EMPLOYMENT,
LABOR &
WORKERS'
COMPENSATION

ADVICE
SOLUTIONS
LITIGATION

Alfred J. Landegger
Larry C. Baron
Michael S. Lavenant
Corey A. Ingber*

*A Professional Law Corporation

Roxana E. Verano
Laura S. Withrow
Christopher L. Moriarty
Oscar E. Rivas
Marie D. Davis
Brian E. Ewing
Jennifer R. Komsky
Diana Vlasova
Clifford J. Weinberg

Main Office
15760 Ventura Blvd.
Suite 1200
Encino, CA 91436
(818) 986-7561
Fax (818) 986-5147

Ventura Office
751 Daily Drive
Suite 325
Camarillo, CA 93010
(805) 987-7128
Fax (805) 987-7148

www.landeggeresq.com

LANDEGGER | BARON | LAVENANT | INGBER

A LAW CORPORATION

GO AHEAD AND TAKE A LEAVE OF ABSENCE

What Do I Need To Know?

Employment Law Workshop

By

Alfred J. Landegger, Esq.
Michael S. Lavenant, Esq.

Table of Contents

I. Vacation

A. Neither federal nor state law requires that an employer provide employees with paid vacation or holiday.

B. However, if vacation is offered to employees, certain requirements must be met:

1. If vacation policy in effect, cannot have "use it or lose it"; and

2. No forfeiture of vested right.

C. Employer may choose to provide benefits to particular groups of employees.

D. Cap on accrual allowed - technical variation of "use it or lose it" - language of policy must be reviewed carefully.

E. DLSE has taken position that vacation policies which provide that all vacation must be taken in the year that it is earned are unfair and will not be enforced.

F. Floating holiday or PTO policies may be seen as vacation.

G. Accrual of Vacation - annual or pro-rata.

1. Vacation accrues on a daily basis, regardless of how employer structures the accrual.

2. Employer must pay pro rata share of accrual at time of termination.

3. If employer really does not want to pay "introductory" employees if they leave, then accrual can start after 90th day, etc., but cannot be a subterfuge to avoid the rule (e.g., 5 days accrued in 9 months).

4. Another example of subterfuge - no vacation accrues in the first year, two weeks in the second year and then back to one week thereafter.

H. Exempt employees - Cannot reduce vacation bank in less than full day increments.

I. Payment of vacation - Paid at rate earned at time taken and must pay all accrued at separation.

J. Interaction with leave laws.

1. Cannot force use during pregnancy disability leave.

2. Can force use for FMLA/CFRA.

3. Must specify that benefits do not accrue during leave.

K. Short-term plant shutdowns - Exempt employees may not have their pay or vacation banks reduced unless the shutdown is for an entire work week. Employer may not force the use of vacation by any employee during a plant shutdown unless the employer has given nine months' notice that it intends to do so.

II. Sick Leave

A. No statutory requirements for employer to have sick leave.

B. If employer has sick leave, then Labor Code section 233 applies: 50% of all sick leave can be used for care of ill family member ("parent, child or spouse or domestic partners").

C. Not a vested right - "Use it or lose it" is acceptable.

D. If an employer uses a PTO system, and thereby lumps vacation and sick time, the employer may not reduce the PTO bank whatsoever if an exempt employee is absent due to illness.

E. Pros and Cons of implementing a PTO policy.

1. Pros:

a. Easy administration; and

b. Employees do not need to lie about being sick or family member sick - more generic.

2. Cons:

a. Loses "use it or lose it" status; (b) exempt employees cannot lose either partial or full day's pay or PTO for illness;

b. Employees are entitled to use up to ½ to care for family members; and

c. Vested right - must pay out at separation.

F. Can force FMLA/CFRA leave employees to use sick leave concurrently if employee is ill or injured.

III. Leaves Related To Medical Conditions

A. FMLA/CFRA Leave

1. FMLA - federal Family and Medical Leave Act of 1993 (29 USC §§ 2601 et seq.).

2. CFRA - California Family Rights Act (Cal. Gov. Code § 12945.2).

3. Covers all public employers and private employers with 50 or more employees working within 75 miles of each other.

4. Employee must have worked at least 1,250 hours in the 12 months preceding the leave request.

5. Leave allowed for:

   a. Birth of a child, placement for adoption or foster care of a child;

   b. Care for spouse, child or parent with a serious health condition;

   c. Employee who is suffering from a serious health condition that renders the employee to be unable to perform functions of the position.

