CITY OF GALVESTON

FAMILY AND MEDICAL LEAVE PROCEDURES

FAMILY MEDICAL LEAVE

(BASED ON FEDERAL FAMILY AND MEDICAL LEAVE ACT OF 1993)

Return Completed Packet <u>Directly</u> to the Human Resources Department

Certification of Health Care Provider for
Family Member's Serious Health Condition
(Family and Medical Leave Act)

Application for Family
Medical Leave

SECTION I: For Completion by the EMPLOYER

Employer name and contact: _____

SECTION II: Instructions to the EMPLOYEE: Please complete Section II before giving form to Medical Provider.

NOTE: An employee requesting leave for the employee's serious health condition or the serious health condition of the employee's spouse, child or parent must submit a verifying medical certification from a physician within 15 days of application for leave.

I hereby authorize a health care provider representing The City of Galveston to contact my physician to verify the reason for my requested family and medical leave.

I understand that a failure to return to work at the end of my leave period may be treated as a resignation unless an extension has been agreed upon and approved in writing by The City of Galveston.

Note: If the City of Galveston pays the employee contributions missed by the employee while on leave, the employee will be required to reimburse the City for delinquent payments through a payroll deduction schedule upon returning to work from leave. The employee will be required to sign a written statement at the beginning of the leave period authorizing the payroll deduction for delinquent payments. Also, the City of Galveston may recover its share of health plan premiums paid during an employee's FMLA leave if the worker fails to return to the job.

Your name: _____
First Middle Last

Employee's Department: _____

Name of family member for whom you will provide care: _____
First Middle Last

Relationship of family member to you: _____

If family member is your son or daughter, date of birth: _____

Describe care you will provide to your family member and estimate leave needed to provide care: _____

_____

_____

_____ _____
Signature of Employee **Date**

MEDICAL RELEASE: I hereby authorize the release of any medical information necessary to process the above request.

_____ _____
Signature of Patient **Date**

CONTINUED ON NEXT PAGE

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. 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 patient needs leave. Page 4 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address:_____

Type of practice / Medical specialty: _____

Telephone: (_____)_____ Fax: (_____)_____

PART A: MEDICAL FACTS

1. Condition patient being treated for: _____

   Approximate date condition commenced: _____

   Probable duration of condition: _____

   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
   ☐ No ☐ Yes. If so, dates of admission: _____

   Date(s) you treated the patient for condition: _____

   Was medication, other than over-the-counter medication, prescribed? ☐ No ☐ Yes.

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

   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 such treatments and expected duration of treatment:

   _____

   _____

   _____

2. Is the medical condition pregnancy? ☐ No ☐ Yes. If so, expected delivery date: _____

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

   _____

   _____

   _____

   _____

CONTINUED ON NEXT PAGE

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ☐ No ☐ Yes.

   Estimate the beginning and ending dates for the period of incapacity: _____

   During this time, will the patient need care? ☐ No ☐ Yes.

   Explain the care needed by the patient and why such care is medically necessary:

   _____

   _____

   _____

   _____

   _____

5. Will the patient require follow-up treatments, including any time for recovery? ☐ No ☐ Yes.

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   _____

   Explain the care needed by the patient, and why such care is medically necessary: _____

   _____

   _____

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? ☐ No ☐ Yes.

   Estimate the hours the patient needs care on an intermittent basis, if any:

   _____ hour(s) per day; _____ days per week from _____ through _____

   Explain the care needed by the patient, and why such care is medically necessary: _____

   _____

   _____

   _____

   _____

   _____

CONTINUED ON NEXT PAGE

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ☐ No ☐ Yes.

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 Does the patient need care during these flare-ups? ☐ No ☐ Yes.

Explain the care needed by the patient, and why such care is medically necessary: _____

_____

_____

_____

_____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Health Care Provider **Address**

_____ _____

Date **Phone Number**

Notice of Intention to Return From Leave

(Completion by employee and signed by Health Provider prior to returning to work.)

