

REQUEST FOR FAMILY MEDICAL LEAVE OF ABSENCE – FAMILY MEMBER

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.

Instructions to Employee:

1. Complete and sign this form and request that your Supervisor and Administrator sign and return to HRRM.
2. Complete the top part of the Certification of Health Care Provider Form 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 employee, Supervisor and Administrator.

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.

Employee Signature _____	Date _____
Supervisor's Signature _____	Date _____
Administrator's Signature _____	Date _____
HR & RM Representative _____	Date _____

Family and Medical Care Leave - Certification of Health Care Provider

Family Member Version

1. TO BE COMPLETED BY EMPLOYEE

Employee Name:	
Patient's 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: <hr/> <hr/>	
Provide an estimate of the time period during which this care will be provided, including a schedule if leave is to be taken intermittently or on a reduced leave schedule. <hr/> <hr/>	

2. TO BE COMPLETED BY HEALTH CARE PROVIDER

Designation of Serious Health Condition	
Indicate "yes" or "no" as to whether a serious health condition exists for the above named employee's family member.	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
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. Does the employee family member's condition qualify under any of the categories described? (See definitions on page 3.) If so, please check the applicable category.	
<input type="checkbox"/> Hospital Care (<i>inpatient</i>)	
<input type="checkbox"/> Absence Plus Treatment (<i>Patient is unable to work or perform other regular daily activities for more than three (3) consecutive calendar days and needs treatment</i>)	
<input type="checkbox"/> Pregnancy	
<input type="checkbox"/> Chronic Serious Health Condition (<i>i.e. asthma, diabetes, epilepsy, etc.</i>)	
<input type="checkbox"/> Permanent/Long-term Condition Requiring Supervision <i>(i.e., Alzheimer's, severe stroke, terminal stages of disease)</i>	
<input type="checkbox"/> Multiple Treatments (<i>i.e., cancer, severe arthritis, therapy, dialysis, etc.</i>)	
<input type="checkbox"/> Not a serious health condition	
Approximate date condition began:	Probable duration of condition:

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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.

Duration of Incapacity and Treatments

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 (care for family)

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does or will the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation?
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<input type="checkbox"/> Yes	<input type="checkbox"/> No	After review of the employee's signed statement above, is the employee's presence necessary or would it be beneficial for the care of the patient? (This may include psychological comfort.)
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Identify the duration and schedule of time needed by employee to care for patient.

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
425.430.7659 (PHONE) * 425.430.7665 (FAX)
Attn: Maria Boggs

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.