

INSTRUCTIONS FOR REQUESTING FMLA LEAVE AND RETURNING TO WORK (Employee 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 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.** **Please Note:** If this is a worker's compensation claim, your physician does not need to complete the Certification of Health Care Provider Form. Your time will automatically be designated as FMLA.

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.

PRIOR TO YOUR RETURN: WHEN LEAVE IS FOR YOUR OWN HEALTH CONDITION

1. As an employee on FMLA leave due to your own serious health condition, your healthcare provider must release you to return to work. Please present the *Fitness for Duty to Return from Leave Certification* form (**FORM 3**) to your provider, along with your job description, and return the completed form to Human Resources. **We must receive this form prior to your return.**
2. If your provider indicates that you need to return in a modified or light duty capacity, the *Fitness for Duty to Return from Leave Certification* form (**FORM 3**) needs to be turned in prior to your return in order to determine if your department can accommodate any restrictions.*
3. If you are unable to return as originally scheduled, please contact Human Resources for information about the possibility of extending your leave of absence.

***IMPORTANT:** If your department is able to accommodate you and you return to work in a modified or light duty capacity, a new *Fitness for Duty to Return from Leave Certification* form (**FORM 3**) must be completed if:

- Your restrictions change at any time during your modified or light duty, or
- To release you to full, unrestricted duty.

Any additional questions
can be directed to:

Carolyn Kraft
Human Resources Analyst
City of Renton
425-430-7654
ckraft@rentonwa.gov

or

Maria Boggs
Benefits Manager
City of Renton
425-430-7659
mboggs@rentonwa.gov

REQUEST FOR FAMILY MEDICAL LEAVE OF ABSENCE – EMPLOYEE

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 that makes you unable to perform the essential functions for your job.
- Workers' Compensation injury/illness – Contact Risk Management for Industrial Insurance Packet.

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 additional 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.**

A Fitness for Duty to Return from Leave Certification form signed by your health care provider will be required prior to return from leave unless you are out five or fewer consecutive days, or when FMLA is required for a family member.

Please sign below and have your supervisor and department administrator sign then return to HRRM.

Employee Signature _____ Date _____

Supervisor's Signature _____ Date _____

Administrator's Signature _____ Date _____

HR & RM Representative _____ Date _____

FMLA LEAVE REQUEST – CERTIFICATION OF HEALTHCARE PROVIDER
(Employee Request)
FORM 2

1. TO BE COMPLETED BY EMPLOYEE

Employee Name:	
Department:	Job Title:
Employee Signature:	Date:

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 employee.</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"/> Not a serious health condition</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>
<p>If condition is a “chronic condition” or pregnancy, state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity:</p> <p>___ Patient <input type="checkbox"/> <i>is</i> <input type="checkbox"/> <i>is not</i> presently incapacitated. (<i>check one</i>)</p> <p>___ Duration of episodes of incapacity = _____ (<i>hours or days, etc.</i>)</p> <p>___ Frequency of episodes of incapacity = _____ (<i>number of times per week or month, etc.</i>)</p>

(Continued on Back)

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 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:

<input type="checkbox"/> Yes	<input type="checkbox"/> No	During the period of incapacity, is the employee able to perform work of any kind?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is the employee able to perform the essential functions of the employee's position? <i>(Answer after reviewing job description describing essential functions of the employee's position, or, if none provided, after discussing with employee.)</i> If yes, elaborate:

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.

**FITNESS FOR DUTY TO RETURN FROM LEAVE CERTIFICATION
FORM 3**

City of Renton Employee: As an employee on Family and Medical Leave due to your own serious medical condition, your healthcare provider must release you to return to work. Please present this form along with your job description to have your provider complete section B which is a 2 sided form. Submit completed form to Human Resources prior to your return.

Supervisor: If this form is turned in to you, please return completed Fitness for Duty form to Human Resources.

A EMPLOYEE INFORMATION

Employee Name: _____

Employee's Job Title: _____

Date Leave Began: _____

Job Description Is Attached

B HEALTH CARE PROVIDER

As a condition of return to work, the employee is required to have a medical examination. This section of the form should be completed by the health care provider, before the employee is allowed to resume his/her job duties.

1. Date of Medical Examination: _____

2. **Date employee may return from leave:** _____

3. Please indicate with a check mark the status of the employee's release for duty

Full, unrestricted duty. (Skip question 4 and proceed to Section C)

Modified duty (Complete question 4)

Not released for any type of duty (Go to Section C)

4. If you are releasing the employee to modified duty, please complete the following:

a. Estimated date that the employee will be able to return to full, unrestricted duty:

b. Date of your next medical evaluation of the employee:

This is a 2-sided document.

C MODIFIED WORK DUTY

Indicate the *exact work restrictions* which apply to the employee *at this time* on the chart below:

PHYSICAL LIMITATIONS		FULL RESTRICTIONS	PARTIAL RESTRICTIONS	NO RESTRICTIONS
Sedentary-Lifting 0 to 10 pounds				
Light-Lifting 10 to 20 pounds				
Moderate-Lifting 20 to 50 pounds				
Heavy-Lifting 50 to 100 pounds				
Pulling/Pushing, carrying				
Reaching or working above shoulder				
Walking	hours			
Standing	hours			
Sitting	hours			
Stooping	hours			
Kneeling	hours			
Repeated bending	hours			
Climbing	hours			
Operating a motor vehicle, crane, tractor, etc.				
Exposure Limitations (Specify)				
Number of hours able to work per day				

CERTIFICATION

I hereby certify that the foregoing facts are true and correct and executed under penalty of perjury in

_____, Washington on this _____ day

of _____.

Signature of Treating Physician or Practitioner

Date

Print Name of Treating Physician or Practitioner

Phone Number

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1055 South Grady Way
Renton, WA 98057
425.430.7665 (FAX)