6. Serious Health Condition:

   a. A condition requiring hospital care as an inpatient;

   b. A condition that requires treatment and causes incapacity lasting more than three (3) consecutive days with treatment during that time period;

   c. Pregnancy or related conditions (FMLA only);

   d. Chronic conditions that require ongoing treatment;

   e. Permanent and long-term conditions that require supervision; or

   f. A condition that requires multiple treatments.

7. Intermittent leave allowed.

8. Second and third opinions allowed, but employer must pay for subsequent opinions.

9. Notice responsibilities of employer - employer is responsible for designating.

10. Certification requirements - employee may be required to obtain medical certification.

11. Rights:

    a. Employee is allowed to continue health care coverage.

        (1) Employer must pay its share of employee medical premiums, but if employee does not return, employer can get reimbursement.

    b. Employee is entitled to be reinstated to the same or an equivalent position, subject to certain exceptions.

B. Americans With Disabilities Act (ADA)
and California Disability Leave Laws
(42 U.S.C. § 12211; Cal. Gov. Code §§ 12940, 12940.3)

1. California law favors the employee.

2. ADA applies to public agencies, and private employers with 15 or more employees.

3. State law covers public agencies; and private employers with 5 or more employees.

4. Protects an employee who has a physical or mental impairment that substantially limits one or more major life activities, or has a record of such impairment, or is regarded as having such impairment.

    a. State definition deletes the term "substantially."

5. Qualified individual with a disability is entitled to a "Reasonable accommodation."

    a. "Essential" v. "non-essential" functions and need for job descriptions.

    b. Other factors involved in whether employer must accommodate (cost, undue hardship).

    c. Engage in interactive process with employee to determine what accommodation is requested and whether such accommodations are feasible.

6. Types of Accommodation:

   a. Restructuring of position;

   b. Leave of absence;

   c. Modified or part-time schedule;

   d. Modified workplace policies;

   e. Reassignment.

7. Disability leave may interact with FMLA/CFRA, Pregnancy, and/or Workers Compensation Leave.

C. Pregnancy Related Disability
(FEHA-Gov. Code § 12945)

1. Must have 5 or more employees.

2. Four months "or equivalent."

   a. Generally 88 working days.

   b. Part-time employees get equivalent so could be longer than 4 mos.

3. No requirement that employee be on payroll for any period of time before benefit allowed.

4. Reasonable accommodation.

   a. 1st option - modify existing job.

   b. 2nd option - move to light duty position.

   c. 3rd option - leave of absence.

5. Coordination with State Disability Insurance payments.

6. Can force use of sick time, but not vacation or PTO.

7. Must return to same position or equivalent.

8. No need to pay medical premiums unless company does so in other medical situations.

D. Interaction of Pregnancy Disability Leave, FMLA and CFRA

1. FMLA and the first 12 weeks of Pregnancy Disability Leave should run concurrently.

2. CFRA may be used after exhaustion of PDL if circumstances are appropriate and job must be held open.

E. Workers Compensation

1. Industrial injuries covered (physical and mental).

2. Length of leave - no maximum.

3. Leave determined by employee's desire/ability to return to same position or utilize vocation rehabilitation benefits.

4. Pursuant to Labor Code §132a, employee cannot be treated differently in regards to the terms and conditions of employee due to the occupational injury.

5. Part-time/reduced duties.

   a. Not required to place employees.

   b. Re-training only if training provided in other leave contexts.

   c. Can adjust wage/salary downward.

   d. Can discontinue reduced schedule.

6. Filling the employee's position.

   a. Temporary replacement.

   b. "Permanent replacement."

   c. Depends on business necessity, training difficulties, length of time gone.

7. When the employee is ready to return.

   a. Generally must bring back to same or equivalent position.

   b. Need not bump replacement if business necessity, passage of time, etc. justify replacement (high standard).

c. Need not bump employee from other position to accommodate returning employee.

