County of Galveston

Department of Human Resources

FMLA

Employee Guide & Forms

Table of Contents

Subject ..... ***Section***

Employee Eligibility 1
Leave Entitlement 2
Leave Types 3
Eligible Reasons for Leave 4
Application and Certifications 5
- WH-380-E ..... Employee's Serious Health Condition
- WH-380-F ..... Family Member's Serious Health Condition
- WH-384 ..... Qualifying Exigency for Military Family Leave
- WH-385 ..... Serious Injury or Illness of Covered Service
- WH-385-V ..... Serious Injury or Illness of a Veteran

Short-Term Disability 6
Sick Leave Pool 7
Maintaining Health Benefits 8
Fitness-for-Duty Certificate 9
Unlawful Acts and Complaints 10
FMLA Poster and Notice & Process Flowchart ..... End

1

Employee Eligibility

This section will help you determine whether you will qualify for FMLA

Although FMLA is available and the County of Galveston is subject to the provisions of the act, you may or may not be eligible for coverage and protection. There are several factors that must first be satisfied before you can be considered for coverage under FMLA.

To be eligible for FMLA benefits, an employee must:

1. Work for a covered employer;
2. Have worked for the employer for a total of 12 months (this 12 months can be nonconsecutive and accumulated over a period of the past 7 years);
3. Have worked at least 1,250 hours in the immediately preceding 12 months;
4. Work at a location in the US where at least 50 employees are employed by the employer within 75 miles.

If you satisfy ALL 4 of these requirements, you are considered eligible for FMLA. However, this does not mean that your leave request or absence from work will qualify to be designated as FMLA.

Important Note

FMLA is not a civil rights law. It is a federal leave law.

Family and Medical Leave Act of 1993. Public Law 103-3

29 USC §2601 et seq.; 29 CFR Part 825

2

Leave Entitlement

This section will explain how much time the act will provide to you

FMLA should be considered a limited resource. It is not available to you on a continual basis and it does not offer you lifetime protection. It does however, offer you a set amount of time each year should you need to handle those difficult times in life.

Amount of Entitlement:

- 12 work weeks during any 12 month period for family, medical or military exigency leave. Up to 26 weeks for military caregiver leave.

- The typical county employee works 8 hours a day, 5 days a week. This calculates to 40 hours a week. Therefore your leave breaks down to 480 working hours. This may be taken in one block of time or over several periods.

"Rolling" 12 month period:

- Galveston County calculates your 12 month period using the "rolling" 12-month period measured backward from the date an employee's FMLA leave request is scheduled to begin.

- Examples:

  Joe has taken 8 weeks of leave in the past 12 months. He can take an additional 4 weeks of leave.

  Maria used 4 weeks beginning February 1, 4 weeks beginning May 1, and 4 weeks beginning July 1. She is not entitled to any additional leave until February 1. Beginning next February 1, Maria is entitled to 4 weeks of leave. Next May 1 she is entitled to an additional 4 weeks, etc.

3

Leave Types

This section will explain the different types of leave available to you

FMLA allows for different types of leave depending on your situation and medical needs or that of a covered family member. Each leave request is different and unique and may require different amounts of time away from work.

Full / Block Leave:

FMLA leave taken in a one, continuous block of time due to a single qualifying reason.

Examples:

Joe was recently hospitalized for 1 week with pneumonia and will require an additional week at home for recovery.

Maria has a surgery scheduled next month to correct a serious back issue and will require 2 full moths of recovery.

Intermittent and Reduced Schedule Leave:

FMLA leave taken in separate blocks of time or on a reduced work schedule due to a single qualifying reason.

Example:

Caroline is a cancer survivor and has been in remittance for several years. Recently she discovered that her cancer has returned and will need several rounds of chemotherapy. Her treatments are every Monday and Thursday afternoon beginning at 2:00pm. The time that Caroline is out every Monday and Thursday afternoon is protected under FMLA as well as any time the Caroline's condition renders her unable to perform the essential functions of her job.

4

Eligible Reasons for Leave

This section will explain the eligible reasons that fall under FMLA

Not all reasons are eligible for FMLA. The act allows for a specific core of reasons that fall under the protections and provisions of FMLA. Generally, the common seasonal cold will not qualify for FMLA designation.

Eligible Reasons:

The birth of a child and to care for the newborn child within one year of birth;

The placement with the employee of a child for adoption or foster care and to care for the newly placed child within one year of placement;

To care for the employee's spouse, child, or parent who has a serious health condition;

A serious health condition that makes the employee unable to perform the essential functions of his or her job;

Any qualifying exigency arising out of the fact that the employee's spouse, son, daughter, or parent is a covered military member on "covered active duty."

