

IX-2 FMLA INSTRUCTIONS AND REQUEST FORM

Request for Medical Leave that may be protected as FMLA or as a request for contractual sick leave

Potential FMLA Leave - The Human Resources Office has been informed that you have a medical need for leave that may be due to a serious health condition of an employee. Accordingly, if you believe that you may be eligible for FMLA leave designation and/or are requesting FMLA leave, Form WH-380-E is located at <http://www.dol.gov/whd/forms/WH-380-E.pdf> . If you would like the college to mail a copy of the form to you, please let us know. In lieu of the WH-380-E form, you may also use the attached abbreviated form entitled “Instructions to Health care Provider”.

To request FMLA leave, Form WH-380-E, or the attached abbreviated form entitled “**Instructions to the Health Care Provider**” (which was agreed to as a substitute by the MCCC and the Employer) should be provided to your Health Care Provider for completion and return. You have fifteen (15) calendar days to return one of the completed forms. Your Health Care Provider will either complete one of the two forms or provide appropriate medical documentation to support any request for FMLA leave. Note there are other forms available on the Federal website for different types of leave such as that for a family member or for leave related to military service: <http://www.dol.gov/whd/fmla/2013rule/militaryForms.htm>

Contractual Medical Leave Requirement – Even if you do not believe your sick leave request would qualify as FMLA protected leave, please have your health care provider complete the attached physician's certificate entitled “**Instructions to the Health Care Provider**”, proving the necessity of such absence for the medical leave you are seeking. As set forth in Article 9.01, the certificate must be filed within seven (7) calendar days of this request, or your absence may be applied at the discretion of the College as absence without pay.

If you need additional time for your health care provider to complete the required information, please contact the Human Resources department to request an extension of time to provide the information.

Please note, the FMLA allows employers to charge your leave concurrently to sick leave under the collective bargaining agreement and to FMLA if you are entitled to the twelve-week unpaid leave allowed for certain employees under FMLA for a “serious health condition.” If FMLA applies, an employee must first use all accrued sick leave and then, if eligible, available sick leave bank days, as part of their twelve-week FMLA leave prior to being placed on unpaid FMLA leave for the remainder of their 12 week FMLA leave period, if any.

INSTRUCTIONS to the HEALTH CARE PROVIDER:

Your patient _____ has requested leave from _____ Community College. 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(s) for which the employee is seeking leave. Please be sure to sign the form.

Provider's name: _____

Type of Practice/Medical Specialty: _____

Provider's signature: _____

Address: _____

Telephone: _____

Fax: _____

Approximated date condition commenced and probable duration: _____

Overnight Admission? No ___ Yes, ___ If yes dates _____

Dates of treatment _____

Will patient need treatment at least twice per year? _____

Referral to other healthcare provider for evaluation or treatment? No ___ Yes ___

If yes, nature of treatments and expected duration: _____

Is the patient incapacitated and unable to perform the essential job functions of _____ position (see attached job description and/or contractual workload requirements) due to the condition: No ___ Yes ___ If yes identify job functions unable to perform: _____

Is medical condition pregnancy? No ___ Yes ___ expected delivery date: _____

Describe other relevant medical facts related to the condition for which the patient is incapacitated and seeks medical leave (diagnosis, symptoms, or any regimen of continuing treatment such as the use of specialized equipment): _____

Amount of Leave needed:

Incapacitated for single continuous period? No ___ Yes ___ Estimate beginning and ending dates _____

Follow-up treatment appointments medically necessary or part-time or reduced schedule needed for leave? No ___ Yes ___ If yes, estimate treatment schedule including dates, length and recovery period for appointments and if leave request is for part-time or reduced schedule specify beginning and ending date and specific limitations on hours and/or days: _____

If request is for intermittent leave specify length and duration of anticipated leave:

Will condition cause episodic flare ups preventing employee from performing job functions? No ___ Yes ___ If yes, is it medically necessary for employee to be absent from work? No ___ Yes? ___ If yes, explain and estimate frequency and duration over next 6 months : ___ episodes every ___ week(s) ___ month(s) lasting ___ hours or days per episode. _____

Date patient is reasonably anticipated to be able to return to the position able to perform the essential functions of his/her position with ___ or without ___ reasonable accommodation(s): _____ If reasonable accommodation(s) are requested, list requested accommodation(s) in order for College to dialogue with employee. For your convenience, requested accommodations may be listed on the attached Fitness-For-Duty Certification necessary to be completed prior to returning to work.