F. State Disability Insurance

1. Employees may receive benefits from the state for a non-industrial illness or injury.

2. Employer need not hold the position, although there may be ADA implications that overlap.

G. Family Temporary Disability Insurance

1. Now referred to as "Paid Family Leave."

2. Effective January 1, 2004, employers will begin deducting, on behalf of the state, from employee paychecks for FTDI. Employees will be entitled to take FTDI beginning July 1, 2004.

3. This program provides up to six (6) weeks per year of partial wage replacement for employees who miss work to care for a sick family member or a newborn, or newly placed adopted or foster child.

4. The law applies even if the employee has only been with the company a short period of time, and would overlap with FMLA and CFRA rights, to the extent the employee (and the employer) qualified.

5. The benefit is similar to SDI, in that the employer need not hold the employee's position.

6. An employer can require employees to use up to two weeks of accrued vacation before using FTDI benefits.

7. There is also a seven (7)-day waiting period before the employee is eligible.

8. Carefully-worded policies should be implemented through handbooks.

9. Notice requirements obligate employees to provide information to new employees and employees utilizing the leave after July 1, 2004.

IV. Miscellaneous Leaves

A. Voting (California Election Code §§ 14000-14002)

1. Applies to all public and private employers.

2. If not enough time to vote outside working hours in statewide election can take time off during work hours.

3. Employer must pay up to two hours and any additional time that is needed is unpaid.

4. Must be at start or end of work.

B. Jury Duty (Labor Code Section 230(a))

1. Applies to all employers.

2. Section 230(a) prohibits discrimination against employees on jury duty.

3. Employer payment for jury duty.

   a. Not required by statute.

   b. Non-exempt employees.

      (1) No need to pay for time missed.

      (2) Employees may apply vacation or PTO.

   c. Exempt employees.

      (1) Must be paid for entire week if only partially on jury duty.

      (2) Employees who work "after hours" qualify for full week's pay.

      (3) Cannot force use of vacation or PTO.

C. Witness Duty (Labor Code § 230(b))

1. Applies to all employers.

2. Prohibits discrimination against employees appearing as witnesses pursuant to subpoena or court order.

3. Need not be paid for time off (non-exempt employees only for partial days).

4. Should provide as much notice to employer as possible.

D. Crime Victims (Labor Code § 230(b))

1. Applies to all employers.

2. Prohibits discrimination for appearances in court.

3. Need not be paid for time off.

E. School Visits For Suspended Child (Labor Code § 230.7)

1. Applies to all employers.

2. No discrimination or discharge of employees for attending suspension meeting.

3. Must be meeting called under Education Code section 48900.1 based on infractions specified in section 48900.

F. Family School Partnership Act (Labor Code § 230.8)

1. Applies to employers with 25 or more employees.

2. Parent, guardian or grandparent with custody must give reasonable notice to attend school or day care center activity.

3. 8 hours per month maximum, up to 40 hours per year.

4. If both parents work for same employer:

   a. Only first parent giving notice may attend.

   b. Second parent allowed to go only with employer approval.

5. Employer may require documentation to verify activity.

6. Vacation must be used by employee or may use time off without pay if allowed by employer.

G. Victims of Domestic Violence and Sex Abuse (Labor Code §§ 230 and 230.1)

1. No discrimination for taking time off from work to obtain or seek judicial relief to ensure health, safety or welfare of employee or child.

2. Reasonable notice required where possible.

3. If discipline occurs due to employee absence, must be rescinded if employee provides evidence of court appearance within reasonable time after.

4. Employers with 25 or more employees must not discriminate if employee takes time off to seek program services, psychological counseling, or to participate in safety planning (medical attention, shelter, etc.).

H. Volunteer Firefighters (Labor Code § 230.3)

1. Applies to all employers.

2. No discrimination for taking time off to perform volunteer firefighter emergency duties.

3. Does not apply to public safety agency or emergency medical services provider if agency determines that employee's absence would hinder availability of services.

I. Employee Literacy Education Assistance Act (Labor Code §§ 1040-1044)

1. Must have 25 or more employees.

2. Requires reasonable accommodation and assistance to employee who:

   a. Discloses illiteracy;

   b. Requests assistance in enrolling in adult literacy program;

      (1) Provide information and location; possible on-site by provider.