Analysis of Terms:

"To care for"	Includes either physical or psychological care.
"Spouse"	Legally married spouse. Verification in the form of a valid marriage license may be requested.
"Child"	Means a biological, adopted, or foster child, a stepchild, a legal ward who is either under 18 years of age or, 18 years of age or older and incapable of self-care because of a mental or physical disability.
"Parent"	Parent of employee only. In-laws do not qualify for FMLA.

5

Application & Certification

This section will explain how to apply and submit the proper documentation for your leave

You have determined that you are eligible and your leave falls under one of the eligible reasons for leave. Now, you need to complete all of the proper paperwork and submit everything to human resources for review and designation.

Step 1 - Application:

Complete and submit the one page application to human resources. County policy requires at least 30 days advance notice when possible and practical.

Step 2 - Certification:

This is perhaps the most important step in the entire FMLA process. Galveston County uniformly requires that all FMLA leave requests be medically certified and all certifications must be submitted directly to human resources within 15 *calendar* days. Certifications that are incomplete and vague will result in a delay of your leave approval.

WH-380-E	Certification of Health Care Provider for ***Employee's Serious Health Condition***
WH-380-F	Certification of Health Care Provider for ***Family Member's Serious Health Condition***
WH-384	Certification of Qualifying Exigency for Military Family Leave
WH-385	Certification for Serious Injury or Illness of Covered Service member for Military Family Leave
WH-385-V	Certification for Serious Injury or Illness of a Veteran for Military Caregiver Leave

Important Note

Never just leave work and assume everything is okay! Communication is key. Always coordinate your leave with both your department and human resources. If human resources is unaware of your leave and status, there is no way for us to help you.

FAMILY AND MEDICAL LEAVE ACT
Application

Section I – Employee Information
Please print clearly and answer all

_____ _____
Last Name First Name MI Employee ID

_____ _____
Mailing Address City State Zip Preferred Contact Phone Number

_____
Email Address

Section II – Type of Leave Requested
Please check one and provide estimated dates

☐ Full / Block Leave Expected leave to begin: _____ Expected date of return: _____

☐ Intermittent Leave Expected leave to begin: _____ Expected date of return: _____

Section III – Leave Details
Appropriate certification must be provided to HR

☐ The birth of a child or placement of a child with you for adoption or foster care.
Employee must contact HR to enroll the child in the medical plan within 31 days of occurrence.

☐ 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 United States Armed Forces.

☐ Because you are the ____ spouse; _____son or daughter; _____ parent; _____ next of kin of a covered service member with a serious injury or illness.

Section IV – Short-Term Disability & Sick Leave Pool
Please answer all

Is employee enrolled in voluntary short-term disability coverage?	☐ Yes	☐ No	☐ Unknown
Is this leave the result of a work related injury?	☐ Yes	☐ No	☐ Unknown
Request for donation from sick leave pool?	☐ Yes	☐ No	☐ Unknown
Does employee have 10 days leave at onset of condition?	☐ Yes	☐ No	☐ Unknown
Contributed a minimum of 24 hours to the sick leave pool?	☐ Yes	☐ No	☐ Unknown

Section V – Signatures
Return completed application to Human Resources

_____ _____
Employee Date

_____ _____
Human Resources Date

Signatures are for verification and acknowledgement purposes only. They do not guarantee leave approval.
This page may be sent to your department for informational purposes only to verify dates for payroll reporting.

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

U.S. Department of Labor Wage and Hour Division

WAGE AND HOUR DIVISION

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

OMB Control Number: 1235-0003
Expires: 6/30/2023

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. 29 U.S.C. §§ 2613, 2614(c)(3); 29 C.F.R. § 825.305. The employer must give the employee **at least 15 calendar days** to provide the certification. If the employee fails to provide complete and sufficient medical certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

SECTION I – EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, this form asks the health care provider for the information necessary for a complete and sufficient medical certification, which is set out at 29 C.F.R. § 825.306. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308.** Additionally, you **may not** request a certification for FMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care.

Employers must generally maintain records and documents relating to medical information, 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.

(1) Employee name: _____
First *Middle* *Last*

(2) Employer name: _____ Date: _____ *(mm/dd/yyyy)*
(List date certification requested)

(3) The medical certification must be returned by _____ *(mm/dd/yyyy)*
(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee's diligent, good faith efforts.)

