, and requests for accommodation.

Name: _____________________________________ Social Security No: ________________________

Signature: __________________________________ Date: ____________________________________

PHYSICIAN OR PRACTITIONER MEDICAL CERTIFICATION EMPLOYEE - SERIOUS HEALTH CONDITION

Note: See attached Physical Requirements Checklist from Employer for job requirements.

1. Employee's Name: ____________________

2. Does the employee have an illness, injury, impairment, or physical or mental condition which constitutes a "serious health condition?" Yes No
   A "serious health condition" is described on the attached sheet. Does the employee's condition qualify under any of the categories described? If so, please check the applicable category.
   (1)_____ (2)____ (3)____ (4)____ (5)____ (6)____, or None of the above ____.

3. Date medical condition or date for treatment commenced:____________________

4. Probable duration of medical condition or need for treatment: ____________________

5. Regimen of treatment to be prescribed (Indicate number of visits, general nature and duration of treatment, including referral to other provider of health services. Include schedule of visits or treatment if it is medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal schedule of hours per day or days per week):

   A. By Physician or Practitioner:____________________

   ____

   ____

   ____

   B. By other provider of health services, if referred by Physician or Practitioner:

   ____

   ____

   ____

Check Yes or No in the space below, as appropriate.

6. Yes____ No____ Is inpatient hospitalization of the employee required?

7. Yes____ No____ Is employee able to perform work of any kind? (if "No", skip to Item 9.)

8. Yes____ No____ Is employee able to perform the functions of employee's position?
   (**See attached Physical Requirements Checklist)**

9. Signature of Physician or Practitioner:____________________

10. Date:____________________

11. Type of Practice (Field of Specialization, if any):____________________

12. Signature of Employee:____________________ Date:____________________

DEFINITION OF "SERIOUS HEALTH CONDITION"

A "Serious Health Condition" means an illness, injury, impairment, or physical or mental condition that involves one of the following:

1. Hospital Care

Inpatient care (i.e. an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

(a) A period of incapacity of more than three consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:

(1) Treatment[1] two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or

(2) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment[2] under the supervision of the health care provider.

3. Pregnancy - Any period of incapacity due to pregnancy, or for prenatal care.

4. Chronic Conditions Requiring Treatments - A chronic condition which:

(1) Requires periodic visits for treatment by a health care provider, or by a nurse physician's assistant under direct supervision of a health care provider;
(2) Continues over an extended period of time (including recurring episodes of a single underlying condition); **and**
(3) May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

5. Permanent/Long-term Conditions Requiring Supervision

A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

6. Multiple Treatment (Non-Chronic Conditions)

Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).

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[1] Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

[2] A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

PHYSICIAN OR PRACTITIONER MEDICAL CERTIFICATION
EMPLOYEE - SERIOUS HEALTH CONDITION, CONTINUED
PHYSICAL REQUIREMENTS CHECKLIST
(Department to provide job requirements)

	COUNTY DEPT.	**PHYSICIAN TO COMPLETE**		
PHYSICAL LIMITATIONS	Dept Requirements (Check all that apply)	No Restrictions	Full Restrictions	Partial Restrictions*
Sedentary-Lifting 0 to 10 pounds				
Light-Lifting 10 to 20 pounds				
Moderate-Lifting 20 to 50 pounds				
Heavy-Lifting 50 to 100 pounds				
Pulling/Pushing, Carrying				
Reaching or working above shoulder				
Walking (hrs)				
Standing (hrs)				
Sitting (hrs)				
Stooping (hrs)				
Kneeling (hrs)				
Repeated Bending (hrs)				
Climbing (hrs)				
Operating a motor vehicle, crane, tractor etc.				
Other:				
Exposure Limitation (Specify):				

*Comments: ____

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7. I hereby certify that the foregoing facts are true and correct, and are executed under penalty of perjury in ____________________, California this ____________ day of ____________________, 199__.

