# Intermittent FMLA: A Continuing Complex Challenge

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## TABLE OF CONTENTS


I. INTERMITTENT LEAVE .......... 1
   A. Introduction .......... 1
   B. Tools for Addressing Intermittent FMLA Leave Challenges .......... 1
      1. Require a Certification of Medical Necessity for any Intermittent Leave. 29 C.F.R. § 825.202(b). .......... 1
      2. Obtain a "Complete and Sufficient" Medical Certification at the Beginning of the Leave. .......... 2
      3. Request a Second Opinion from a Health Care Provider Selected by the Company if the Company Has a Reason to Doubt the Validity of the Certification. .......... 3
      4. Request Recertification as Allowed. .......... 4
      5. Request a New Medical Certification. .......... 5
      6. Request Certification Regarding Ability to Work Safely. .......... 5
      7. Require a Fitness-for-Duty Certification as Allowed. .......... 5
      8. Enforce the FMLA's Notice Requirements and the Company's Call-In Procedures for Each Intermittent Absence. .......... 6
      9. Enforce the Requirements for Use of Paid Time During Intermittent Leave. .......... 6
      10. Require Employees to Make a "Reasonable Effort" to Schedule Planned Medical Treatment So As Not to Unduly Disrupt the Company's Operations. .......... 7
      11. Consider a Transfer for Intermittent Leave for Planned Medical Treatment. .......... 7
      12. Carefully Track the Amount of Intermittent Leave Taken. .......... 8
      13. Train Managers/Supervisors. .......... 8

# I. INTERMITTENT LEAVE

## A. Introduction

1. Intermittent leave under the federal Family and Medical Leave Act ("FMLA) has proven to be one of the most difficult aspects of the FMLA for covered employers. Almost every employer has a story to tell about the employee whose periodic, unplanned full or partial day absences significantly disrupt the workplace or, worse, may be a misuse or abuse of FMLA leave. The FMLA requires that employers allow intermittent (and full-time or reduced schedule) FMLA leave, as follows:

    a. For an employee's own chronic condition – migraine headache, irritable bowel syndrome, severe morning sickness, severe depression, etc.

    b. For an employee's family member's serious health condition – child's ADHD; parent's stroke, spouse's cancer, etc.

    c. But <u>not</u> for parenting leave unless the company chooses to allow it (and the company must treat all employees consistently).

2. While there are no magic solutions to stopping the disruption, misuse or abuse of intermittent leave, employers should use all of the tools allowed under the FMLA to gain and maintain as much control as allowed.

## B. Tools for Addressing Intermittent FMLA Leave Challenges

1. **Require a Certification of Medical Necessity for any Intermittent Leave. 29 C.F.R. § 825.202(b).**

    a. See questions 6 and 7 on the "Certification of Health Care Provider for Employee's Serious Health Condition" form.

    b. See questions 5, 6 and 7 on the "Certification of Health Care Provider for Family Member's Serious Health Condition" form.

        i. If intermittent leave is for the employee's own serious health condition, including pregnancy, the Certification must establish the medical necessity for the leave and an estimate of the frequency and duration of the episodes of incapacity. 29 C.F.R. §825.306(a)(7).

        ii. For intermittent leave to care for a covered family member, the Certification must include a statement that such leave is medically necessary, which can include assisting in the

family member's recovery, and an estimate of the frequency and duration of the required leave. 29 C.F.R. §825.306(a)(8)

iii. For planned medical treatment, the Certification must establish the medical necessity for the leave and an estimate of the dates and duration of such treatments and any periods of recovery. 29 C.F.R. § 825.306(a)(6).

**2. Obtain a "Complete and Sufficient" Medical Certification at the Beginning of the Leave.**

a. If a Certification form is "incomplete or insufficient," the company has every right to request complete and sufficient information. 29 C.F.R. §§ 825.305 and 825.307.

i. See the bottom portion of the Designation Notice where the employer must state what additional information is needed and that the "FMLA Leave request is Not Approved."

ii. The employer must provide the employee no less than seven calendar days to obtain the missing information.

iii. If the employer receives "complete and sufficient" information," the employer will need to give the employee a new Designation Notice.

iv. A Certification is "incomplete" if the employer receives a Certification, "but one or more of the applicable entries have not been completed."

v. A Certification is "insufficient" if the employer receives a complete Certification, "but the information provided is vague, ambiguous, or non-responsive."