Name: ____

Supervisor: ____

Date leave commenced: ____

Date of planned return: ____

I understand that my restoration to employment is subject to the following conditions:

1. As a condition of restoration, each employee must provide a written certification from his or her health care provider that the employee is able to resume working. [This is optional for employers.]
2. Every attempt will be made to restore an employee returning from leave to his or her original position. If the employee's original position is unavailable, the employee will be placed in an equivalent position with equivalent pay and benefits.
3. An employee returning from family and medical leave shall not be entitled to the accrual of any seniority or employment benefits during the period of leave.

____

Employee's signature Date

_ _

I have examined [employee / patient] and can certify that she/he is fully able to resume working without limitations.

____

Health care provider's signature Date

Family and Medical Leave Act of 1993

Section 1 **Leave Available**

A. The City is subject to the provisions of the Family and Medical Leave Act of 1993 and will grant job protected unpaid family and medical leave to eligible employees for up to 12 weeks per 12 - month period.

B. The reasons are as follows:

1. The birth of a child and in order to care for such child, or the placement of a child with the employee for adoption or foster care (leave for this reason must be taken within the 12-month period immediately following the child's birth or placement with the employee; or

2. In order to care for an immediate family member (spouse, child or parent) of the employee if such immediate family member has a serious health condition; or

3. The employee's own serious health condition makes the employee unable to perform the functions of his/her position.

Section 2 **Definitions**

A. The 12-month entitlement period means a rolling 12-month period measured forward from the date the first day leave is taken.

B. Spouse does not include unmarried domestic partners. If both spouses work for the City of Galveston, their total leave in any 12-month period may be limited to an aggregate of 12 weeks if the leave is taken for either the birth or placement for adoption or foster care of a child, or to care for a sick parent.

C. Child means a child either under 18 years of age, or 18 years of age or older who is incapable of self-care because of a mental or physical disability. An employee's child is one for whom the employee has actual day-to-day responsibility for care and includes a biological, adopted, foster or step-child.

D. Serious Health Condition means an illness, injury, impairment, or a physical or mental condition that involves:
1. Inpatient care; or
2. Any period of incapacity requiring absence from work for more than three business days and that involves continuing treatment by a health care provider;
3. Continuing treatment by a health care provider for a chronic or long-term health condition that is incurable or which, if left untreated, would likely result in a period of incapacity of more than three calendar days; or
4. Prenatal care by a health provider.

E. Continuing Treatment means:
1. Two or more visits to a health care provider; or
2. Two or more treatments by a health care practitioner on referral from, or under the direction of, a health care provider; or
3. A single visit to a health care provider that results in a regimen of continuing treatment; or
4. In the case of a serious, long term or chronic condition or disability that cannot be cured, being under the continuing supervision of, but not necessarily being actively treated by, a health care provider.

Section 3 **Coverage and Eligibility**

A. Full-time Employees are entitled to leave under the Act if they have been employed by the City for at least 12 months and have worked a minimum of 1,250 hours during the twelve-month period immediately prior to the first day of the requested leave.

B. Hours worked do not include time paid but not worked such as paid vacation, personal or sick leave, and holidays nor does it include unpaid leave or periods of layoff.

C. The immediate twelve months prior to the request will be used for the calculation.

D. Request for unpaid leave must be in writing and submitted to the appropriate Department Head. Thirty (30) days advance notice must be given whenever possible. The request must specify the reason for the request and the length of time desired. Approval of the request must be in writing on "Response to Employee Request for Family and Medical Leave Act Leave" form.

E. All authorized leaves of absence must be reported by the Department Head and Employee to the City's Personnel Director, Risk Manager, and Finance Department.

Section 4 **Leave Available**

A. An eligible Employee is entitled to a combined twelve (12) work weeks of paid and unpaid leave during any twelve-month period due to:

1. the birth of a child and to care for that child (Family Leave);

2. adoption or foster care placement of a child (Family Leave);

3. need to care for a spouse, child or parent with a serious health condition (Medical Leave); and

4. the serious health condition of an employee that makes the employee unable to perform the functions of his job (Medical Leave.)