____
Signature of Treating Physician or Practitioner

____
Date

____
Print Name of Treating Physician or Practitioner

____
Phone Number

PHYSICIAN OR PRACTITIONER MEDICAL CERTIFICATION
FAMILY MEMBER - SERIOUS HEALTH CONDITION

1. Employee's Name: ____

2. Patient's Name: ____

   Relationship to employee: Child Parent Spouse

3. Does the employee's child, parent, or spouse have an illness, injury, impairment, or physical or mental condition which constitutes a "serious health condition?" Yes No
   A "serious health condition" is described on the attached sheet. Does the patient's condition qualify under any of the categories described? If so, please check the applicable category.

   (1)______ (2)______ (3)______ (4)______ (5)______ (6)______, or None of the above ________.

4. Date medical condition or need for treatment commenced:____

5. Probable duration of medical condition or need for treatment:_____________________________________

6. Regimen of treatment to be prescribed (Indicate number of visits, general nature and duration of treatment, including referral to other provider of health services. Include schedule of visits or treatment if it is medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal schedule of hours per day or days per week):

   A. By Physician or Practitioner: ____

   ____

   B. By other provider of health services, if referred by Physician or Practitioner: _________________

   ____

   ____

Check Yes or No in the space below, as appropriate.

7. Yes______ No______ Is inpatient hospitalization of the family member (patient) required?

8. Yes______ No______ Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation?

9. Yes______ No______ After review of the employee's signed statement (See Item 11 below), is the employee's presence necessary or would it be beneficial for the care of the patient? (This may include psychological comfort and/or the arranging for third-party care for the family member.)

PHYSICIAN OR PRACTITIONER MEDICAL CERTIFICATION FAMILY MEMBER - SERIOUS HEALTH CONDITION, continued

10. Estimate the period of time care is needed or the employee's presence would be beneficial: ________________

____

____

ITEM 11 TO BE COMPLETED BY THE EMPLOYEE REQUESTING FAMILY LEAVE.

11. When Family Leave is needed to care for a seriously ill family member, the employee shall state the care he or she will provide and an estimate for the time period during which this care will be provided, including a schedule if leave is to be taken intermittently or on a reduced leave schedule:

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____

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____

____

Employee Signature:____ Date:___________________________

12. Signature of Physician or Practitioner:____

13. Date:____

14. Type of Practice (Field of Specialization, if any):____

DEFINITION OF "SERIOUS HEALTH CONDITION"

A "Serious Health Condition" means an illness, injury, impairment, or physical or mental condition that involves one of the following:

1. Hospital Care

Inpatient care (i.e. an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

(a) A period of incapacity of more than three consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:

(1) Treatment[1] two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or

(2) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment[2] under the supervision of the health care provider.

3. Pregnancy - Any period of incapacity due to pregnancy, or for prenatal care.

4. Chronic Conditions Requiring Treatments - A chronic condition which:

(1) Requires periodic visits for treatment by a health care provider, or by a nurse physician's assistant under direct supervision of a health care provider;
(2) Continues over an extended period of time (including recurring episodes of a single underlying condition); and
(3) May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

5. Permanent/Long-term Conditions Requiring Supervision

A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

6. Multiple Treatment (Non-Chronic Conditions)

Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).

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[1] Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

[2] A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

DEPARTMENTAL RESPONSE TO EMPLOYEE REQUEST FOR FAMILY OR MEDICAL CARE LEAVE

Date: ________________________________ **TO:** ________________________________
(Employee's Name)

FROM: ________________________________ **DEPARTMENT:** ______________________
(Name of Dept. Representative)

SUBJECT: Request For Family/Medical Leave

On _______________, you notified us of your need to take family/medical leave due to:
(date)

the birth of your child, or the placement of a child with you for adoption or foster care; or

a serious health condition that makes you unable to perform the essential functions of your job; or

a serious health condition affecting your child, spouse, parent, for which you are needed to provide care.

You notified us that you need this leave beginning on ____________ *(date)* and that you expect leave to continue until or about ____________ *(date)*.