b. If the deficiencies are not cured in the resubmitted Certification, the employer may deny FMLA leave in accordance with the applicable FMLA regulation at 29 C.F.R. § 825.313.

c. If an employee's Certification is complete and sufficient, the employer may not request additional information from the health care provider. But, the employer can do the following if needed:

i. Through a human resources professional, leave administrator, management official, or a health care provider (but not the employee's direct supervisor), the company may contact the health care provider for purposes of "clarification and

authentication" of the medical certification. 29 C.F.R. § 825.307.

ii. "Authentication" means providing the health care provider a copy of the certification and requesting verification that the information contained on the certification form was completed and/or authorized by the health care provider who signed the document.

iii. "Clarification" means contacting the health care provider to understand the handwriting on the certification or to understand the meaning of a response.

iv. Employers may not ask health care providers for additional information beyond that required by the certification form.

v. When requesting "authentication" and "clarification," the HIPAA requirements must be satisfied before the health care provider discloses "individually-identifiable health information" to the employer. If an employee chooses not to provide a needed HIPAA authorization, and the employee does not otherwise clarify the certification, the employer may deny FMLA leave if the certification is unclear. It is the employee's responsibility to provide the employer with a complete and sufficient certification and to clarify the certification if necessary.

**3. Request a Second Opinion from a Health Care Provider Selected by the Company if the Company Has a Reason to Doubt the Validity of the Certification.**

a. The selected health care provider may not be one whose services the company regularly uses or with whom the company regularly contracts. The company must pay for the second opinion and The company and also reimburse the employee for any other out-of-pocket expenses, including travel expenses. 29 C.F.R. § 825.307(b).

b. If the opinions of the employee's and the employer's designated health care providers differ, the employer may require the employee to obtain certification from a third health care provider at the employer's expense. The third opinion shall be final and binding. The third health care provider must be designated or approved jointly by the employer and the employee. 29 C.F.R. § 825.307(c).

## 4. Request Recertification as Allowed.

a. In all cases an employer may request recertification every six months but only in connection with an absence of the employee. This 6-month request is allowed even if the medical certification states that the minimum duration of the condition is more than six months (e.g., for a lifetime). 29 C.F.R. § 825.308.

b. More specifically, an employer may request recertification no more often than every 30 days and then only in connection with an absence by the employee.

c. But, if the original medical certification states that the minimum duration of the condition is more than 30 days, the employer must not request recertification until the minimum duration has expired unless an exception applies.

d. The exceptions that allow an employer to request recertification in less than 30 days (or the minimum duration specified on the original certification) include the following:

    i. The employee requests a leave extension from the amount stated on the original medical certification;

    ii. Circumstances described by the previous certification have changed significantly (e.g., the duration or frequency of the absence, the nature or severity of the illness, complications). This could include a pattern of using unscheduled FMLA that is suspicious and does not fit within the parameters of the previous certification, in particular a Monday/Friday absence pattern, or

    iii. The employer receives information casting doubt upon the employee's stated reason for the absence or the continuing validity of the certification.

e. When requesting recertification, the employer may provide the health care provider a record of the employee's absence pattern and ask the health care provider if the serious health condition and need for leave is consistent with such a pattern.

f. The company must allow the employee at least 15 calendar days to comply with the request for recertification. The employee is entitled to more time to provide the recertification if it is not practicable under the particular circumstances, despite the employee's diligent, good faith efforts to meet the 15-day requirement.

g. The employee must pay the expenses for the recertification. The company may not require a second or third opinion on recertification.

**5. Request a New Medical Certification.**

Request a whole new medical certification if the intermittent leave lasts beyond a single 12-month period (as defined by the employer in accordance with its regular policy). 29 C.F.R. § 825.305(e).

**6. Request Certification Regarding Ability to Work Safely.**

a. If an employee's serious health condition may also be a disability under the Americans with Disabilities Act, as amended ("ADA"), the employer may follow the procedures for requesting medical information under the ADA regarding the employee's ability to perform his/her work duties safely while at work. 29 C.F.R. § 825.306(d).

b. Any information received also may be considered in determining the employee's entitlement to FMLA leave.

c. The ADA only allows employers to request medical information that is job-related and consistent with business necessity. Therefore, this type of request generally will not need to be made.

d. One situation where it may apply is if the employer questions whether the employee, who has an ongoing medical condition for which s/he is taking intermittent FMLA leave, is able to perform the functions of his/her position without a direct threat to his/her own health or safety or that of others. It is strongly recommend that employers check with their employment counsel before making this type of ADA request during an FMLA intermittent leave.