(4) Employee's job title: _____ Job description (☐ is / ☐ is not) attached.
Employee's regular work schedule: _____
Statement of the employee's essential job functions: _____
_____
(*The essential functions of the employee's position are determined with reference to the position the employee held at the time the employee notified the employer of the need for leave or the leave started, whichever is earlier.)*

SECTION II - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form. Your patient has requested leave under the FMLA. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of the employee. For FMLA purposes, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves *inpatient care* or *continuing treatment by a health care provider*. For more information about the definitions of a serious health condition under the FMLA, see the chart on page 4.

You may, but are **not required** to, provide other appropriate medical facts including symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment. Please note that some state or local laws may not allow disclosure of private medical information about the patient's serious health condition, such as providing the diagnosis and/or course of treatment.

This form can be faxed to Galveston County Human Resources at 409-770-5351

Employee Name: _____

Health Care Provider's name: *(Print)* _____

Health Care Provider's business address: _____

Type of practice / Medical specialty: _____

Telephone: (___) _____ Fax: (___) _____ E-mail: _____

PART A: Medical Information

Limit your response to the medical condition(s) for which the employee is seeking FMLA leave. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. **After completing Part A, complete Part B to provide information about the amount of leave needed.** Note: For FMLA purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. 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).

(1) State the approximate date the condition started or will start: _____ *(mm/dd/yyyy)*

(2) Provide your **best estimate** of how long the condition lasted or will last: _____

(3) Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

☐ **Inpatient Care**: The patient (☐ has been / ☐ is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): _____

☐ **Incapacity plus Treatment**: *(e.g. outpatient surgery, strep throat)*
Due to the condition, the patient (☐ has been / ☐ is expected to be) incapacitated for *more than* three consecutive, full calendar days from _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*.

The patient (☐ was / ☐ will be) seen on the following date(s): _____
_____

The condition (☐ has / ☐ has not) also resulted in a course of continuing treatment under the supervision of a health care provider *(e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment)*

☐ **Pregnancy**: The condition is pregnancy. List the expected delivery date: _____ *(mm/dd/yyyy)*.

☐ **Chronic Conditions**: *(e.g. asthma, migraine headaches)* Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

☐ **Permanent or Long Term Conditions**: *(e.g. Alzheimer's, terminal stages of cancer)* Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

☐ **Conditions requiring Multiple Treatments**: (*e.g. chemotherapy treatments, restorative surgery)* Due to the condition, it is medically necessary for the patient to receive multiple treatments.

☐ **None of the above**: If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed. Go to page 4 to sign and date the form.

Employee Name: _____

(4) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. *(e.g., use of nebulizer, dialysis*) _____

_____

PART B: Amount of Leave Needed

For the medical condition(s) checked in Part A, complete all that apply. 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.

(5) Due to the condition, the patient (☐ had / ☐ will have) **planned medical treatment(s)** (scheduled medical visits) *(e.g. psychotherapy, prenatal appointments)* on the following date(s): _____

_____

(6) Due to the condition, the patient (☐ was / ☐ will be) **referred to other health care provider(s)** for evaluation or treatment(s).

State the nature of such treatments: *(e.g. cardiologist, physical therapy)* _____

Provide your **best estimate** of the beginning date _____ *(mm/dd/yyyy)* and end date _____ *(mm/dd/yyyy)* for the treatment(s).

Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery *(e.g. 3 days/week)*

_____

(7) Due to the condition, it is medically necessary for the employee to work a **reduced schedule**.

Provide your **best estimate** of the reduced schedule the employee is able to work. From _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)* the employee is able to work: *(e.g., 5 hours/day, up to 25 hours a week)*

_____

(8) Due to the condition, the patient (☐ was / ☐ will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.

Provide your **best estimate** of the beginning date _____ *(mm/dd/yyyy)* and end date _____ *(mm/dd/yyyy)* for the period of incapacity.

(9) Due to the condition, it (☐ was / ☐ is / ☐ will be) medically necessary for the employee to be absent from work on an **intermittent basis** (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, episodes of incapacity are estimated to occur _____ times per (☐ day / ☐ week / ☐ month) and are likely to last approximately _____ (☐ hours / ☐ days) per episode.

Employee Name: _____

PART C: Essential Job Functions

If provided, the information in Section I question #4 may be used to answer this question. If the employer fails to provide a statement of the employee's essential functions or a job description, answer these questions based upon the employee's own description of the essential job functions. An employee who must be absent from work to receive medical treatment(s), such as scheduled medical visits, for a serious health condition is considered to be *not able* to perform the essential job functions of the position during the absence for treatment(s).

