



TOWN OF DAVIE Family and Medical Leave (FMLA) Instructions

The following FMLA DOCUMENTS are included in the FMLA Instructions packet:

1. REQUEST FOR FMLA LEAVE – Town of Davie Form (Revised 05/2016)
2. CERTIFICATION OF HEALTH CARE PROVIDER – Town of Davie Form (Revised 05/2016)
3. MEDICAL RETURN TO WORK EVALUATION (NON-WORK RELATED HEALTH CONDITION) – Town of Davie Form (Revised 05/2016)
4. EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT – U.S. DOL/WHI Poster (Revised 02/2013)

- ❖ If your FMLA is **FORESEEABLE**: your request must be submitted thirty (30) days in advance of taking the leave
- ❖ If your FMLA is **UNFORESEEABLE**: your request must be submitted no more than two (2) working days from the date you learned of the need for leave

INSTRUCTIONS FOR SUBMITTING FMLA LEAVE REQUEST

1. If FMLA is requested for an employee or family member's **SERIOUS HEALTH CONDITION**:
 - Submit REQUEST FOR FMLA LEAVE FORM AND approved LEAVE REQUEST FORM.
 - Have Health Care Provider (HCP) complete the CERTIFICATION HEALTH CARE PROVIDER FORM for absences related to **YOUR** serious health condition or the serious health condition of a **FAMILY MEMBER** (spouse, son, daughter or parent – proof of relationship may be required).
 - Intermittent FMLA leave can be taken, however, when leave is needed for planned medical treatment, the employee must make a reasonable effort to schedule treatment so as not to unduly disrupt the employer's operation.
2. If FMLA is requested to care for or bond with a newborn child or for a newly placed adopted or foster child:
 - Submit REQUEST FOR FMLA LEAVE FORM AND approved LEAVE REQUEST FORM.
 - An eligible employee is entitled to take a block of twelve (12) weeks of FMLA leave to care for or bond with the child.
 - Intermittent FMLA leave can be taken, however, time off must be requested in advance and requires approval by the Department Director. Leave must conclude within twelve (12) months after the birth or placement.

Example: I took a week of protected leave under the FMLA to care for my baby who was born 2 months ago. Now I want to take the week of July 4th off to be with my baby. Since caring for my newborn is a condition covered under the FMLA, does my employer have to let me off for the week of July 4th? Not necessarily. You are requesting time off for the birth and care of a child on an intermittent basis. Therefore, your request for the week of July 4th is subject to your supervisor's approval in accordance with current leave policies.
 - Proof of birth and relationship is required (***if adding child to the Town Health Insurance, paperwork must be completed within 30 days of birth*).
 - BOTH parents employed by TOWN OF DAVIE - FMLA combined total for both parents (Medical Necessity **AND** Bonding Time) shall not exceed 12 weeks.
3. If FMLA is requested for Qualifying Exigency Leave:
 - 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.

- Eligible employees must submit the following:
 - REQUEST FOR FMLA LEAVE FORM AND approved LEAVE REQUEST FORM.
 - A copy of the military member's active duty orders (or other official documentation issued by the military) which indicates the military member is on covered active duty or call to covered active duty status;
 - A statement or description of the appropriate facts regarding the qualifying exigency;
 - The approximate date on which the leave began (or will begin) and an estimated timeframe of how long and/or how often leave is needed.
 - 4. If FMLA is requested for Military Caregiver Leave:
 - Eligible employees may 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.
 - Eligible employees must submit the following:
 - REQUEST FOR FMLA LEAVE FORM AND approved LEAVE REQUEST FORM.
 - Have Health Care Provider (HCP) complete the CERTIFICATION HEALTH CARE PROVIDER FORM for the covered servicemember.
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REMINDERS

- In order to qualify for FMLA leave, employees must have worked 1,250 hours prior to the start of the leave and have worked with the Town of Davie for 12 months.
- FMLA provides up to 12 weeks of unpaid, job-protected leave (unless otherwise stated).
- **FMLA INTERMITTENT LEAVE**: leave taken in separate blocks of time due to a single qualifying reason or on a reduced leave schedule – reducing the employee's usual weekly or daily work schedule.
- If the usage of FMLA becomes questionable based on *frequency, pattern and/or duration of absences*, clarification and authentication of the Certification of Health Care Provider will be required.
- Employees are prohibited from engaging in unauthorized work for personal gain while on FMLA leave.
- FMLA leave secured by fraud is not protected and any employee who fraudulently obtains FMLA may be subject to termination.

Please contact Grace Garagozzo at (954) 797-1094 for additional information.

TOWN OF DAVIE

CERTIFICATION OF HEALTH CARE PROVIDER (FAMILY AND MEDICAL LEAVE ACT OF 1993)

COMPLETED FORM REQUIRED - may be faxed by HEALTH CARE PROVIDER (HCP) to (954) 797-1079.