**7. Require a Fitness-for-Duty Certification as Allowed.**

a. A fitness-for-duty Certification may only be requested if the company notified the employee on the Designation Notice or otherwise that a fitness-for-duty certification would be required. 29 C.F.R. § 825.312(f).

b. A Fitness-for-Duty Certification may be required for an employee who takes intermittent leave no more often than once every 30 days and then only if reasonable safety concerns exist regarding the employee's ability to perform his/her duties, based on the serious health condition for which the employee took such leave.

c. In such cases, the employer must inform the employee at the same time it issues the Designation Notice that for each subsequent instance of intermittent leave, the employee will be required to submit a fitness-for-duty certification unless one has already been submitted within the previous 30 days.

d. "Reasonable safety concerns means a reasonable belief of significant risk of harm to the individual employee or others."

**8. Enforce the FMLA's Notice Requirements and the Company's Call-In Procedures for Each Intermittent Absence.**

a. If the need for FMLA leave is foresee eable, even intermittent leave, an employee must provide at least 30 days' advance notice or provide notice as soon as practicable. Oral notice is sufficient. An employee need not mention the "FMLA." 29 C.F.R. § 825.303.

b. If an employee fails to give 30 days' advance notice for foreseeable leave (e.g., a planned medical appointment) and the employee had actual notice of the requirement for giving advance notice (e.g., the employer properly posted the required FMLA notice at the worksite where the employee is employed), the employer may delay the taking of FMLA leave until at least 30 days after the date the employee provides notice but only if the employee had actual notice of the FMLA notice requirements. 29 C.F.R. § 825.304.

c. When the need for leave is not foreseeable, an employee should give notice to the employer of the need for FMLA leave as soon as practicable (i.e., possible and practical) under the facts and circumstances of the particular case. 29 C.F.R. § 825.303.

d. State in the FMLA policy that employees on intermittent leave must follow the usual requirements for reporting an unplanned absence or tardy. 29 C.F.R. § 825.303(c).

e. Enforce discipline for employees who fail to comply with the call-in procedures unless unusual circumstances apply.

**9. Enforce the Requirements for Use of Paid Time During Intermittent Leave.**

a. The FMLA regulations specifically allow an employer to deduct against a salaried-exempt employee's salary for FMLA leave time without loss of the exemption under the Fair Labor Standards Act. 29 C.F.R. § 825.206.

b. If an employee chooses, or if the employer requires, use of employer-provided paid time concurrently with FMLA leave (whether intermittent or otherwise), the employer may require the employee to follow its established terms and conditions for use of such time so long as the employer has informed the employee of those terms and conditions. If the employee does not comply with the employer's requirements for use of paid time, no paid time need be provided but the employee is still entitled to take unpaid FMLA leave. 29 C.F.R. § 825.207.

**10. Require Employees to Make a "Reasonable Effort" to Schedule Planned Medical Treatment So As Not to Unduly Disrupt the Company's Operations.**

a. Include this requirement in the company's FMLA policy. 29 C.F.R. § 825.203.

b. Include this requirement in any correspondence to the employee.

**11. Consider a Transfer for Intermittent Leave for Planned Medical Treatment.**

a. If intermittent leave is required based on planned medical treatment, the employer may transfer the employee temporarily to an available position of equivalent pay and benefits where the required schedule can be better accommodated. 29 C.F.R. § 825.204.

b. The alternative position for these purposes does not have to have equivalent duties.

c. While on intermittent leave, the employer is prohibited from eliminating benefits which otherwise would not be provided to part-time employees. An employer may, however, proportionately reduce benefits such as vacation leave where an employer's normal practice is to base accrual of such benefits on the number of hours worked.

d. A transfer must <u>not</u>

i. Discourage the employee from taking leave, or

ii. Cause hardship to the employee.