(10) Due to the condition, the employee (☐ was not able / ☐ is not able / ☐ will not be able) to perform *one or more* of the essential job function(s). Identify at least one essential job function the employee is not able to perform:

_____

_____

Signature of Health Care Provider _____ **Date** _____ *(mm/dd/yyyy)*

Definitions of a Serious Health Condition *(See 29 C.F.R. §§ 825.113-.115)*
Inpatient Care
• An overnight stay in a hospital, hospice, or residential medical care facility. • Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.
Continuing Treatment by a Health Care Provider (any one or more of the following)
Incapacity Plus Treatment: A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either: o Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or, o At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.
Pregnancy: Any period of incapacity due to pregnancy or for prenatal care.
Chronic Conditions: Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.
Permanent or Long-term Conditions: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.
Conditions Requiring Multiple Treatments: Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.

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

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

U.S. Department of Labor
Wage Hour Division

WAGE AND HOUR DIVISION

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

OMB Control Number: 1235-0003
Expires: 6/30/2023

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave to care for a family member with a serious health condition to submit a medical certification issued by the family member's health care provider. 29 U.S.C. §§ 2613, 2614(c)(3); 29 C.F.R. § 825.305. The employer must give the employee **at least 15 calendar days** to provide the certification. If the employee fails to provide complete and sufficient medical certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

SECTION I - EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, this form asks the health care provider for the information necessary for a complete and sufficient medical certification, which is set out at 29 C.F.R. § 825.306. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308**. Additionally, you **may not** request a certification for FMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care.

Employers must generally maintain records and documents relating to medical information, 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, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

(1) Employee name: _____
First *Middle* *Last*

(2) Employer name: _____ Date: _____ *(mm/dd/yyyy)*
(List date certification requested)

(3) The medical certification must be returned by _____ *(mm/dd/yyyy)*
(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee's diligent, good faith efforts.)

SECTION II - EMPLOYEE

Please complete and sign Section II before providing this form to your family member or your family member's health care provider. The FMLA allows an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of your family member. If requested by your employer, your response is required to obtain or retain the benefit of the FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). **You are responsible for making sure the medical certification is provided to your employer within the time frame requested, which must be at least 15 calendar days.** 29 C.F.R. §§ 825.305-825.306. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA leave request. 29 C.F.R. § 825.313.

(1) Name of the family member for whom you will provide care: _____

(2) Select the relationship of the family member to you. The family member is your:

☐ Spouse ☐ Parent ☐ Child, under age 18
☐ Child, age 18 or older and incapable of self-care because of a mental or physical disability

Spouse means a husband or wife as defined or recognized in the state where the individual was married, including in a common law marriage or same-sex marriage. The terms "child" and "parent" include *in loco parentis* relationships in which a person assumes the obligations of a parent to a child. An employee may take FMLA leave to care for an individual who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave to care for a child for whom the employee has assumed the obligations of a parent. No legal or biological relationship is necessary.

This form can be faxed to Galveston County Human Resources at 409-770-5351

Employee Name: _____

(3) Briefly describe the care you will provide to your family member: (*Check all that apply)*

☐ Assistance with basic medical, hygienic, nutritional, or safety needs ☐ Transportation

☐ Physical Care ☐ Psychological Comfort ☐ Other: _____

(4) Give your **best estimate** of the amount of leave needed to provide the care described: _____

_____

(5) If a **reduced work schedule** is necessary to provide the care described, give your **best estimate** of the reduced schedule you are able to work. From _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy),* I am able to work _____ (*hours per day*) _____ (*days per week).*

Employee Signature _____ **Date** _____ *(mm/dd/yyyy)*

SECTION III - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form below. A family member of your patient has requested leave under the FMLA to care for your patient. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a family member with a serious health condition. For FMLA purposes, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that *involves inpatient care* or *continuing treatment by a health care provider*. For more information about the definitions of a serious health condition under the FMLA, see the chart at the end of the form.

You also may, but are **not required** to, provide other appropriate medical facts including symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment. Please note that some state or local laws may not allow disclosure of private medical information about the patient's serious health condition, such as providing the diagnosis and/or course of treatment.

Health Care Provider's name: *(Print)* _____

Health Care Provider's business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____) _____ Fax: (____) _____ E-mail: _____

PART A: Medical Information

Limit your response to the medical condition for which the employee is seeking FMLA leave. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. **After completing Part A, complete Part B to provide information about the amount of leave needed.** Note: For FMLA purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. 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).

