



# TOWN OF DAVIE

## LEAVE REQUEST FORM

EMPLOYEE NAME: \_\_\_\_\_ DATE SUBMITTED: \_\_\_\_\_  
First Middle Last

TOWN OF DAVIE EMPLOYEE I.D. NUMBER: \_\_\_\_\_ Department: \_\_\_\_\_

PAYROLL CLASSIFICATION: \_\_\_\_\_ UNION:  YES  NO - UNION NAME: \_\_\_\_\_

WHEN AN EMPLOYEE'S ABSENCE IS FOR PERSONAL OR FAMILY MEDICAL REASONS OR FOR A WORK RELATED INJURY AND WHETHER UNPAID OR PAID LEAVE (ACCRUED SICK LEAVE, VACATION OR DONATED LEAVE) TIME IS USED AND THE LEAVE EXCEEDS THREE (3) DAYS, ALL TIME MISSED FOR THAT MEDICAL REASON SHALL BE DESIGNATED AS FAMILY MEDICAL LEAVE (FMLA) AND THE EMPLOYEE MUST PROVIDE THEIR DEPARTMENT DIRECTOR OR DESIGNEE WITH THE TOWN OF DAVIE APPROVED PHYSICIANS CERTIFICATION OF A SERIOUS MEDICAL CONDITION FORM.

*ALL NON-EMERGENCY (SICK OR VACATION) LEAVE **MUST** BE PRE-APPROVED BY THE DEPARTMENT DIRECTOR OR DESIGNEE, BEFORE LEAVE COMMENCES.*

Reason for Requesting Leave: \_\_\_\_\_

### TYPE LEAVE

- VACATION: IS THIS MEDICAL/FAMILY MEDICAL LEAVE (FMLA)?  YES  NO
- SICK: IS THIS MEDICAL/FAMILY MEDICAL LEAVE (FMLA)?  YES  NO  Donated Leave?
- WORKER'S COMPENSATION (THIS IS FMLA IF IT EXCEEDS 3 DAYS).
- OTHER (I.E.  EXEC. LEAVE  BEREAVEMENT, ETC.) \_\_\_\_\_

Starting Date: \_\_\_\_\_ - \_\_\_\_\_ Return Date: \_\_\_\_\_ - \_\_\_\_\_ Total # Hours: \_\_\_\_\_  
DATE TIME DATE TIME

LIST ALL REQUESTED DATES: \_\_\_\_\_

EMPLOYEE SIGNATURE: \_\_\_\_\_

DEPARTMENT DIRECTOR / DESIGNEE (PRINT) : \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ Approved ? :  YES  NO DATE: \_\_\_\_\_

**\*LEAVE REQUESTS ARE NOT APPROVED UNTIL DEPARTMENT DIRECTOR OR DESIGNEE HAS SIGNED THE REQUEST**

The Department Director/ or Designee is responsible for completion and submission of this form for any employee that is physically unable to do so.

- Payroll - Send a corrected copy to Originating Department when discrepancies are noted.
- Department - Timekeeper **must verify** that employees requested hours are available \_\_\_\_\_

*Distribution: Payroll (original) - Human Resources - Employee's Department - Employee*  
**(Only When Leave is for FMLA Medical Reasons)**



**TOWN OF DAVIE**  
**HUMAN RESOURCES MANAGEMENT**  
**Medical Certification of Physician or Practitioner**  
**For Family Medical Leave Request - FMLA**

**Print all information**

**Physician: FAX TO: 954-797-1079**

<b>Part A : Employee Name:</b>	<b>Patient Name:</b> (if other than employee):
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**Part B : Health Care Provider to complete all the information in this section.**

Does the patient's condition qualify under one of the categories below as a "serious health condition" under the Family and Medical Leave Act (FMLA)?     Yes     No

If yes, mark which category below:

Hospital Care                       Permanent/Long-Term Conditions                       Pregnancy

Absence Plus Treatment     Multiple Treatment (Non-chronic condition)     Chronic Condition On-going Treatment

Provide a brief statement as to how the medical facts meet the criteria of one of these categories: Continue on Back:

Date Condition Commenced:	Probable duration of condition:
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**Part C : Health Care Provider to complete the following relating to an employee's serious health condition.**

**Employee's ability to work his/her regular work schedule:**

The serious health condition prevents/will prevent the employee from working for a period of time.  
The duration of this leave is/will be from \_\_\_\_\_ to \_\_\_\_\_.  
(date) (date)

For pregnancies: estimated due date is: \_\_\_\_\_

The serious health condition allows the employee to only work a **Reduced / Intermittent** work schedule. (Circle One)  
The recommended work schedule is the following:  
This altered work schedule should begin \_\_\_\_\_ and continue until \_\_\_\_\_.  
(date) (date)

During this **Reduced / Intermittent** work schedule, the employee: (Circle One)

Will be able to perform all of his/her essential job functions.