## 12. Carefully Track the Amount of Intermittent Leave Taken.

a. The amount of any one instance of required intermittent leave cannot be greater than one hour. 29 C.F.R. § 825.205.

b. But employees must be allowed to take intermittent leave in an increment no greater than the shortest period of time that the employer uses to account for use of other forms of leave.

c. Only the amount of leave actually taken counts against the employee's 12-weeks.

d Count the amount of leave taken against the 12 weeks in fractions of a week. For example, if an employee's schedule is 40 hours per week and he/she misses four hours, that's 4/40 = 1/10 week of FMLA leave take.

e. Alternatively, count the hours of leave taken based on the employee's regular weekly hours worked before FMLA leave began. For example, an employee who works 35 hours per week: 35 x 12 = 420 hours of FMLA to use. Subtract any hours used from the 420 available hours.

f. Overtime – If overtime is mandatory, any mandatory overtime missed counts against the employee's available FMLA leave. But the mandatory overtime hours also must be counted toward the employee's total available FMLA. For example, an employee's mandatory weekly hours are 50. So, the employee's 12 weeks of FMLA = 600 hours (12 x 50). When the employee misses 10 hours of mandatory overtime, the time missed = 1/5 week. Or it reduces her FMLA allotment by 10 hours to 590 hours.

## 13. Train Managers/Supervisors.

a. Regarding employee rights and responsibilities for intermittent (and all other types of) FMLA leave.

b. Regarding their obligation to notify human resources of employee absences/tardies.

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

**U.S. Department of Labor**
Employment Standards Administration
Wage and Hour Division

**DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT**

OMB Control Number 1235-0003
Expires: 5/31/2018

## SECTION I: For Completion by the EMPLOYER

**INSTRUCTIONS to the EMPLOYER:** The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. Section 1635.9, if the Genetic Information Nondiscrimination Act applies..

Employer name and contact: ____________________

Employee's job title: ____________________ Regular work schedule: ____________________

Employee's essential job functions: ____________________

____________________

Check if job description is attached: ______

## SECTION II: For Completion by the EMPLOYEE

**INSTRUCTIONS to the EMPLOYEE:** Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: ____________________
First Middle Last

## SECTION III: For Completion by the HEALTH CARE PROVIDER

**INSTRUCTIONS to the HEALTH CARE PROVIDER:** Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. 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 employee is seeking leave. Do not provide information about genetic tests, as defined in 29 C.F.R. Section 1635.3(f), genetic services, as defined in 29 C.F.R. Section 1635.3(b). 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. Approximate date condition commenced: ____________________

Probable duration of condition: ____________________

**Mark below as applicable:**

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:

____________________

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

Was medication, other than over-the-counter medication, prescribed? _____ 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. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition: _____ No _____ Yes.

If so, identify the job functions the employee is unable to perform:

____________________

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

____________________

____________________

____________________

____________________

____________________

____________________

____________________

**PART B: AMOUNT OF LEAVE NEEDED**

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? _____ No _____ Yes.

   If so, estimate the beginning and ending dates for the period of incapacity: ______________________________

6 Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? _____ No _____ Yes.

   If so, are the treatments or the reduced number of hours of work medically necessary?
   _____ 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:

   ______________________________________________________________________

   Estimate the part-time or reduced work schedule the employee needs, if any:

   _______ hour(s) per day; ________ days per week from ____________ through _______________

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? _____ No _____ Yes.

   Is it medically necessary for the employee to be absent from work during the flare-ups?
   _____ No _____ Yes. If so, explain:

   ______________________________________________________________________

   ______________________________________________________________________

   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

**ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.**

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

**Signature of Health Care Provider** **Date**

**PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT**

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**

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

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division

OMB Control Number 1235-0181
Expires: 5/31/2018

**SECTION I: For Completion by the EMPLOYER**

**INSTRUCTIONS to the EMPLOYER**: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

Employer name and contact: ______________________________

______________________________

**SECTION II: For Completion by the EMPLOYEE**

**INSTRUCTIONS to the EMPLOYEE:** Please complete Section II before giving this form to your family member or his/her medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a covered family member with a serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. § 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Your name: ______________________________
First Middle Last

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:

______________________________

______________________________

______________________________

______________________________

______________________________ Employee Signature

______________________________ Date

## 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 3 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. 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):

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

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: ________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

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** **Date**

**PUBLIC BURDEN STATEMENT**

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**

Designation Notice
(Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 5/31/2018

**Leave covered under the Family and Medical Leave Act (FMLA) must be designated as FMLA-protected and the employer must inform the employee of the amount of leave that will be counted against the employee's FMLA leave entitlement. In order to determine whether leave is covered under the FMLA, the employer may request that the leave be supported by a certification. If the certification is incomplete or insufficient, the employer must state in writing what additional information is necessary to make the certification complete and sufficient. While use of this form by employers is optional, a fully completed Form WH-382 provides an easy method of providing employees with the written information required by 29 C.F.R. §§ 825.300(c), 825.301, and 825.305(c).**