(1) Patient's Name: _____

(2) State the approximate date the condition started or will start: _____ *(mm/dd/yyyy)*

(3) Provide your **best estimate** of how long the condition lasted or will last: _____

(4) For FMLA to apply, care of the patient must be medically necessary. Briefly describe the type of care needed by the patient (*e.g., assistance with basic medical, hygienic, nutritional, safety, transportation needs, physical care, or psychological comfort).*

_____

_____

Employee Name: _____

(5) Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

☐ **Inpatient Care**: The patient (☐ has been / ☐ is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): _____

☐ **Incapacity plus Treatment**: *(e.g. outpatient surgery, strep throat)*
Due to the condition, the patient (☐ has been / ☐ is expected to be) incapacitated for *more than* three consecutive, full calendar days from _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*.

The patient (☐ was / ☐ will be) seen on the following date(s): _____

_____

The condition (☐ has / ☐ has not) also resulted in a course of continuing treatment under the supervision of a health care provider *(e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment)*

☐ **Pregnancy**: The condition is pregnancy. List the expected delivery date: _____ *(mm/dd/yyyy)*.

☐ **Chronic Conditions**: *(e.g. asthma, migraine headaches)* Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

☐ **Permanent or Long Term Conditions**: *(e.g. Alzheimer's, terminal stages of cancer)* Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

☐ **Conditions requiring Multiple Treatments**: (*e.g. chemotherapy treatments, restorative surgery)* Due to the condition, it is medically necessary for the patient to receive multiple treatments.

☐ **None of the above**: If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed. Go to page 4 to sign and date the form.

(6) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. *(e.g., use of nebulizer, dialysis)* _____

_____

PART B: Amount of Leave Needed

For the medical condition(s) checked in Part A, complete all that apply. 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 if the benefits and protections of the FMLA apply.

(7) Due to the condition, the patient (☐ had / ☐ will have) **planned medical treatment(s)** (scheduled medical visits) *(e.g. psychotherapy, prenatal appointments)* on the following date(s): _____

_____

(8) Due to the condition, the patient (☐ was / ☐ will be) **referred to other health care provider(s)** for evaluation or treatment(s).

State the nature of such treatments: *(e.g. cardiologist, physical therapy)* _____

Provide your **best estimate** of the beginning date _____ *(mm/dd/yyyy)* and end date _____ *(mm/dd/yyyy)* for the treatment(s).

Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery

_____ *(e.g. 3 days/week)*

Employee Name: _____

(9) Due to the condition, the patient (☐ was / ☐ will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.

Provide your **best estimate** of the beginning date: _____ *(mm/dd/yyyy)* and end date _____ *(mm/dd/yyyy)* for the period of incapacity.

(10) Due to the condition it, (☐ was / ☐ is / ☐ will be) medically necessary for the employee to be absent from work to provide care for the patient on an **intermittent basis** (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, episodes of incapacity are estimated to occur _____ times per (☐ day / ☐ week / ☐ month) and are likely to last approximately _____ (☐ hours / ☒ days) per episode.

Signature of
Health Care Provider _____ **Date** _____ *(mm/dd/yyyy)*

Definitions of a Serious Health Condition *(See 29 C.F.R. §§ 825.113-.115)*
Inpatient Care
• An overnight stay in a hospital, hospice, or residential medical care facility. • Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.
Continuing Treatment by a Health Care Provider (any one or more of the following)
Incapacity Plus Treatment: A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either: o Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or, o At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.
Pregnancy: Any period of incapacity due to pregnancy or for prenatal care.
Chronic Conditions: Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.
Permanent or Long-term Conditions: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.
Conditions Requiring Multiple Treatments: Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.

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 15 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 Avenue, N.W., Washington, D.C. 20210.

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

6

Short-Term Disability

This section will explain your optional Short-Term Disability coverage

While you are out on FMLA, county policy requires you to use all of your personal, paid leave. This includes sick, vacation and compensatory time. Your FMLA leave entitlement runs concurrently with your personal leave. FMLA is not a tool only to be used once you run out of paid leave.

What happens when you run out of paid leave?