3. No obligation by employer to pay for program or provide time off with pay.

4. Must reasonably safeguard employee privacy.

J. Military Leave

1. State law protection - Military and Veteran's Code section 394 prohibits discrimination by private employers.

2. Federal law - prohibits discrimination against members of "uniformed services" (broadly defined) 38 U.S.C. § 4301 et seq.

3. **NEW –*Military Spouse Leave (AB 392)*** This bill was signed by Governor Schwarzenegger on October 9, 2007 and took effect immediately. This new law states that California businesses employing 25 or more people must give up to 10 unpaid days off to any "qualified" employee whose spouse is on leave from military deployment.

   a. Under AB 392, a qualified employee is one who works more than 20 hours per week whose spouse is a member of the Armed Forces, National Guard or Reserves who has been deployed during a period of military conflict.

   b. Employees who desire to take time off pursuant to this policy must provide a copy of the official notice that the qualified member will be on leave to their supervisor and the Human Resources Department no later than two (2) business days after the employee receives the official notice.

K. Drug and Alcohol Rehabilitation

1. 25 or more employees required.

2. Employee must come forward voluntarily and request to enter rehabilitation program.

3. No time limit in statute.

4. Employer must hold job.

5. "Last Chance Agreement" allowed.

L. Bereavement

1. No statutory requirements.

2. Can require use of PTO or vacation.

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

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

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

OMB Control Number: 1215-0181
Expires: 12/31/2011

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):

   _____

   _____

   _____

   _____

   _____

   _____

   _____

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.**

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

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

WHD

OMB Control Number: 1215-0181
Expires: 12/31/2011

SECTION I: For Completion by the EMPLOYER

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

Employer name and contact: _____

_____

SECTION II: For Completion by the EMPLOYEE

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

Your name: _____
First Middle Last

Name of family member for whom you will provide care: _____
First Middle Last

Relationship of family member to you: _____

If family member is your son or daughter, date of birth: _____

Describe care you will provide to your family member and estimate leave needed to provide care:

_____

_____

_____

_____ _____
Employee Signature Date

CONTINUED ON NEXT PAGE

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the patient needs leave. Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____) _____ Fax:(_____) _____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
   ___No ___Yes. If so, dates of admission: _____

   Date(s) you treated the patient for condition: _____

   Was medication, other than over-the-counter medication, prescribed? ___No ___Yes.

   Will the patient need to have treatment visits at least twice per year due to the condition? ___No ____ Yes

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
   ____ No ____Yes. If so, state the nature of such treatments and expected duration of treatment:

   _____

   _____

2. Is the medical condition pregnancy? ___No ___Yes. If so, expected delivery date: _____

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

_____

_____

_____

_____

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ___No ___Yes.

   Estimate the beginning and ending dates for the period of incapacity: _____

   During this time, will the patient need care? __ No __ Yes.

   Explain the care needed by the patient and why such care is medically necessary:

   _____

   _____

   _____

   _____

   _____

5. Will the patient require follow-up treatments, including any time for recovery? ___No ___Yes.

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   _____

   Explain the care needed by the patient, and why such care is medically necessary: _____

   _____

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? __ No __ Yes.

   Estimate the hours the patient needs care on an intermittent basis, if any:

   _____ hour(s) per day; _____ days per week from _____ through _____

   Explain the care needed by the patient, and why such care is medically necessary:

   _____

   _____

   _____

   _____

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ____No ____Yes.

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

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

Duration: _____ hours or ___ day(s) per episode

Does the patient need care during these flare-ups? ____ No ____ Yes.

Explain the care needed by the patient, and why such care is medically necessary: _____

_____

_____

_____

_____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Health Care Provider **Date**

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.

Notice of Eligibility and Rights & Responsibilities (Family and Medical Leave Act)

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

WHD

OMB Control Number: 1215-0181
Expires: 12/31/2011

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 servicemember's serious injury or illness which would entitle you to FMLA leave; or 3) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your 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.**

Designation Notice (Family and Medical Leave Act)

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

WHD

OMB Control Number: 1215-0181
Expires: 12/31/2011

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
(Provide at least seven calendar days)
practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied.

