

## INSTRUCTIONS FOR REQUESTING FMLA LEAVE (Family Member Request)

### **PRIOR TO LEAVE: TO REQUEST FMLA LEAVE OF ABSENCE**

1. Complete and sign the *Request for Family Medical Leave of Absence* form (**FORM 1**) and request that your Supervisor and Administrator sign and return to HRRM.
2. Complete the top part of the *Certification of Healthcare Provider* form (**FORM 2**) and have your family member's health care provider complete the balance of the form and return it to HRRM within 15 calendar days. **A completed Medical Certification must be submitted to HRRM prior to FMLA final approval.**

Once the request is completed and the Medical Certification is received by HRRM, notice of approval or denial will be sent to you, your Supervisor and Administrator.

**\*\*If you are unable to return as originally scheduled, please contact Human Resources for information about the possibility of extending your leave of absence.\*\***

Any additional questions can be directed to:

Carolyn Kraft  
Human Resources Analyst  
City of Renton  
425-430-7654  
[ckraft@rentonwa.gov](mailto:ckraft@rentonwa.gov)

or

Maria Boggs, CEBS  
Benefits Manager  
City of Renton  
425-430-7659  
[mboggs@rentonwa.gov](mailto:mboggs@rentonwa.gov)

**REQUEST FOR FAMILY MEDICAL LEAVE OF ABSENCE  
(Family Member Request)**

**FORM 1**

City Policy 350-03

Employees who have worked for the City of Renton for at least 12 months, including at least 1,250 hours during the 12-month period immediately before the request for leave, are eligible for leave. FMLA provides for twelve total weeks of protected leave. In cases of intermittent leave, regular full-time employees receive a total of 480 hours. The hourly conversion for Police and Fire may be different depending on the actual shift schedule worked. Please contact Human Resources & Risk Management for clarification.

Name:		Employee Number:
Address:	City:	Zip:
Department:	Hire Date:	

**FMLA: Reason for requesting leave (check one):**

- The birth of a child, or the placement of a child with you for adoption or foster care.
- A serious health condition affecting your  spouse,  child, or  parent, for which you are needed to provide care.
- Because of a qualifying exigency out of the fact that your  spouse,  child, or  parent is on active duty status in support of contingency operation as a member of the National Guard or Reserves.
- Because you are the  spouse,  child, or  parent, or  next of kin of a covered service member with a serious injury or illness.

Date leave is to start: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date I expect to return to work: \_\_\_\_/\_\_\_\_/\_\_\_\_

Type of Leave Requested:	<input type="checkbox"/> Continuous Leave	<input type="checkbox"/> Intermittent Leave
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I understand that benefits will continue during any approved FMLA leave. If I 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 me to FMLA leave; or (2) other circumstances beyond my control, I may be required to reimburse the City for the City's share of health insurance premiums paid on my behalf during my FMLA leave. **I understand that it is my responsibility to pay my portion of applicable health benefits to continue healthcare coverage. Failure to pay my applicable portion of any of the health premium will result in loss of coverage and the City's obligation to maintain such coverage ceases under FMLA when my premium becomes delinquent or when I exhaust FMLA hours.**

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

Supervisor's Signature \_\_\_\_\_ Date \_\_\_\_\_

Administrator's Signature \_\_\_\_\_ Date \_\_\_\_\_

HR & RM Representative \_\_\_\_\_ Date \_\_\_\_\_

**FMLA LEAVE REQUEST – CERTIFICATION OF HEALTHCARE PROVIDER**  
**(Family Member Request)**  
**FORM 2**

**1. TO BE COMPLETED BY EMPLOYEE**

Employee Name:	
Patients Name:	Patient's relationship to employee: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent
Employee Signature:	Date:
State the care you will provide for your family member:	
Provide an estimate of the time period of care, including a schedule if leave is to be taken intermittently or consecutively:	