Except as explained below, you have a right under the FMLA/CFRA for up to 12 weeks of unpaid leave in a 12 month period for the reasons listed above. If you are first taking leave for pregnancy disability you are also eligible for up to 4 months leave of absence as medically necessary under the California pregnancy disability statute prior to the start of your family leave period. Your health benefits will be maintained during any period of unpaid leave under the same conditions as if you continued to work, and 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 leave. If you do not return to work following FMLA/CFRA leave for a reason other than: (1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA/CFRA leave; or (2) other circumstances beyond your control, you will be required to reimburse us for the County health insurance contribution paid on your behalf during your FMLA/CFRA leave.

The taking of a leave of absence may impact your employment record in the following ways:

- Leave Accrual Date - Periods of unpaid leave do not count towards the accrual of vacation or sick leave benefits.
- Anniversary Date - Periods of unpaid leave over 30 days will postpone your merit salary increase date.
- Probation Status - If you are on probation, your leave of absence will not be counted towards completion of your probation period.

This is to inform you that: *(check appropriate boxes; explain where indicated.):*

1. You are eligible not eligible for leave under the FMLA/CFRA.

Departmental Response To Employee Request For Family Or Medical Care Leave, continued

2. The requested leave will will not be counted against your annual FMLA/CFRA leave entitlement.

3. If you are applying for leave due to a maternity related medical disability, you have a right to medical/maternity leave for up to 4 months under the California pregnancy disability statute. The actual amount of leave time authorized is determined by a physician's certificate attached to this letter which you should have completed and returned to our office. This period of medical/maternity leave will not be counted against your family leave entitlement, however, any bonding period with your newborn child after your medical/maternity leave period will be counted. You may also request to be transferred to a less strenuous or hazardous position for the duration of your pregnancy where we can reasonably accommodate your request.

4. You will will not be required to furnish medical certification of a serious health condition. If required, you must furnish certification by ______________________ *(insert date)* (must be at least 15 days after you are notified of this requirement) or we may delay the commencement of your leave until the certification is submitted.

5. Your job class is is not covered by the State Disability Insurance (SDI) benefits. If it is, in order to receive SDI benefit payments you will be required to apply to the State Disability Office. You are eligible for SDI benefits after 8 consecutive days of absence from work due to illness or injury but you should apply as soon as possible. **(Attached is an SDI application packet.)** Under the County's SDI policy, your sick leave balances must be used to supplement your SDI benefits to compute your total compensation. You may also choose to use other leave balances (vacation, holiday, etc.)to supplement your SDI benefits. These accrued leaves will be used to supplement your SDI benefits up to 80% of your gross pay.

6. You may elect to substitute accrued paid leave for unpaid FMLA/CFRA leave, however, you may not use sick leave during any bonding period with your new child. We will not require that you substitute accrued paid leave for unpaid FMLA/CFRA leave. If paid leave will be used the following conditions will also apply:

____

____

7.(a). If you normally pay a portion of the premiums for your health insurance, these payments will continue during the period of FMLA/CFRA leave. You must make arrangements for payment with the County Personnel Employee Benefits Division (568-2814/2818). If your biweekly payroll earnings are not sufficient to pay your insurance premiums you are responsible for paying them directly to Personnel each pay period or in advance.

(b). You have a 30-day grace period in which to make premium payments. If payment is not made timely, your group health and other insurance may be canceled. We will not pay your share of health or other insurance premiums (including optional life, accident, SDI, etc.) while you are on leave.

8. You will will not be required to present a fitness-for duty certificate prior to being reinstated to employment. If such certification is required but not received, your return to work may be delayed until the certification is provided.

9. While on leave, you will will not be required to furnish us with periodic reports every ______________ *(indicate interval of periodic reports, as appropriate for the particular leave situation)* of your status and intent to return to work. If the circumstances of your leave change and you are able to return to work earlier than the date indicated on the first page of this form, you will will not be required to notify us at least two work days prior to the date you intend to report for work.

