FMLA Checklist

FMLA Checklist Table of Contents

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### Employer Criteria

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>
| 1 |     |    | Does the private-sector employer have 50 or more employees? *Count employees that worked each working day in 20 or more workweeks during the current or preceding calendar year to determine the applicable number of employees.*
|   | YES | NO |
| 2 |     |    | Is the employer a governmental employer (such as a municipality or county government) or a local educational agency of any size?  

If yes to either, the employer is subject to FMLA.

### Employee Criteria

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>
| 3 |     |    | Has the employee worked for the employer for at least 12 months? *(need not be consecutive)*  

*Do not count prior service for any employee who experienced a five-year break in service.*

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>
| 4 |     |    | Has the employee worked at least 1,250 hours within the last 12-month period?  

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>
| 5 |     |    | Does the employee work at a worksite that has at least 50 employees within a 75-mile radius of the worksite?  

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>
| 6 |     |    | Does the employee qualify for leave under any one of the following reasons?  

- The employee’s own serious health condition.
- The birth of a child (if the leave is concluded within 12 months of the birth).
- The adoption or placement for foster care of a child (if the leave is concluded within 12 months of placement).
- The employee’s spouse (as defined by state law), child or parent has a serious health condition.
- The employee’s spouse, child or parent has a “qualifying exigency” arising from the fact that the spouse, child or parent is a military service member on active duty or has been notified of an impending call or order to active duty.
- The employee is the nearest blood relative to a military service member who has a serious illness or injury resulting from or aggravated by active duty and is requesting leave to care for the covered service member.

1. A serious health condition is defined in general as an illness, injury, impairment or physical or mental condition that involves:
   1. Inpatient care in a hospital, hospice or residential medical care facility
   2. A period of incapacity of at least three consecutive days and at least one of the following:
      a. At least two treatments or visits by a health care provider within 30 days
      b. At least one treatment by a health care provider that results in a regimen of continuing treatment under the health care provider
   3. Any incapacity due to pregnancy or for prenatal care
   4. Any incapacity for a chronic health condition that requires periodic visits to the health care provider, continues over an extended period of time and that may cause episodes of incapacity rather than a continuous period of incapacity
   5. Permanent or long-term incapacity that is not treatable (such as the last stages of terminal cancer or Alzheimer’s)
   6. Any period of absence to receive multiple treatments (such as chemotherapy)
2. Child for this purpose means the employee’s biological, adopted or foster child, stepchild, legal ward or a child for whom the employee stood in loco parentis who is under 18 years of age, or 18 years of age or older and incapable of self care because of a mental or physical disability
3. Child for this purpose means the employee’s biological, adopted or foster child, stepchild, legal ward or a child of any age for whom the employee stood in loco parentis who is on active duty or called to active duty status.
If all answers to Questions 3 through 6 are, “Yes,” the employee may be entitled to:

- Up to 12 weeks of unpaid leave during a 12-month period under FMLA. An employee who is the nearest blood relative to a military service member who has a serious illness or injury is entitled to up to 26 weeks of unpaid leave during a 12 month period to care for a covered service member.
- The option to continue health insurance benefits at the same rate and under the same conditions as if the employee were still actively at work.
- Have his or her benefits restored upon return without penalty, including no waiting period or pre-existing condition exclusion, if the employee does not continue his or her health insurance benefits during the leave period.
- Be restored to the same or equivalent position upon return.

**Employer Obligations**

- Post an FMLA Poster notifying employees of rights. A poster titled “Employee Rights and Responsibilities Under the Family and Medical Leave Act” is available in this package.
- Distribute the FMLA Poster (also known as the FMLA General Notice) to each employee either by including it in employee handbooks or other written guidance to employees concerning benefits, or must distribute a copy of the general notice to each new employee upon hiring.
- Develop an FMLA policy, taking into consideration:
  - How the employer’s 12-month period is determined
    - Calendar year
    - Any fixed 12-month period such as a fiscal year or a year starting on the employee’s anniversary date
    - A 12-month period measured from the start date of the employee’s first FMLA leave
    - A rolling 12-month period measured backward from the date that the employee uses FMLA
  - Whether the employer will require certification for leave. The following model certification forms are included in this package:
    - Certification of Health Care Provider for Employee’s Serious Health Condition (Form WH-380-E)
    - Certification of Health Care Provider for Family Member’s Serious Health Condition (Form WH-380-F)
    - Certification of Qualifying Exigency for Military Family Leave (Form WH-384)
    - Certification for Serious Injury or Illness of Covered Servicemember for Military Family Leave (Form WH-385)
  - Whether the employer will require certification to return from leave (a template is included in this package)
  - Whether the employer will require the employee to use any accrued paid leave during FMLA leave.
  - How the employer’s method of recouping employee’s premiums is determined. If the employee is on unpaid leave, the employee is permitted to pre-pay or the employer may require periodic payments due on a monthly or per pay period basis. The employer may also permit payment upon return.
- Provide employee with written notification of eligibility and rights and responsibilities under FMLA within five business days of the employee’s request for leave. A model form titled “Notice of Eligibility and Rights and Responsibilities” (Form WH-381) is included in this package.
- If the employer requires certification, the employee has at least 15 calendar days from the request to submit certification.
- Provide employee with written notification of whether leave qualifies under FMLA, and will be designated as such, within five business days of receiving the required information from the employee (including certification). A model form titled “Designation Notice” (Form WH-382) is included in this package.