**2. TO BE COMPLETED BY HEALTHCARE PROVIDER**

Designation of Serious Health Condition
<p>Under FMLA a "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves one or more of the categories below (see definitions on page 3.) If so, please check the applicable category. Indicate "yes" or "no" as to whether a serious health condition exists for the above named patient.</p> <p align="center"> <input type="checkbox"/> Yes                      <input type="checkbox"/> No         </p> <p><input type="checkbox"/> (1) Hospital Care (<i>inpatient</i>)</p> <p><input type="checkbox"/> (2) Absence Plus Treatment (<i>Patient is unable to work or perform other regular daily activities for more than three consecutive calendar days and needs treatment</i>)</p> <p><input type="checkbox"/> (3) Pregnancy</p> <p><input type="checkbox"/> (4) Chronic Serious Health Condition (<i>i.e. asthma, diabetes, epilepsy, etc.</i>)</p> <p><input type="checkbox"/> (5) Permanent/Long-term Condition Requiring Supervision  <i>(i.e., Alzheimer's, severe stroke, terminal stages of disease)</i></p> <p><input type="checkbox"/> (6) Multiple Treatments (<i>i.e., cancer, severe arthritis, therapy, dialysis, etc.</i>)</p> <p><input type="checkbox"/> <b>Not a serious health condition</b></p>
<p>Describe the medical facts which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e). Please be sure to sign the form on the last page.</p>

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**Duration of Incapacity and Treatments**

Approximate date condition began:

Probable duration of condition:

**Schedule of Treatment**

Please state the nature of the treatment and period of time covered.

\_\_\_\_\_  
\_\_\_\_\_

If a regiment of continuing treatment by the patient is required under your supervision, provide a general description of such regiment (e.g. prescription drugs, physical therapy):

\_\_\_\_\_  
\_\_\_\_\_

By other provider of health services:

\_\_\_\_\_  
\_\_\_\_\_

**Employee Work Status**

Due to the family member's medical conditions identified, it is medically necessary for employee to:

Take a consecutive leave starting on: \_\_\_\_\_ and returning to work on: \_\_\_\_\_

Take intermittent leave according to the following schedule:

\_\_\_\_\_  
\_\_\_\_\_

Work less than employee's normal schedule of hours per days or days per week according to the following schedule:

\_\_\_\_\_

Yes

No

Does or will the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation?

Yes

No

After review of the employee's signed statement above, is the employee's presence necessary and/or would it be beneficial for the care of the patient? (*This may include psychological comfort.*)

**Physician Information**

Name of Health Care Provider (please print)

Type of Practice

Signature of Health Care Provider

Date

Address

Telephone Number

**Please Return to:** City of Renton - Human Resources and Risk Management  
1055 South Grady Way  
Renton, WA 98057  
425.430.7665 (FAX)

## Description of Serious Health Condition

A "Serious Health Condition" means an illness, injury impairment, or physical or mental condition that involves one of the following:

### 1. Hospital Care

Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity of or subsequent treatment in connection with, or consequent to such inpatient care.

### 2. Absence Plus Treatment

A period of incapacity of more than three consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:

- a) Treatment two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or
- b) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider.

### 3. Pregnancy

Any period of incapacity due to pregnancy, or for prenatal care.

### 4. Chronic Conditions Requiring Treatments

A chronic condition which:

- a) Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;
- b) Continues over an extended period of time (including recurring episodes of a single underlying condition); and
- c) May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

### 5. Permanent/Long-term Conditions Requiring Supervision

A period of incapacity, which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal states of a disease.

### 6. Multiple Treatments (Non-Chronic Conditions)

Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), and kidney disease (dialysis).

This optional form may be used by employees to satisfy a mandatory requirement to furnish a medical certification (when requested) from a health care provider, including second or third opinions and recertification (29 CFR 825.306).

#### Definitions:

**Incapacity** for purposes of FMLA is defined to mean inability to work, attend school or perform other regular activities due to the serious health condition.

**Treatment** includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.