Departmental Response To Employee Request For Family Or Medical Care Leave, continued

10. You will will not be required to furnish period physician recertification relating to a serious health condition. *(Explain below, if necessary, including the interval between certifications).*

____

____

Attachments: ____ Physician or Practitioners Certification

____ SDI Application Packet

____ Fitness for Duty to Return From Leave Certification

DEPARTMENTAL NOTICE THAT EMPLOYEE REQUESTED LEAVE WILL RUN AGAINST YOUR FAMILY MEDICAL LEAVE ENTITLEMENT

Date: ___________________________________ **TO:** _____________________________________
(Employee's Name)

FROM: _____________________________________ **DEPARTMENT:** ___________________________
(Name of Dept. Representative)

SUBJECT: Request For Leave Which Qualifies as Leave under the Federal Family and Medical Care Leave (FMLA) and California Family Rights Act (CFRA).

On _______________, you notified us of your need to take family/medical leave due to:
(date)

the birth of your child, or the placement of a child with you for adoption or foster care; or

a serious health condition that makes you unable to perform the essential functions of your job; or

a serious health condition affecting your spouse, child, parent, for which you are needed to provide care.

You notified us that you need this leave beginning on ____________ *(date)* and that you expect leave to continue on or about ____________ *(date)*.

Please be advised that your requested leave is for an FMLA/CFRA qualifying reason, and FMLA/CFRA leave will run concurrently with your requested leave. **<u>This notice is to inform you that your requested leave will run concurrently with your FMLA/CFRA entitlement.</u>** Pursuant to the FMLA/CFRA, you have the right to up to 12 weeks of unpaid leave in a 12-month period for the reasons listed above. Also, your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work, and 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 leave. If you do not return to work following FMLA/CFRA leave other than:(1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA/CFRA leave; or (2) other circumstances beyond your control, you will be required to reimburse us for our share of County health insurance contributions paid on your behalf during your FMLA/CFRA leave.

The taking of a leave of absence may impact your employment record in the following ways:

- Leave Accrual Date - Periods of unpaid leave do not count towards the accrual of vacation or sick leave benefits.
- Anniversary Date - Periods of unpaid leave over 30 days will postpone your merit salary increase date.
- Service Credit - Periods of unpaid leave will not be counted towards your service credit for increases in the salary range.
- Probation Status - If you are on probation, your leave of absence will not be counted towards completion of your probation period.

Departmental Notice That Employee Requested Leave Will Run Against Your Family Medical Leave Entitlement, continued

1. If you are applying for leave due to a maternity related medical disability, you have a right to medical/maternity leave for the period of disability for up to 4 months under the California pregnancy disability statute. statute. The amount of leave time is determined by a physician's certificate (attached to this letter) which you must have completed and returned to our office. This period of medical/maternity leave will not be counted against your family leave entitlement; however, any bonding period with your newborn child after your medical/maternity leave period will be counted. You may also request to be transferred to a less strenuous or hazardous position for the duration of your pregnancy where we can reasonably accommodate your request.

2. You will will not be required to furnish medical certification of a serious health condition. If required, you must furnish certification by ___________________________ *(insert date)* (must be at least 15 days after you are notified of this requirement) or we may delay the commencement of your leave until the certification is submitted.

3. Your job class is is not covered by the State Disability Insurance (SDI) benefits. If it is, in order to receive SDI benefit payments you will be required to apply to the California State Disability Office. You are eligible for SDI benefits after 8 consecutive days of absence from work due to illness or injury but you should apply as soon as possible. (Attached is an SDI application packet). Under the County's SDI policy, your sick leave balances must be used to supplement your SDI benefits to compute your total compensation. You may also choose to use other leave balances (vacation, holiday, etc.)to supplement your SDI benefits. These accrued leaves may be used to supplement your SDI benefits up to 80% of your gross pay.

4. You may also elect to substitute accrued paid leave for unpaid FMLA/CFRA leave, however, you may not use sick leave during any bonding period with your new child. We will not require that you substitute accrued paid leave for unpaid FMLA/CFRA leave. If paid leave will be used the following conditions will apply:

____

____

____

5. If you normally pay a portion of the premiums for your health insurance, these payments will continue during the period of FMLA/CFRA leave. You must make arrangements for payment with the County Personnel Employee Benefits Division (568-2814/2818). If your biweekly payroll earnings are not sufficient to pay your insurance premiums you are responsible for paying them directly to Personnel each pay period or in advance.