**Additional Information**

This checklist highlights an employer’s obligations under the FMLA. Some states have additional leave laws and obligations for employers that are not reflected in this checklist. Please contact your advisor for additional information regarding compliance with individual state leave laws.

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Collaborate. Innovate. Elevate:
Fitness to Return To Work Form

If the employee has been absent from work due to a medical-related leave, the employee must obtain written authorization from his or her health care provider that he or she is released to return to work. A list of the essential functions of the employee’s position must be attached to this form.

The following section must be completed by the employee.

Employee Name: ___________________________ Date: ___________________________

Department: ___________________________ Supervisor: ___________________________

The following section must be completed by the employee’s health care provider.

I have reviewed the employee’s job description and have determined that the above referenced patient is released to return to work:

Effective (insert date): __________________________________________

Are there any restrictions in place related to the performance of the patient’s job when he or she returns to work?

________________________________________________________________________

________________________________________________________________________

How long will these limitations apply?

________________________________________________________________________

________________________________________________________________________

Are there any accommodations that could be made that would enable the patient to perform the duties?

________________________________________________________________________

________________________________________________________________________

Will the patient need to continue any form of treatment once he or she returns to work? If so, what is the frequency and duration of the treatment?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Health Care Provider’s Signature ___________________________ Date

Employee’s Signature ___________________________ Date

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.

This form is provided as an example and is for informational purposes only. If utilized, the form should be adapted to reflect the company’s own policies and procedures. Please consult with a legal or tax professional as appropriate.
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 or 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 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.

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 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.

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 one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

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

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. Please be sure to sign the form on the last page.

Provider’s name and business address: ____________________________________________

Type of practice / Medical specialty: ____________________________________________

Telephone: (___________) ____________________________ Fax: (___________) ____________________________

CONTINUED ON NEXT PAGE
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):

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

CONTINUED ON NEXT PAGE  Form WH-380-E Revised January 2009
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.

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

CONTINUED ON NEXT PAGE
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.

Form WH-380-E  Revised January 2009
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: ____________________________

Relationship of family member to you: ____________________________
First          Middle          Last

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 ____________________________

CONTINUED ON NEXT PAGE

Form WH-380-F Revised January 2009
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):

   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________

   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:

   ____________________________________________________________

   ____________________________________________________________

   ____________________________________________________________

   ____________________________________________________________
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 __________

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.

Form WH-380-F Revised January 2009
Notice of Eligibility and Rights & Responsibilities  
(Family and Medical Leave Act)

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, 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:  
Employer Representative  

DATE:  

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 active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves.
___ 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 1,250-hours-worked 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: ____________________________

____________________________________________________

___ 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. (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 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 servicemen’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 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. § 2617; 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.

Form WH-381 Revised January 2009
Designation Notice
(Family and Medical Leave Act)

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 ____________________, unless it is not practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied.

(Provide at least seven calendar days)

(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.

Form WH-382 January 2009
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 leave due to a qualifying exigency to submit a certification. Please complete Section I before giving this form to your employee. Your response is voluntary, and 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. § 825.309.

Employer name: ____________________________________________________________

Contact Information: _______________________________________________________

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II fully and completely. The FMLA permits an employer to require that you submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a qualifying exigency. Several questions in this section seek a response as to the frequency or duration of the qualifying exigency. Be as specific as you can; terms such as “unknown,” or “indeterminate” may not be sufficient to determine FMLA coverage. Your response is required to obtain a benefit. 29 C.F.R. § 825.310. While you are not required to provide this information, failure to do so may result in a denial of your request for FMLA leave. Your employer must give you at least 15 calendar days to return this form to your employer.