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

_____

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

_____ Your FMLA Leave request is Not Approved.
_____ The FMLA does not apply to your leave request.
_____ You have exhausted your FMLA leave entitlement in the applicable 12-month period.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

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

Certification of Qualifying Exigency For Military Family Leave (Family and Medical Leave Act)

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

WHD

OMB Control Number: 1215-0181
Expires: 12/31/2011

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.

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.

_____ _____

Signature of Employee 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 AV, NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE EMPLOYER.**

Certification for Serious Injury or Illness of Covered Servicemember - - for Military Family Leave (Family and Medical Leave Act)

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

WHD

OMB Control Number: 1215-0181
Expires: 12/31/2011

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

Certification for Serious Injury or Illness of Covered Servicemember - - for Military Family Leave (Family and Medical Leave Act)

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

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:

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:

_____

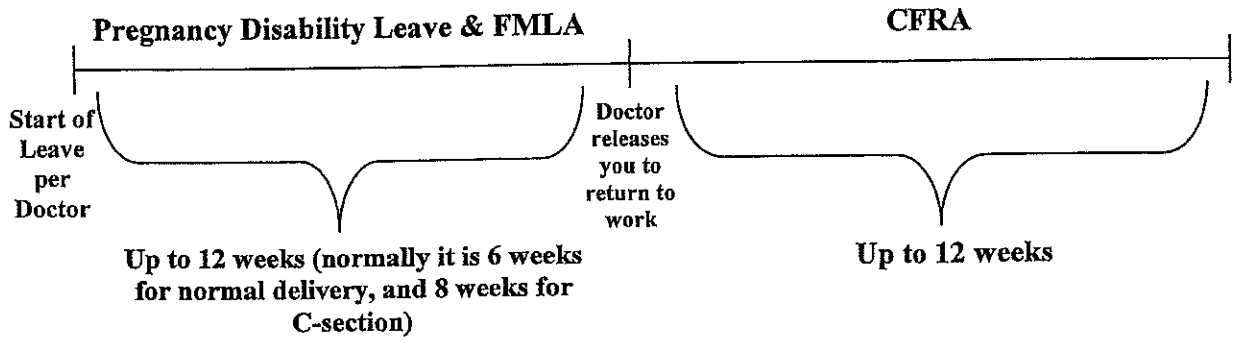
_____

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.**

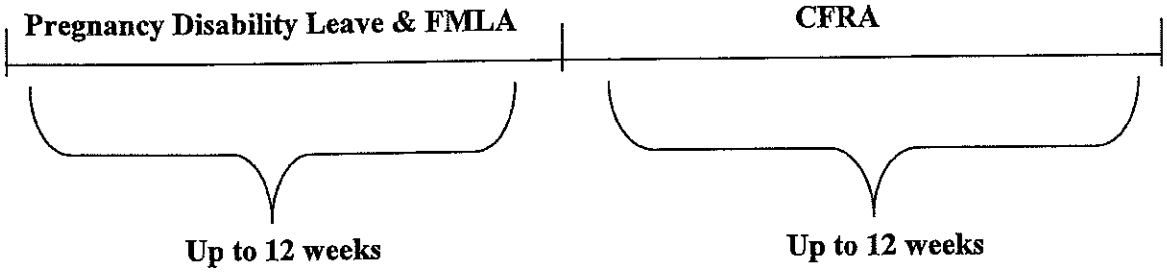
Pregnancy Leaves



PDL & FMLA:

- **First Regional Bank continues to pay Insurance and employee is responsible for their portion**
- **Your position will be held open while on leave**

How do I get paid?



PDL & FMLA:

- **Sick Time**
- **Vacation**
- **State Disability (7 day waiting period for benefits counting Saturday & Sunday)**

CFRA:

- **Sick Time**
- **Vacation**
- **Paid Family Leave from State of California (up to 6 weeks)**

* **PDL – Pregnancy Disability Leave (4 months)**
* **FMLA – Family Medical Leave Act (12 weeks)**
* **CFRA – California Family Rights Act (12 weeks)**

LEAVE OF ABSENCE CHECK-OFF LIST

EMPLOYEE: _____BR/DEPT:_____

HIRE DATE:_____

==========

Leave Information

Type of Leave: _____ Last Day Worked: _____

First Day Out: _____ # of Sick Hrs: _____

Vacation: Vacation days will be prorated for Leave of Absence one month or longer.