To: ________________________________

Date: ________________________

We have reviewed your request for leave under the FMLA and any supporting documentation that you have provided. We received your most recent information on ___________________________________ and decided:

_____ **Your FMLA leave request is approved. All leave taken for this reason will be designated as FMLA leave.**

**The FMLA requires that you notify us as soon as practicable if dates of scheduled leave change or are extended, or were initially unknown. Based on the information you have provided to date, we are providing the following information about the amount of time that will be counted against your leave entitlement:**

_____ Provided there is no deviation from your anticipated leave schedule, the following number of hours, days, or weeks will be counted against your leave entitlement: ______________________________________

_____ Because the leave you will need will be unscheduled, it is not possible to provide the hours, days, or weeks that will be counted against your FMLA entitlement at this time. You have the right to request this information once in a 30-day period (if leave was taken in the 30-day period).

**Please be advised (check if applicable):**

_____ You have requested to use paid leave during your FMLA leave. Any paid leave taken for this reason will count against your FMLA leave entitlement.

_____ We are requiring you to substitute or use paid leave during your FMLA leave.

_____ You will be required to present a fitness-for-duty certificate to be restored to employment. If such certification is not timely received, your return to work may be delayed until certification is provided. A list of the essential functions of your position ___ **is** ___ **is not** attached. If attached, the fitness-for-duty certification must address your ability to perform these functions.

_____ **Additional information is needed to determine if your FMLA leave request can be approved:**

_____ The certification you have provided is not complete and sufficient to determine whether the FMLA applies to your leave request. You must provide the following information no later than ____________________ (Provide at least seven calendar days), unless it is not practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied.

______________________________________________________________________
(Specify information needed to make the certification complete and sufficient)

______________________________________________________________________

_____ We are exercising our right to have you obtain a second or third opinion medical certification at our expense, and we will provide further details at a later time.

_____ Your FMLA Leave request is Not Approved.

_____ The FMLA does not apply to your leave request.

_____ You have exhausted your FMLA leave entitlement in the applicable 12-month period.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

It is mandatory for employers to inform employees in writing whether leave requested under the FMLA has been determined to be covered under the FMLA. 29 U.S.C. § 2617; 29 C.F.R. §§ 825.300(d), (e). It is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 10 – 30 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.**

OMB Control Number 1235-0003

In general, to be eligible an employee must have worked for an employer for at least 12 months, have worked at least 1,250 hours in the 12 months preceding the leave (special rules apply to airline flight crew members), and work at a site with at least 50 employees within 75 miles. While use of this form by employers is optional, a fully completed Form WH-381 provides employees with the information required by 29 C.F.R. § 825.300(b), which must be provided within five business days of the employee notifying the employer of the need for FMLA leave. Part B provides employees with information regarding their rights and responsibilities for taking FMLA leave, as required by 29 C.F.R. § 825.300(b), (c).

**[Part A – NOTICE OF ELIGIBILITY]**

TO: ____________________________________________
Employee

FROM: ____________________________________________

DATE: ____________________________________________
Employer Representative

On ________________________, you informed us that you needed leave beginning on ___________________ for:

_____ The birth of a child, or placement of a child with you for adoption or foster care;

_____ Your own serious health condition;

_____ Because you are needed to care for your _____ spouse; _____ child; _____ parent due to his/her serious health condition.

_____ Because of a qualifying exigency arising out of the fact that your _____ spouse; _____ son or daughter _____ parent is on covered active duty or call to covered active duty with the Armed Forces.

_____ Because you are the _____ spouse; _____ son or daughter; _____ parent; _____ next of kin of a covered servicemember with a serious injury or illness.

This Notice is to inform you that you:

_____ Are eligible for FMLA Leave (See Part B below for Rights and Responsibilities)

_____ Are **not** eligible for FMLA leave, because (only one reason need be checked, although you may not be eligible for other reasons):

  _____ You have not met the FMLA's 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately _____ months towards this requirement.

  _____ You have not met the FMLA's hours of service requirement

  _____ You do not work and/or report to a site with 50 or more employees within 75-miles.

If you have any questions, contact ___________________________________ or view the FMLA poster located in ________________________
_____________________________________________________________________________________.