Your Name: _______________________________________________________________

First   Middle   Last

Name of covered military member on active duty or call to active duty status in support of a contingency operation:

First   Middle   Last

Relationship of covered military member to you: ____________________________________________________________

Period of covered military member’s active duty: ____________________________________________________________

A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes written documentation confirming a covered military member’s active duty or call to active duty status in support of a contingency operation. Please check one of the following:

☐ A copy of the covered military member’s active duty orders is attached.

☐ Other documentation from the military certifying that the covered military member is on active duty (or has been notified of an impending call to active duty) in support of a contingency operation is attached.

☐ I have previously provided my employer with sufficient written documentation confirming the covered military member’s active duty or call to active duty status in support of a contingency operation.

CONTINUED ON NEXT PAGE
PART A: QUALIFYING REASON FOR LEAVE

1. Describe the reason you are requesting FMLA leave due to a qualifying exigency (including the specific reason you are requesting leave):

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

2. A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes any available written documentation which supports the need for leave; such documentation may include a copy of a meeting announcement for informational briefings sponsored by the military, a document confirming an appointment with a counselor or school official, or a copy of a bill for services for the handling of legal or financial affairs. Available written documentation supporting this request for leave is attached. □ Yes □ No □ None Available

PART B: AMOUNT OF LEAVE NEEDED

1. Approximate date exigency commenced: ____________________________________________

Probable duration of exigency: ______________________________________________________

2. Will you need to be absent from work for a single continuous period of time due to the qualifying exigency? □ No □ Yes.

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

____________________________________________________________________________________

3. Will you need to be absent from work periodically to address this qualifying exigency? □ No □ Yes.

Estimate schedule of leave, including the dates of any scheduled meetings or appointments:

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Estimate the frequency and duration of each appointment, meeting, or leave event, including any travel time (i.e., 1 deployment-related meeting every month lasting 4 hours):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours ___ day(s) per event.

CONTINUED ON NEXT PAGE
PART C:
If leave is requested to meet with a third party (such as to arrange for childcare, to attend counseling, to attend meetings with school or childcare providers, to make financial or legal arrangements, to act as the covered military member’s representative before a federal, state, or local agency for purposes of obtaining, arranging or appealing military service benefits, or to attend any event sponsored by the military or military service organizations), a complete and sufficient certification includes the name, address, and appropriate contact information of the individual or entity with whom you are meeting (i.e., either the telephone or fax number or email address of the individual or entity). This information may be used by your employer to verify that the information contained on this form is accurate.

Name of Individual: ___________________________ Title: ___________________________

Organization: ____________________________________________

Address: ____________________________________________

Telephone: (_____ ) Fax: (_____ )

Email: ____________________________________________

Describe nature of meeting: ____________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

PART D:
I certify that the information I provided above is true and correct.

_________________________________________ Date

Signature of Employee

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 AV, NW, Washington, DC 20210. DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE EMPLOYER.
Notice to the EMPLOYER  INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a serious injury or illness of a covered servicemember to submit a certification providing sufficient facts to support the request for leave. 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. § 825.310. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees or 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.

SECTION I: For Completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the Employee Is Requesting Leave  INSTRUCTIONS to the EMPLOYEE or COVERED SERVICEMEMBER: Please complete Section I before having Section II completed. The FMLA permits an employer to require that an employee submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a serious injury or illness of a covered servicemember. If requested by the employer, your response is required to obtain or retain the benefit of FMLA-protected leave. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to do so may result in a denial of an employee’s FMLA request. 29 C.F.R. § 825.310(f). The employer must give an employee at least 15 calendar days to return this form to the employer.

SECTION II: For Completion by a UNITED STATES DEPARTMENT OF DEFENSE (“DOD”) HEALTH CARE PROVIDER or a HEALTH CARE PROVIDER who is either: (1) a United States Department of Veterans Affairs (“VA”) health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider  INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed on Page 2 has requested leave under the FMLA to care for a family member who is a member of the Regular Armed Forces, the National Guard, or the 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. For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty that may render the servicemember medically unfit to perform the duties of his or her office, grade, rank, or rating.

A complete and sufficient certification to support a request for FMLA leave due to a covered servicemember’s serious injury or illness includes written documentation confirming that the covered servicemember’s injury or illness was incurred in the line of duty on active duty and that the covered servicemember is undergoing treatment for such injury or illness by a health care provider listed above. 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.

CONTINUED ON NEXT PAGE
SECTION I: For Completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the Employee Is Requesting Leave: (This section must be completed first before any of the below sections can be completed by a health care provider.)