Galveston County offers voluntary short-term disability coverage through Lincoln financial to help you supplement your income if any part of your leave is un-paid. Listed below are some features of the plan:

- Pays you **60%** of your weekly salary up to $1,750 per week **after** you exhaust all available paid leave (vacation, sick and comp). You will not be able to draw from short-term coverage while still receiving pay from the county.
- 8, 15 & 31 day waiting period available depending on your needs. You elect the waiting period you want when you enroll in the coverage.
- Maximum benefit duration of 26 weeks.
- Once you satisfy the 180 day elimination period for long-term disability (LTD), your short-term disability (STD) will automatically rollover to LTD without a separate claim process.

If you are unsure if you are enrolled in this coverage please contact Human Resources to verify. To submit your short-term disability (STD) claim over the phone please call 866-783-2255. Galveston County does not approve or deny short-term disability claims.

Important Note

FMLA is not paid leave protection. FMLA only provides for up to 12 weeks of unpaid, job-protected leave. Do not assume that you will be paid for your entire leave.

Lincoln Financial Group®

Convenient, quick, easy

A simple way to file your short-term disability claim with One Call Claims

Less time, less paperwork

With One Call Claims, it's easy to submit your short-term disability (STD) claim over the phone in a matter of minutes.

Call 866-STD-CALL (866-783-2255)

Submit an STD claim over the phone if:

- You've been absent from work because of a non-work-related illness or injury, and will not be returning within the elimination period (the period of time before your benefits kick in) outlined in your company's policy.
- You're within one week of a planned surgery or childbirth.

What information do I need to provide?

- Name and date of birth
- Address and phone number
- Social Security Number
- Employer Galveston County (GALVESTNTX Group ID)
- Group policy number 000010148836
- Doctor's name, address, phone and fax numbers
- Your occupation and the last day you worked
- Your condition or diagnosis
- Direct deposit information

A claims examiner will process your claim and, if necessary, contact your employer and physician.

If more information is needed from you, your employer or physician, the claims examiner will inform you of the necessary steps to complete the claim process.

When can I call?

Lincoln Financial Group® claims examiners are available at 866-STD-CALL (866-783-2255):

Or fax us anytime at 877-843-3950.

In some cases, a claim decision will be made the same day.

Insurance products issued by:
The Lincoln National Life Insurance Company
Lincoln Life & Annuity Company of New York

What to expect

During the call, your claims examiner will explain the process and how they will work with your physician to gather the necessary information.

In most cases, your physician will need to complete an STD Attending Physician's Statement. There are three ways for your physician to receive this form:

1. You can supply your doctor's fax number during your call, and we will fax the form directly to their office.

2. Your claims examiner can send you the form for you to give to your doctor.

3. You can print the form at Lincoln4Benefits.com.

Once we receive all your information, we will make a claim decision. If we approve your claim, your benefits will be paid as outlined in your company's policy.

You can also access forms and personal benefit information online

1. Go to **LincolnFinancial.com** and click the **REGISTER** link in the **LOG IN / REGISTER** dropdown in the top navigation panel.
2. Select **Employee Benefits** and follow the instructions.
3. Once you register, you can review coverage, claim status and policy information. You can also print forms and report claim information such as child delivery or a return-to-work date.

LincolnFinancial.com

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates.

Affiliates are separately responsible for their own financial and contractual obligations.

LCN-1863394-080317
PDF 12/17 **Z04**
Order code: STD-CLM-FLI001

Lincoln Financial Group®

7

Sick Leave Pool

This section will explain the use and policies of the Sick Leave Pool

While you are out on FMLA, county policy requires you to use all of your personal, paid leave. This includes sick, vacation and compensatory time. Your FMLA leave entitlement runs concurrently with your personal leave. FMLA is not a tool only to be used once you run out of paid leave.

What happens when you run out of paid leave?

Galveston County has established a Sick Leave Pool program for those that need it. However, you must first meet several eligibility requirements. They are as follows:

- Employee or their immediate family member prevented from performing the duties of their position for a minimum period of three (3) weeks
- You must be a full time or half time employee (not an hourly position)
- You must have twelve (12) or more months of continuous employment with the County as of the date of the onset of your injury or illness
- You must have ten (10) or more days of vacation and/or sick leave as of the date of the onset of your injury or illness
- You must have contributed a minimum of three (3) sick days to the pool with the exception of first year eligible employee, who must have contributed at least one (1) day of sick leave to the pool

If you are eligible for an award from the sick leave pool you must first utilize all of your own paid, personal leave (sick, vacation and comp.) before hours will be awarded from the SLP. Once your hours have been depleted, the sick leave pool administrator will review your leave and make the appropriate award.