Expected Date of Return: Approx.

BENEFITS:

Medical Premiums: $

Dental Premiums: $

Vision Premiums: $

Conexis Premium: $

Voluntary Life: $
(EE, Spouse,Child)

Long Term Care: $

Colonial Premiums: $

Total Premiums: $

** Premiums calculated at 2009rates

Premiums Due: 30th of each month payable to First Regional Bank.

==========

☑ Leave Memo to Employee *

☑ CA SUI Notice *

☑ State Disability Form & Pamphlet or Paid Family Leave Information *

* Received by employee

_____ _____

Signature Date

Completed By: _____

For Human Resources Use:
_____ Doctors Note
_____ Employee Change Notice
__na__ CONEXIS
_____ Network Form

First Regional Bank

Memo

To:

From: Kim Meyer, SVP/Human Resources Manager

Date: July 8, 2008

Re: Leave of Absence

Your Pregnancy Disability/Federal Family Care and Medical Leave began on June 30, 2008. You have indicated you will be claiming State Disability, as we discussed, there is a 7 day waiting period, counting Saturdays and Sundays, during which no benefits are payable. As of June 27, 2008 you have accrued 12sick days. On the 6/30/08 payroll, you were paid 1 sick day (6/30/08) and you have requested to be paid an additional 4 days (7/1/08 – 7/4/08) on the 7/15/08 payroll.

The maximum amount of time for a pregnancy disability leave is four (4) months providing you are physically disabled from working, as qualified by your physician. The Pregnancy Disability Leave and Family Care leave run concurrently. During your leave of absence you will not be accruing sick time or vacation.

Please notify me when your doctor releases you to return to work, you are then eligible for a leave under the California Family Rights Act. You are eligible for this leave based on: to care for a newborn child. The maximum time allowed for this leave is 12 weeks in a 12-month period. This is an unpaid leave although you can apply for Paid Family Leave through the state of California. The California Family Rights Act leave and Paid Family Leave will run concurrently.

The bank will continue to pay its portion of the group insurance premiums during your Pregnancy Disability/Federal Family Care and Medical Leave and your California Family Care and Medical Leave. However, during your leave you will still be responsible for your portion of your medical, dental and vision insurance benefits. Your Medical Insurance premium of $345.00 (per month), Delta Dental premium of $36.00 (per month) and VSP Vision premium of $15.00 (per month) will be due on the 30th of each month. This comes to a total of $396.00 per month. These premiums

will continue to be deducted from your payroll as long as you are receiving pay. . Should you not be receiving pay, please forward a check to Human Resources on the 30th of each month, payable to First Regional Bank in the amount of $396.00.

You have 30 days in which to add your new baby to your group insurance if you wish. To add your child to your group insurance, please contact the Human Resources Department. The cost of your benefits will not change, as the premium is not based on the number of children.

Please call me if you have any questions and please sign the copy of this letter acknowledging receipt as well as a copy of the Leave of Absence Check-Off List.

_____

Kim Meyer, SVP/Director of Human Resources

_____

(Employee Name) Date

First Regional Bank

Notice to Employee as to Change in Relationship

(Termination Notice Pursuant to Provisions of Section 1089 of the California Unemployment Insurance Code)

The attached pamphlet describes California's program for the unemployed. It is a requirement of the State of California that we furnish you with this notice along with the State Pamphlet of Unemployment Insurance Benefits.

The change in relationship information below will assist you in filing for unemployment benefits if you believe you are eligible. Please retain the notice for your records and furnish it to the EDD, if requested, as proof of your employment termination from First Regional Bank. Verification of information should be directed to **First Regional Bank, attn: Human Resources, 1801 Century Park East, Suite 480, Los Angeles, CA 90067**, or by calling 310-552-1776 and ask to speak to Human Resources.

_____ _____

Name Social Security #

Your employment status has changed for the reason checked below:

☐ Voluntary quit effective: _____
Date

☐ Involuntary Termination effective: _____
Date

☐ Layoff effective: _____
Date

☐ Leave of absence effective: _____, with a return to work date of _____
Date Date

Comments:

_____

_____

_____

_____

_____ _____

Human Resources Date

I received a copy of this notice on _____ _____
Date Signature