Part A: EMPLOYEE INFORMATION

Name and Address of Employer (this is the employer of the employee requesting leave to care for covered servicemember):
____________________________________________________________________________________________

Name of Employee Requesting Leave to Care for Covered Servicemember:
____________________________________________________________________________________________

First                       Middle                       Last
Name of Covered Servicemember (for whom employee is requesting leave to care):
____________________________________________________________________________________________

First                       Middle                       Last
Relationship of Employee to Covered Servicemember Requesting Leave to Care:
□ Spouse □ Parent □ Son □ Daughter □ Next of Kin

Part B: COVERED SERVICEMEMBER INFORMATION

(1) Is the Covered Servicemember a Current Member of the Regular Armed Forces, the National Guard or Reserves?  □ Yes □ No

If yes, please provide the covered servicemember’s military branch, rank and unit currently assigned to:
____________________________________________________________________________________________

Is the covered servicemember assigned to a military medical treatment facility as an outpatient or to a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients (such as a medical hold or warrior transition unit)?  □ Yes □ No  If yes, please provide the name of the medical treatment facility or unit:
____________________________________________________________________________________________

(2) Is the Covered Servicemember on the Temporary Disability Retired List (TDRL)?  □ Yes □ No

Part C: CARE TO BE PROVIDED TO THE COVERED SERVICEMEMBER

Describe the Care to Be Provided to the Covered Servicemember and an Estimate of the Leave Needed to Provide the Care:
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
SECTION II: For Completion by a United States Department of Defense (“DOD”) Health Care Provider or a Health Care Provider who is either: (1) a United States Department of Veterans Affairs (“VA”) health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider. If you are unable to make certain of the military-related determinations contained below in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator). (Please ensure that Section I above has been completed before completing this section.) Please be sure to sign the form on the last page.

Part A: HEALTH CARE PROVIDER INFORMATION
Health Care Provider’s Name and Business Address: ____________________________________________________________

Type of Practice/Medical Specialty: ____________________________________________________________

Please state whether you are either: (1) a DOD health care provider; (2) a VA health care provider; (3) a DOD TRICARE network authorized private health care provider; or (4) a DOD non-network TRICARE authorized private health care provider: ____________________________________________________________

Telephone: ( ) ___________ Fax: ( ) ______________ Email: ___________________________________

PART B: MEDICAL STATUS

(1) Covered Servicemember’s medical condition is classified as (Check One of the Appropriate Boxes):

☐ (VSI) Very Seriously Ill/Injured – Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

☐ (SI) Seriously Ill/Injured – Illness/injury is of such severity that there is cause for immediate concern, but there is no imminent danger to life. Family members are requested at bedside. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

☐ OTHER Ill/Injured – a serious injury or illness that may render the servicemember medically unfit to perform the duties of the member’s office, grade, rank, or rating.

☐ NONE OF THE ABOVE (Note to Employee: If this box is checked, you may still be eligible to take leave to care for a covered family member with a “serious health condition” under § 825.113 of the FMLA. If such leave is requested, you may be required to complete DOL FORM WH-380 or an employer-provided form seeking the same information.)

(2) Was the condition for which the Covered Service member is being treated incurred in line of duty on active duty in the armed forces? ☐ Yes ☐ No

(3) Approximate date condition commenced: ____________________________

(4) Probable duration of condition and/or need for care: ____________________________

(5) Is the covered servicemember undergoing medical treatment, recuperation, or therapy? ☐ Yes ☐ No. If yes, please describe medical treatment, recuperation or therapy:

_________________________________________________________________________________________

CONTINUED ON NEXT PAGE
PART C: COVERED SERVICEMEMBER’S NEED FOR CARE BY FAMILY MEMBER

(1) Will the covered servicemember need care for a single continuous period of time, including any time for treatment and recovery?  □ Yes  □ No
   If yes, estimate the beginning and ending dates for this period of time: ________________________________

(2) Will the covered servicemember require periodic follow-up treatment appointments?  
   □ Yes  □ No  If yes, estimate the treatment schedule: ________________________________

(3) Is there a medical necessity for the covered servicemember to have periodic care for these follow-up treatment appointments?  □ Yes  □ No

(4) Is there a medical necessity for the covered servicemember to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)?  □ Yes  □ No  If yes, please estimate the frequency and duration of the periodic care:
   __________________________________________________________________________
   __________________________________________________________________________

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, in accordance with 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 AV, NW, Washington, DC 20210. DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE PATIENT.