Important Note

FMLA is not paid leave protection. FMLA only provides for up to 12 weeks of unpaid, job-protected leave. Do not assume that you will be paid for your entire leave.

8

Maintaining Health Benefits

This section will review the benefits protection portion of FMLA

While you are out on FMLA, Galveston County will continue to maintain your health benefits as mandated by the law. Your health coverage will be maintained on the same conditions as coverage would have been provided if you had been continuously employed during your entire leave period.

Employee Responsibilities:

Should any period of your leave be un-paid and you do not qualify for an award from the sick leave pool, you will still be responsible for paying your portion of any insurance premiums. In the event that you owe premiums, you will receive an invoice from the county auditor's office for any and all benefit products with amounts and instructions for submission of payment. Failure to pay could lead to the eventual termination of coverage if the matter is not resolved.

Employer Responsibilities:

Galveston County will continue to pay their portion of the medical premium during your leave and maintain all benefits as if you were actively working during your leave entitlement.

9

Fitness-for-Duty Certificate

This section will explain what you need to do in order to return to work

If the reason that you are away from work is due to your own, personal medical reasons, you will be required to submit a fitness-for-duty certificate to human resources **prior** to your return to work.

Requirements:

For your convenience, human resources as developed a standardized form for you and your doctor to use. However, any note from your doctor will satisfy this requirement. During your initial leave approval, human resources will mail you a copy of your official job description. This job description will list the physical duties of your job. Please take this to your doctor for review. The doctor will release you to work with or without restrictions based on your job description.

Restrictions:

If your doctor has released you to return to work with restrictions, those restriction must be clearly listed as well as the anticipated time frame.

Important Note

Failure to submit proper a doctor's release to human resources could lead to the delay in your restoration of employment.

FAMILY AND MEDICAL LEAVE ACT
Fitness-for-Duty Certificate

PART I – To be completed by employee

Name of employee (please print clearly): _____

Date leave commenced: _____

Employee's signature: _____

Date: _____

PART II – To be completed by health care provider

Date examined: _____

Effective *(date)* _____ the above named employee is:
_____ Released to return to work without restrictions *(see attached job description)*; or
_____ Released to work with restrictions. Please describe restrictions below:

_____

Health Care Provider's Signature: _____

Health Care Provider's Name (please print): _____

Date: _____

Phone Number: _____

Genetic Information Nondiscrimination Act of 2008

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. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

PART III – County of Galveston, Department of Human Resources

Date received: _____

Signature: _____

10

Unlawful Acts & Complaints

This section explain how to recognize unlawful retaliation for your use of FMLA

FMLA and your use of your leave entitlement is your right and is guaranteed to you by federal law. No one can force you to waive your rights to the protections and benefits of FMLA.

No one can:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA; or

- 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

If you feel that you are being unfairly singled out, harassed or treated different in any way for your use and exercise of your rights under FMLA, please immediately contact human resources to report any violations, either real or perceived, to attempt to resolve any conflict.

Enforcement:

U.S. Department of Labor, Wage and Hour Division

1-866-4US-WAGE (1-866-487-9243)

www.dol.gov/whd

Important Note

You cannot waive your own FMLA rights nor can your employer request that you waive your rights.

Your Employee Rights Under the Family and Medical Leave Act

What is FMLA leave?

The Family and Medical Leave Act (FMLA) is a federal law that provides eligible employees with **job-protected leave** for qualifying family and medical reasons. The U.S. Department of Labor's Wage and Hour Division (WHD) enforces the FMLA for most employees.

Eligible employees can take **up to 12 workweeks** of FMLA leave in a 12-month period for:

- The birth, adoption or foster placement of a child with you,
- Your serious mental or physical health condition that makes you unable to work,
- To care for your spouse, child or parent with a serious mental or physical health condition, and
- Certain qualifying reasons related to the foreign deployment of your spouse, child or parent who is a military servicemember.

An eligible employee who is the spouse, child, parent or next of kin of a covered servicemember with a serious injury or illness **may take up to 26 workweeks** of FMLA leave in a single 12-month period to care for the servicemember.

You have the right to use FMLA leave in **one block of time**. When it is medically necessary or otherwise permitted, you may take FMLA leave **intermittently in separate blocks of time, or on a reduced schedule** by working less hours each day or week. Read Fact Sheet #28M(c) for more information.

FMLA leave is **not paid leave**, but you may choose, or be required by your employer, to use any employer-provided paid leave if your employer's paid leave policy covers the reason for which you need FMLA leave.

Am I eligible to take FMLA leave?