Will not be able to perform the following essential job functions without reasonable accommodation:

**Physicians suggestions** for accommodating the work limitations listed above:

**Part D : Employee must complete if requesting leave to care for a seriously ill family member:**

Relationship to Patient:	Will other family members assist with care? <input type="checkbox"/> Yes <input type="checkbox"/> No
State the care you will provide and an estimate of the time period during which care will be provided by you:	

**Part E : Health Care Provider to complete ONLY IF for an employee's seriously ill family member:**

Does the patient's condition require assistance for basic medical, personal, nutritional or safety needs, psychological comfort or for transportation by or received from the employee listed on this form?     Yes     No

If Yes, please indicate the period of time (including start date) and probable duration of this need:

What are the nature of care or services the employee will provide for the seriously ill family member: Continue on Back:

**Part F : Health Care Provider Information:**

Health Care Provider Name (PRINT):	Type of Practice:	
Health Care Provider Signature:	Date:	Address, Phone Number and FAX Number:

**Part G : Patient/Employee Medical Release**

I authorize the release of any medical information necessary to process the above request.

Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Employee: Return Completed Form to Your Department for forwarding to Department of Human Resources Mgmt.**

# INFORMATION INTENDED TO ASSIST PHYSICIAN

## DEFINITION OF A “SERIOUS HEALTH CONDITION”

**Serious Health condition:** Means an illness, injury impairment, or physical or mental condition that involves one of the following:

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.

Absence Plus Treatment: A period of incapacity of more than 3 consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:

Treatment of 2 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

Treatment by; a health care provider on at least one occasion which results in regimen of continuing treatment under the supervision of the health care provider.

Pregnancy: Any period of incapacity due to pregnancy, or for parental care.

Chronic Conditions Requiring Intermittent Treatments: A chronic condition which:

Requires periodic visits for treatment by a health care provider, or by a nurse or physician’s assistant under direct supervision of a health care provider;

Continues over an extended period of time (including recurring episodes of a single underlying condition); and

May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, cancer, etc.).

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 stroke, or the terminal stages of a disease.

**Multiple Treatments (Non-Chronic Conditions):** Requires **INTERMITTANT** periods of absence to receive multiple treatments (including any period of recovery there from) 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 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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**Here and elsewhere on these forms, the information sought relates only to the condition for which the employee is taking FMLA leave.**

**Incapacity:** For purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery there from.

**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.

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, salves, bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

# TOWN OF DAVIE

## MEDICAL RETURN TO WORK EVALUATION – Not-Work Related Health Condition

*The Treating PHYSICIAN must complete this form Before the Employee May Return To Work!*

Patient/Employee Name: \_\_\_\_\_ Date: \_\_\_\_\_

Department: \_\_\_\_\_ Date Disablement Began/Will Begin: \_\_\_\_\_

Job Title: \_\_\_\_\_ Describe Work Duties: \_\_\_\_\_

Duties Continued: \_\_\_\_\_

### TO BE COMPLETED BY PHYSICIAN

1). Is this employee able to perform the duties listed above without Restriction?  Yes  No  
( If NO Complete # 2 )

If Yes, Indicate date able to resume regular work assignment: \_\_\_\_\_

2). Is the employee able to perform Light Duty assignments?  Yes  No

If YES, check the workplace limitations below.

Number of HOURS a Day able to work: \_\_\_\_\_  Full-Time

Type Work	Full Restriction	Partial Restriction	No Restriction
Sedentary – Lifting 0 – 10 Pounds			
Light – Lifting 10 – 20 Pounds			
Moderate – Lifting 20 – 50 Pounds			
Heavy – Lifting 50 – 100 Pounds (Occasional)			
Pulling / Pushing / Carrying			
Reaching or Working Above Shoulder			
Walking			
Standing			
Sitting			
Stooping			
Kneeling			
Repeated Bending and Crawling			
Climbing			
Operating a Vehicle, Truck, Etc.			

Exposure Limitations:  Heat  Cold  Stress  Dust  Fumes

3). Period of Disability (Estimated): \_\_\_\_\_

Total Disability: From \_\_\_\_\_ To \_\_\_\_\_

Partial Disability: From \_\_\_\_\_ To \_\_\_\_\_

Date Able to Assume Work Duties: \_\_\_\_\_

Light Work? \_\_\_\_\_ Employee Advised?

Regular Work? \_\_\_\_\_ Employee Advised ? \_\_\_\_\_

4). Nature of Illness, Treatment Frequency if On-going, and Prognosis: \_\_\_\_\_

Date and Time of Next Appointment: \_\_\_\_\_ Discharged?  Yes  No

Physicians Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Clinic Name: \_\_\_\_\_

Fax Completed Form to HUMAN RESOURCES AT: ( 954 ) 797 – 1079