Dear Colleague,

Enclosed you will find information regarding Family Medical Leave. Following is a summary of the enclosed items:

**Family and Medical Leave Rights and Responsibilities** - Information regarding your rights under this law. Please read and keep for your records.

**Family and Medical Leave Act Request** – This form must be filed with the Human Resources Department as soon as possible or a minimum of 30 days before taking leave.

**Certification of Health Care Provider** – This form must be completed by the attending physician. Please do not give this form to your Supervisor. This form must be returned to the Human Resources Department within 15 days of receipt.

**Certification to Return to Work Form** – This form is to be completed by the attending physician at the end of your illness before you return to work.

You may be using Family Medical Leave in conjunction with the Sick Leave Bank. If you need Sick Leave Bank information and it is not attached, please notify our office.

Please feel free to call your contact Tiffany Sackett or your generalist in the Human Resources Department at 296-5827 if you have questions or concerns.

Regards,

*The Benefits Team*
EMPLOYEE RIGHTS AND RESPONSIBILITIES
UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement
FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- for incapacity due to pregnancy, prenatal medical care or child birth;
- to care for the employee’s child after birth, or placement for adoption or foster care;
- to care for the employee’s spouse, son, daughter or parent, who has a serious health condition;
- for a serious health condition that makes the employee unable to perform the employee’s job.

Military Family Leave Entitlements
Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for attending certain counseling sessions, and attending post-deployment reintegrations 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 service member during a single 12-month period. A covered service member is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness.

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

Benefits and Protections
During FMLA leave, the employer must maintain the employee’s health coverage under any “group health plan” on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee’s leave.

Eligibility Requirements
Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

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

Definition of Serious Health Condition
A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee’s job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may mean 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, circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities
Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees’ rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee’s leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers
FMLA makes it unlawful for any employer to:

- interfere with, restrain, or deny the exercise of any right provided under FMLA; and
- discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement
An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulation 29 C.F.R. § 825.303(a) may require additional disclosures.

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

WHD Publication 1420 - Revised February 2013

U.S. Department of Labor | Wage and Hour Division
County of Albemarle  
Human Resources Department  

Leave Request Form  
This form must be filed with the Human Resources Department as soon as possible or a minimum of 30 days before taking leave.

Name:______________________________  
Position:____________________________  
School/Department:__________________  
Supervisor(s): ______________________  
Email Address:_____________________

Primary Phone:______________________  
Alternate Phone:____________________

Current Home Address:______________  
Emergency Contact:_________________

I hereby request consecutive and/or intermittent leave for the following reason:

☐ Personal serious health condition
☐ To care for child after birth, or placement for adoption or foster care (maternity, paternity)
☐ To care for spouse, son or daughter, or parent, who has a serious health condition
☐ For a qualifying exigency arising from a spouse, son or daughter or parent on active duty or called to active duty (Military)
☐ To care for a spouse, son or daughter, or parent service member who has a serious injury or illness incurred on active duty (Military)
☐ Unpaid Leave of Absence

I have notified my Principal/Department Head/Designee of this request which will be effective from / / to / / . I will return to work / / .

MM DD YY  MM DD YY  MM DD YY

Other Notes (including if leave will be intermittent):
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

_______________________________________________  _________________________________
(Employee Signature)  (Date)

HR USE ONLY

The following leave type(s) may apply (multiple types may be used concurrently):

☐ FMLA (Family Medical Leave Act)
☐ Worker’s Compensation
☐ Sick Leave Bank
☐ STD (Short-Term Disability for Hybrid members only)
☐ Maternity Leave (non-FMLA)
☐ ADA Accommodation (Americans with Disabilities Act)
☐ LOA (Unpaid Leave of Absence)
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. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: Albemarle County, Tiffany Sackett HR, Phone: 434-296-5827 Fax: 434-244-7044

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. 29 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. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee’s family members, 29 C.F.R. § 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.**
ALBEMARLE COUNTY FITNESS FOR DUTY
CERTIFICATION TO RETURN TO WORK

Patient’s Name:___________________________________________________________

Date the “serious health condition” of the patient started:_________and ended:_______

Date the EMPLOYEE is approved to return to work:___________________________

IF APPLICABLE

Restrictions or Limitations? _____None _____Schedule _____Activity

Nature of Restrictions or Limitations:

Expected to return to full function: _____YES or _____NO

I have examined the employee and can certify to the best of my knowledge, and within
the limitations, if any listed above, that the patient named here is, or on the approved
return date will be, able to resume working and perform all the essential functions of
his/her job.

______________________________________ ________________________
Physician’s Signature Date

Please return to:
County of Albemarle
Department of Human Resources
401 McIntire Road
Charlottesville, VA 22902
Phone (434) 296-5827
Fax (434) 244-7044