Section 1: Employee Information - Complete Box #7 if FMLA is for a family member

Employee Name: _____ Patient Name: _____ Relationship OF PATIENT TO EMPLOYEE Self _____ Parent _____ Spouse _____ Dependent Child/Age of Child: ____/____

Section 2: Health Care Provider (HCP) to Complete this Section (See Instructions - Page 2)

1. Check the appropriate Serious Health Condition (Definition of Serious Health Condition - next page) [] a. Hospital Care [] b. Absence Plus Treatment [] c. Pregnancy [] d. Chronic Conditions Requiring Treatment [] e. Permanent./Long-Term Conditions Requiring Treatment [] f. Multiple Treatments (Non-Chronic Conditions) [] g. Not a serious health condition 2. Medical Facts that support Serious Health Condition: (Sufficient Certification - definition - see next page)

3a. Onset: _____ Estimated Delivery Date Pregnancy: _____ 3b. Anticipated duration of condition*: _____ Employee's PREGNANCY: # of weeks required for MEDICALLY NECESSARY LEAVE 4. Date(s) of present incapacity if different from 3a.

5a. Please indicate type of leave required: [] Consecutive: Give duration of time off from work: Start Date: _____ Return to Work Date: _____ [] Intermittent - Please estimate episodic leave: Frequency of illness episodes: _____ Duration of illness episodes: _____ [] Reduced Schedule: Hours per day: _____ OR Days per week: _____ 5b. Prescribed treatment regimen and schedule (if applicable): [] Office Visits: # of visits: _____ PER DAY/WEEK/MONTH FOR _____ DAY(S)/WEEK(S)/MONTH(S) [] Therapy Visits: # of visits: _____ PER DAY/WEEK/MONTH FOR _____ DAY(S)/WEEK(S)/MONTH(S) [] Surgery (date): _____ [] Other treatments ~ Type: _____ # _____ PER DAY/WEEK/MONTH FOR _____ DAY(S)/WEEK(S)/MONTH(S) [] Prescription Medication: _____ [] Referral to other providers (describe): _____

FAMILY MEMBER'S SERIOUS HEALTH CONDITION HCP ~ Complete 6a - 6b *Employee - complete #7

6a. Will PATIENT require assistance for basic medical or personal needs, safety or transportation? [] Yes ~ Complete 6b. [] No

6b. How frequently will PATIENT require assistance? _____ # of HOURS OR DAYS _____ PER DAY/WEEK/MONTH Duration _____ DAY(S)/WEEK(S)/MONTH(S)

7. EMPLOYEE ~ State the care you will provide. Include schedule for intermittent leave or reduced schedule: Attach additional page(s) if necessary.

Health Care Provider Information ~ Please Print Legibly ~

HCP PRINTED NAME: _____ Telephone #: _____ Field of specialty (if any): _____ Fax #: _____ HCP Signature: _____ Address: _____ Date: _____ City, State, Zip: _____

Please note: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.



TOWN OF DAVIE
MEDICAL RETURN TO WORK EVALUATION
Non-Work Related Health Condition
(To be completed by the employee's healthcare provider)

Instructions: Employees returning to work from a medical leave of absence or use of Sick Leave for an employee's own medical condition must provide this or a doctor's office version of a return to work form before actually returning to work. *This form must be submitted to the Human Resources Department prior to returning to work. Fax: (954) 797-1079.*

EMPLOYEE INFORMATION

Employee Name: _____ Date: _____

Title/Position: _____ Department: _____

PHYSICIAN'S STATEMENT

Before an employee may return to work, the return to work clearance process must be fully completed. Based on the employee's current medical examination and the job description, please complete the following:

- Employee can return to work with no restrictions on: _____
- Employee can return to work on: _____ with the below restrictions.
- Restrictions can be re-evaluated on: _____ OR Restrictions will end on _____.
- Employee remains unable to work because of the following reason(s): _____
 Until the following date: _____ (New Return to Work Evaluation Form will be required).

Type of Work	No Restriction	Partial Restriction	Full Restriction
Lift or carry maximum			
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.			
Other			

Exposure Limitations: Heat Cold Dust Fumes

Date and Time of next appointment: _____ Discharged? YES NO

Healthcare provider's Signature: _____ Date: _____

Printed Name of healthcare provider: _____

Address: _____ Phone: _____
 _____ Fax: _____

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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, 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 whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status 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: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness*; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness.*

***The FMLA definitions of "serious injury or illness" for current servicemembers and veterans are distinct from the FMLA definition of "serious health condition".**

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 12 months, have 1,250 hours of service in the previous 12 months*, and if at least 50 employees are employed by the employer within 75 miles.

***Special hours of service eligibility requirements apply to airline flight crew employees.**

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; and
- 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. Regulation 29 C.F.R. § 825.300(a) may require additional disclosures.



For additional information:
1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627
WWW.WAGEHOUR.DOL.GOV

U.S. Department of Labor | Wage and Hour Division



WHD Publication 1420 · Revised February 2013