6. You have a 30-day grace period in which to make premium payments. If payment is not made timely, your group health and other insurance may be canceled. We will not pay your share of health or other insurance premiums (including optional life, accident, SDI, etc.) while you are on leave.

7. You will will not be required to present a fitness-for duty certificate prior to being reinstated to employment. If such certification is required but not received, your return to work may be delayed until the certification is provided.

8. While on leave, you will will not be required to furnish us with periodic reports every _______________ *(indicate interval of periodic reports, as appropriate for the particular leave situation)* of your status and intent to return to work. If the circumstances of your leave change and you are able to return to work earlier than the date indicated on the first page of this form, you will will not be required to notify us at least two work days prior to the date you intend to report for work.

Departmental Notice That Employee Requested Leave Will Run Against Your Family Medical Leave Entitlement, continued

9. You will will not be required to furnish periodic physician recertification relating to a serious health condition. *(Explain below, if necessary, including the interval between certifications).*

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Attachments: ____ Physician or Practitioners Certification

____ SDI Application Packet

FITNESS FOR DUTY TO RETURN FROM LEAVE CERTIFICATION

To Employee: You must present this release to your supervisor, if required, before or on the day you return to work. You may not work without this release.

To: Treating Physician or Practitioner

From: ______________________________ Department:: ______________________________
(Department Representative)

Our employee began a period of medical care leave for his/her serious health condition on

______________________________.
date employee commenced leave

As a condition of returning to work, the employee must take a physical examination and have his/her physician complete this from. This form must be completed before the employee is allowed to resume his/her job duties.

1. Employee Name: ______________________________

2. Employee's Job Title: ______________________________

3. Date of Physical Examination: ______________________________

4. With respect to your understanding as to what are the employee's essential job functions, please see the attached Physical Requirements Checklist. If this is not provided to you, please check the source(s) where you received your information:

___ County job description

___ Discussion with the employee's supervisor

___ Discussion with the employee

___ Other. Please explain: ______________________________

5. Please indicate the status of the employee's release for duty.

   ___ Full unrestricted duty. Please *skip* question 6 and proceed to question 7.

   ___ Modified duty. You must complete question 6.

   ___ Not released for any type of duty.

6. If you are releasing the employee to modified work duty, you must complete this section thoroughly.

   a. Estimated date that employee will be able to return to full, unrestricted duty:______________________

   b. Date of your next evaluation of the employee: ______________________________

   c. Indicate the exact work restrictions which apply to the employee at this time on the chart below:

Fitness For Duty To Return From Leave Certification, continued

PHYSICAL REQUIREMENTS CHECKLIST
(Department to provide job requirements)

	COUNTY DEPT.	**PHYSICIAN TO COMPLETE**		
PHYSICAL LIMITATIONS	Dept Requirements (Check all that apply)	No Restrictions	Full Restrictions	Partial restrictions
Sedentary-Lifting 0 to 10 pounds				
Light-Lifting 10 to 20 pounds				
Moderate-Lifting 20 to 50 pounds				
Heavy-Lifting 50 to 100 pounds				
Pulling/Pushing, Carrying				
Reaching or working above shoulder				
Walking (hrs)				
Standing (hrs)				
Sitting (hrs)				
Stooping (hrs)				
Kneeling (hrs)				
Repeated Bending (hrs)				
Climbing (hrs)				
Operating a motor vehicle, crane, tractor etc.				
Other:				
Exposure Limitation (Specify):				

*Comments: ____

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7. I hereby certify that the foregoing facts are true and correct, and are executed under penalty of perjury in ____________________, California this ____________ day of ____________________, 199__.

______________________________________ ______________________
Signature of Treating Physician or Practitioner Date

______________________________________ ______________________
Print Name of Treating Physician or Practitioner Phone Number

FAMILY LEAVE TRACKING FORM

This form is used to track all family leave periods used by an employee and should be placed in their departmental Personnel file. This form only reflects leave time that qualifies under the family leave policy and that the employee has written notice will count against their family leave entitlement. This form should be referred to whenever subsequent leaves are requested to determine how much of the “12 weeks in a 12 month period” entitlement an employee has used. Periods of “pregnancy disability” (coded “maternity”) of less than 4 months are excluded from tracking.