Section 5 **Intermittent or Reduced Leave**

A. Family Leave may not be taken intermittently.

B. Medical Leave may be taken intermittently or on a reduced leave schedule when medically necessary.

1. Medically necessary means there must be a medical need for the leave and that the leave can best be accomplished through an intermittent or reduced leave schedule.

2. The Employee may be required to transfer temporarily to a position with equivalent pay and benefits that better accommodates recurring periods of leave when the leave is planned based on scheduled medical treatment.

Section 6 **Use of Paid Leave**

A. Employees desiring Family Leave are required to utilize unused vacation prior to unpaid leave.

B. Employees desiring Medical Leave are required to utilized unused sick leave and vacation prior to unpaid leave.

Section 7 **Benefits**

A. Employees may not accumulate additional vacation or sick benefits while on the unpaid portion of FMLA leave.

B. The City will maintain health and life insurance benefits for an Employee taking leave for the duration of such leave in the same manner as if the Employee had been continuously employed during that period.

C. The Employee will be required by direct payment to continue the coverage on any supplemental insurance. The employee will be advised in writing at the beginning of the leave period as to the amount and method of payment.

D. If the employee's contribution is more than 30 days late, the City of Galveston may terminate the employee's insurance coverage.

E. An Employee is not entitled to seniority or benefit (vacation, sick days, etc.) accrual during periods of unpaid leave.

Section 8 **Both Spouses Employed**

A. If both husband and wife are employed by the City then leave on the basis of birth, adoption or care of a sick parent is limited to a combined 12 weeks for both Employees.

Section 9 **Notice Required**

A. Thirty (30) days prior notice is required for family leave unless that amount of notice cannot reasonably be provided. For medical leave, an Employee must make a reasonable effort to schedule treatment so as not to unduly disrupt work operations. In addition, the same thirty (30) day notice is required.

Section 10 **Medical Certification**

A. Medical certification of "Certification for Health Care Provider" forms available in the Personnel office is required for Medical Leave. The certification must be submitted to Personnel before leave begins if the need for leave is foreseeable. If the need for leave is not foreseeable, the certification must be submitted no later than 15 days after leave begins. If an Employee does not provide the certification, then the leave is NOT FMLA leave.

B. Second and third medical opinions and subsequent recertification may be required. An Employee must also periodically report on his/her status and on his/her intentions to return to work throughout the course of the leave.

Section 11 **Return to Work**

A. Employees returning from leave are entitled to be restored to their previous position held at the time that the leave commenced or to an equivalent position with the same pay and benefits and other terms and conditions of employment.

Serious Health Condition:

An illness, injury impairment, or physical or mental condition that involves one of the following:

1. **Hospital Care**
   Inpatient Care (overnight stay) in a hospital, hospice or residential medical care facility, including any period of **incapacity, (inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment or recovery)**

2. **Absence Plus Treatment**
   A period of **incapacity** of more than three consecutive calendar days that involves:

   a. **Treatment two or more times** by a health provider, nurse or physician’s assistant under direct supervision of health care provider, or by a provider of health care services under orders of, or on referral by a health care provider.

b. **Treatment** (includes examinations to determine serious health condition, but does not include physical, eye, and dental examinations) by health care provider **on at least one occasion** which results in a regimen of continuing treatment 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:

a. Requires periodic visits for treatment by health care provider, nurse or physician's assistant under direct supervision of a health care provider
b. Continues over an **extended period of time** (including recurring episodes of single underlying condition).
c. 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. Example is Alzheimer's, a serious stroke, or the terminal stages of a disease.

6. Multiple Treatments (Non-Chronic Conditions)

Any period of absence to receive **multiple treatments** (including any period of recovery) 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), and kidney disease (dialysis).