**(PART B-RIGHTS AND RESPONSIBILITIES FOR TAKING FMLA LEAVE)**

As explained in Part A, you meet the eligibility requirements for taking FMLA leave and still have FMLA leave available in the applicable 12-month period. **However, in order for us to determine whether your absence qualifies as FMLA leave, you must return the following information to us by** ___________________________. (If a certification is requested, employers must allow at least 15 calendar days from receipt of this notice; additional time may be required in some circumstances.) If sufficient information is not provided in a timely manner, your leave may be denied.

_____ Sufficient certification to support your request for FMLA leave. A certification form that sets forth the information necessary to support your request _____ **is** / _____ **is not** enclosed.

_____ Sufficient documentation to establish the required relationship between you and your family member.

_____ Other information needed (such as documentation for military family leave): ______________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

_____ No additional information requested

 CONTINUED ON NEXT PAGE 

**If your leave does qualify** as FMLA leave you will have the following **responsibilities** while on FMLA leave (only checked blanks apply):

__________ Contact ___________________________________ at ______________________________ to make arrangements to continue to make your share of the premium payments on your health insurance to maintain health benefits while you are on leave. You have a minimum 30-day (or, indicate longer period, if applicable) grace period in which to make premium payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse, or, at our option, we may pay your share of the premiums during FMLA leave, and recover these payments from you upon your return to work.

__________ You will be required to use your available paid _______ **sick**, _______**vacation**, and/or _______ **other leave** during your FMLA absence. This means that you will receive your paid leave and the leave will also be considered protected FMLA leave and counted against your FMLA leave entitlement.

__________ Due to your status within the company, you are considered a "key employee" as defined in the FMLA. As a "key employee," restoration to employment may be denied following FMLA leave on the grounds that such restoration will cause substantial and grievous economic injury to us. We _____**have**/_____**have not** determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic harm to us.

__________ While on leave you will be required to furnish us with periodic reports of your status and intent to return to work every ___________ (Indicate interval of periodic reports, as appropriate for the particular leave situation).

**If the circumstances of your leave change, and you are able to return to work earlier than the date indicated on the reverse side of this form, you will be required to notify us at least two workdays prior to the date you intend to report for work.**

**If your leave does qualify** as FMLA leave you will have the following **rights** while on FMLA leave:

- You have a right under the FMLA for up to 12 weeks of unpaid leave in a 12-month period calculated as:

  __________ the calendar year (January – December).

  ____________ a fixed leave year based on ________________________________________________________________________

  __________ the 12-month period measured forward from the date of your first FMLA leave usage.

  __________ a "rolling" 12-month period measured backward from the date of any FMLA leave usage.

- You have a right under the FMLA for up to 26 weeks of unpaid leave in a single 12-month period to care for a covered servicemember with a serious injury or illness. This single 12-month period commenced on ______________________________________________________
- Your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work.
- 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 FMLA-protected leave except as allowed under applicable law. (If your leave extends beyond the end of your FMLA entitlement, you do not have return rights under FMLA.)
- If you do not return to work for at least 30 calendar days following FMLA leave for a reason other than: 1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; 2) the continuation, recurrence, or onset of a covered servicemember's serious injury or illness which would entitle you to FMLA leave; or 3) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your unpaid FMLA leave.
- If we have not informed you above that you must use accrued paid leave while taking your unpaid FMLA leave entitlement, you have the right to have ____ **sick**, ____**vacation**, and/or ____ **other leave** run concurrently with your unpaid leave entitlement, provided you meet any applicable requirements of the leave policy. Applicable conditions related to the substitution of paid leave are referenced or set forth below. If you do not meet the requirements for taking paid leave, you remain entitled to take unpaid FMLA leave.

  __________ For a copy of conditions applicable to sick/vacation/other leave usage please refer to___________ available at: ___________________

  __________ Applicable conditions for use of paid leave: ________________________________________________________________

  ____________________________________________________________________________________________

  ____________________________________________________________________________________________

  ____________________________________________________________________________________________

  ____________________________________________________________________________________________

**Once we obtain the information from you as specified above, we will inform you, within 5 business days, whether your leave will be designated as FMLA leave and count towards your FMLA leave entitlement. If you have any questions, please do not hesitate to contact:**

_____________________________________________ at __________________________________

**PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT**

It is mandatory for employers to provide employees with notice of their eligibility for FMLA protection and their rights and responsibilities. 29 U.S.C. § 617; 29 C.F.R. § 825.300(b), (c). It is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 10 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.**