Employee Name: ____

	-- Leave Period --		--- Total Leave Counted ---			Cumulative.	
Reason for Leave	**From:**	**To:**	**#Weeks**	**#Days**	**#Hours**	**Total**	**Since Date**

*** Leave Reasons include:**

- Medical Non-Work Related
- Medical - Work-Related
- Family (bonding period for newborn or adopted children or care of seriously ill spouse, child or parent).

YOUR RIGHTS UNDER THE FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA) & CALIFORNIA FAMILY RIGHTS ACT OF 1993 (CFRA)

FMLA & CFRA require covered employers to provide up to 12 weeks of unpaid, job-protected leave in a 12 month period to "eligible" employees for certain family and medical reasons. Employees are eligible if they have worked for a covered employer for at least one year, and for 1,250 hours over the previous 12 months, and if there are at least 50 employees within 75 miles.

Even if you are not eligible for CFRA leave, if you are disabled by pregnancy, childbirth or related medical conditions, you are entitled to take a pregnancy disability leave of up to four months, depending on your period(s) of actual disability. If you are CFRA-eligible, you have certain rights to take BOTH a pregnancy disability leave and a CFRA leave after the birth of your child. Both leaves contain a guarantee of reinstatement to the same or to a comparable position at the end of the leave, subject to any defense allowed under the law.

<u>REASONS FOR TAKING LEAVE:</u> Unpaid leave must be granted for <u>any</u> of the following reasons:

- The birth of a child or to care for a newborn child of an employee;
- The placement of a child with an employee in connection with the adoption or foster care of a child;
- Leave to care for a child, parent or a spouse who has a serious health condition; or
- Leave because of a serious health condition that makes you unable to perform the functions of your position, including both work-related and non-work-related illness or injury.

With departmental approval, certain kinds of accrued <u>paid</u> leave may be substituted for unpaid leave.

<u>ADVANCE NOTICE AND MEDICAL CERTIFICATION:</u> You may be required to provide advance leave notice and medical certification. Taking of leave may be denied if requirements are not met.

- You ordinarily must provide 30 days advance notice when the leave is "foreseeable," for events such as the birth of a child or a planned medical treatment for yourself or of a family member. For events which are unforeseeable, we need you to notify us, at least verbally, as soon as you learn of the need for the leave.
- Your department may require medical certification to support a request for leave because of a serious health condition for yourself or family member, and may require second or third opinions (at the department's expense) and a fitness for duty report to return to work.
- When medically necessary, leave may be taken on an intermittent or reduced leave schedule.
- If you are taking a leave for the birth, adoption or foster care placement of a child, the basic minimum duration of the leave is two weeks and you must conclude the leave within one year of the birth or placement for adoption or foster care.

<u>JOB BENEFITS AND PROTECTION:</u>

- For the duration of FMLA/CFRA leave, the employer must maintain the employee's health coverage under any "group health plan." In order maintain coverage, you must continue to make your regular premium payments, if applicable.
- Upon return from FMLA/CFRA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.
- The use of FMLACFRA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.
- Taking a family care or pregnancy disability leave may impact certain of your benefits and your seniority date. If you want more information regarding your eligibility for a leave and/or the impact of the leave on your seniority and benefits, please contact the Personnel Benefits Division at 568-2814/2818.

<u>UNLAWFUL ACTS BY EMPLOYERS:</u> FMLA/CFRA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA/CFRA;

- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA/CFRA or for involvement in any proceeding under or relating to FMLA/CFRA.

ENFORCEMENT:

- The U.S. Department of Labor is authorized to investigate and resolve complaints of FMLA violations.
- The California Department of Fair Employment and Housing responds to complaints of CFRA violations.
- An eligible employee may bring a civil action against an employer for violations.

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.

FOR ADDITIONAL INFORMATION: Contact the nearest office of the Wage and Hour Division, Department of Labor (FMLA) or the California Fair Employment and Housing Department (CFRA) listed in most telephone directories.

This notice fulfills the requirements of both the federal Family & Medical Leave Act & the California Family Rights Act.