You are an **eligible employee** if **all** of the following apply:

- You work for a covered employer,
- You have worked for your employer at least 12 months,
- You have at least 1,250 hours of service for your employer during the 12 months before your leave, and
- Your employer has at least 50 employees within 75 miles of your work location.

Airline flight crew employees have different "hours of service" requirements.

You work for a **covered employer** if **one** of the following applies:

- You work for a private employer that had at least 50 employees during at least 20 workweeks in the current or previous calendar year,
- You work for an elementary or public or private secondary school, or
- You work for a public agency, such as a local, state or federal government agency. Most federal employees are covered by Title II of the FMLA, administered by the Office of Personnel Management.

How do I request FMLA leave?

Generally, **to request FMLA leave you must**:

- Follow your employer's normal policies for requesting leave,
- Give notice at least 30 days before your need for FMLA leave, or
- If advance notice is not possible, give notice as soon as possible.

You **do not have to share a medical diagnosis** but must provide enough information to your employer so they can determine whether the leave qualifies for FMLA protection. You **must also inform your employer if FMLA leave was previously taken** or approved for the same reason when requesting additional leave.

Your **employer may request certification** from a health care provider to verify medical leave and may request certification of a qualifying exigency.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

State employees may be subject to certain limitations in pursuit of direct lawsuits regarding leave for their own serious health conditions. Most federal and certain congressional employees are also covered by the law but are subject to the jurisdiction of the U.S. Office of Personnel Management or Congress.

What does my employer need to do?

If you are eligible for FMLA leave, your **employer must**:

- Allow you to take job-protected time off work for a qualifying reason,
- Continue your group health plan coverage while you are on leave on the same basis as if you had not taken leave, and
- Allow you to return to the same job, or a virtually identical job with the same pay, benefits and other working conditions, including shift and location, at the end of your leave.

Your **employer cannot interfere with your FMLA rights** or threaten or punish you for exercising your rights under the law. For example, your employer cannot retaliate against you for requesting FMLA leave or cooperating with a WHD investigation.

After becoming aware that your need for leave is for a reason that may qualify under the FMLA, your **employer must confirm whether you are eligible** or not eligible for FMLA leave. If your employer determines that you are eligible, your **employer must notify you in writing**:

- About your FMLA rights and responsibilities, and
- How much of your requested leave, if any, will be FMLA-protected leave.

Where can I find more information?

Call **1-866-487-9243** or visit **dol.gov/fmla** to learn more.

If you believe your rights under the FMLA have been violated, you may file a complaint with WHD or file a private lawsuit against your employer in court. **Scan the QR code to learn about our WHD complaint process**.

WAGE AND HOUR DIVISION
UNITED STATES DEPARTMENT OF LABOR

SCAN ME

PREGNANT WORKERS FAIRNESS ACT (PWFA)

WHAT IS PWFA?

The Pregnant Workers Fairness Act (PWFA) is a federal law that, starting June 27, 2023, requires covered employers to provide “reasonable accommodations” to a qualified worker’s known limitations related to pregnancy, childbirth, or related medical conditions, unless the accommodation will cause the employer an “undue hardship.” An undue hardship is defined as causing significant difficulty or expense.

"Reasonable accommodations” are changes to the work environment or the way things are usually done at work.

WHAT ARE SOME POSSIBLE ACCOMMODATIONS FOR PREGNANT WORKERS?

- Being able to sit or drink water
- Receiving closer parking
- Having flexible hours
- Receiving appropriately sized uniforms and safety apparel
- Receiving additional break time to use the bathroom, eat, and rest
- Taking leave or time off to recover from childbirth
- Being excused from strenuous activities and/or exposure to chemicals not safe for pregnancy

WHAT OTHER FEDERAL EMPLOYMENT LAWS MAY APPLY TO PREGNANT WORKERS?

Other laws that apply to workers affected by pregnancy, childbirth, or related medical conditions, include:

- Title VII which prohibits employment discrimination based on sex, pregnancy, or other protected categories (enforced by the U.S. Equal Employment Opportunity Commission (EEOC))
- The ADA which prohibits employment discrimination based on disability (enforced by the EEOC)
- The Family and Medical Leave Act which provides unpaid leave for certain workers for pregnancy and to bond with a new child (enforced by the U.S Department of Labor)
- The PUMP Act which provides nursing mothers a time and private place to pump at work (enforced by the U.S. Department of Labor)

Learn more at www.EEOC.gov/Pregnancy-Discrimination.

The FMLA Leave Process

County of Galveston