

HUMAN RESOURCES POLICY

POLICY TITLE: FMLA LEAVE OF ABSENCE

POLICY NUMBER: HR XII - 1205*

PURPOSE: To provide a qualified employee with leave under the Family and Medical Leave Act (“FMLA”) with job protection and no loss of accumulated service provided the employee returns to work.

A family and/or medical leave of absence (“FMLA LOA”) shall be defined as an approved absence available to eligible employees for up to twelve weeks of unpaid/paid leave per year under particular circumstances that are critical to the life of a family. Leave may be taken: upon the birth of the employee's child; upon the placement of a child with the employee for adoption or foster care; when the employee is needed to care for a child, spouse, or parent who has a serious health condition; or when the employee is unable to perform the functions of his or her position because of his or her own serious health condition.

The provisions of this policy shall apply to all family and medical leaves of absences to the extent that such leaves are covered under other paid employment benefit plans or policies. For any part of the available duration of the FMLA leave to which the employee may be entitled under this policy, the employee must take the paid leave prior to taking unpaid leave. Such paid vacation or sick leave will run concurrently with FMLA leave.

Eligibility

To be eligible for family and/or medical leave under this policy an employee must have been employed for at least twelve months in total, and must have worked at least 1250 hours during the twelve month period preceding the commencement for the leave.

Exception: If the employee on leave is a salaried employee and is among the highest paid ten percent of Hospital employees within seventy-five miles, and keeping the job open for the employee would result in substantial economic injury to the Hospital, reinstatement to the employee on leave can be denied. In this situation, however, the employee will be given an opportunity to return to work prior to after notice of the Hospital’s intention to deny reinstatement.

The 12 month period during which leave may be taken is a “rolling” period measured backward from the date on which an employee uses any approved FMLA leave.

* Formerly Policy No. 102-31(c)

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Basic Regulations and Conditions for Family and/or Medical Leave

The Hospital will require all medical certification on approved United States Department of Labor Form WH-380, a copy of which is attached to this policy. The Hospital will require certification to support a claim for leave for an employee's own serious health condition or to care for a seriously ill child, spouse or parent. For the employee's own medical leave, the certification must include a statement that the employee is unable to perform the essential functions of his or her position. For leave to care for a seriously ill child, spouse or parent, the certification must include an estimate of the amount of time the employee is needed to provide care.

An employee must provide certification of the need for leave at the time the employee gives notice of the need for leave, or within five business days thereafter, or, in the case of unforeseen leave, within five business days after the leave commences. Employees working on 12 hour shifts must provide certification after being absent for more than three scheduled shifts. In any event, an employee's failure to provide appropriate certification within 15 days of the request for leave or the date the leave began may result in the requested leave being delayed or in the absence not being counted as FMLA leave.

In its discretion, the Hospital, at its own expense, may require a second medical opinion and periodic recertification at its own expense. If the first and second opinions differ, the Hospital, at its own expense, may require the binding opinion of a third health care provider, approved jointly by the Hospital and the employee.

If medically necessary for a serious health condition of the employee or his or her spouse, child or parent, leave may be taken on an intermittent or reduced leave schedule. If leave is requested on this basis, however, the Hospital may require the employee to transfer temporarily to an alternative position which better accommodates recurring periods of absence or a part-time schedule, provided that the position has equivalent pay and benefits.

Spouses who are both employed by the Hospital are entitled to a total of twelve weeks of leave (rather than twelve weeks each) for the birth or adoption of a child or for the care of a sick parent.

The Hospital requires that an employee substitute any accrued paid vacation leave for any part of the 12 week leave period. Furthermore, in the case of a serious illness of the employee, the Hospital requires that the employee use any accrued sick leave during the 12 week period before substituting accrued paid vacation leave. Any accrued paid vacation or sick leave taken will be considered part of the 12 week leave period and cannot be used to extend the family or medical leave period beyond 12 weeks.

Any benefit to which an employee is entitled pursuant to his or her employment with the Hospital including sick, vacation, and workers' compensation leave will run concurrently with the employee's family and/or medical leave. An employee on FMLA leave will not accrue additional benefits during the leave, but will be entitled to accrue hours of service during periods of paid leave.

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Notification and Reporting Requirements for Family and/or Medical Leave of Absence

When the need for leave is foreseeable, such as the birth or adoption of a child, or planned medical treatment, the employee must provide reasonable prior notice, and make efforts to schedule leave so as not to disrupt Hospital operations. In cases of illness, the employee will be required to report periodically on his or her leave status and intention to return to work. Failure to return to work on the day approved on the FMLA LOA form, will be considered voluntary resignation without notice. One week prior to return the employee is responsible for contacting the Hospital to make arrangements for his/her return. The Hospital may require a fitness for duty prior to an employee's return from FMLA leave.

Status of Employee Benefits During Leave of Absence

Any employee who is granted an approved leave of absence under this policy is advised to provide for the retention of his or her dependent group insurance coverage by arranging to pay the premium contributions during the period of unpaid absence.

In the event that an employee elects not to return to work upon completion of an approved unpaid leave of absence, the Hospital may recover from the employee the cost of any payments made to maintain the employee's coverage, unless the failure to return to work was for due to (i.) the continuation, recurrence or onset of a serious health condition of the employee or the employee's immediate family member; or (ii.) other circumstances beyond the employee's control. Benefit entitlements based upon length of service will be calculated as of the last paid work day prior to the start of the unpaid leave of absence.

Accruals for vacation, sick and holiday will not continue during the unpaid part of the FMLA LOA.

Employees who intend to work for another employer during the FMLA LOA must notify Human Resources in writing in advance for approval. Employees on FMLA LOA for their own serious health condition must use the leave for its intended purpose and are not permitted to work in any other employment comparable to their position with the Hospital or in any position requiring work outside their physician certified limitations during the pendency of their FMLA LOA.

Procedures

Completion of Request for Leave of Absence Form

A Request for Leave of Absence Form must be completed by the employee. This form should be completed in detail, signed by the employee, submitted to the immediate supervisor for proper approvals, and forwarded to the Human Resources Department. (Addendum - Request for Leave of Absence Form) If possible, the form should be submitted thirty (30) days in advance of the effective date of the leave. A leave request must be completed when an employee is out of work for more than one week.

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All requests for family and medical leaves of absence due to illness will include the following information attached to a completed Request for Leave of Absence sufficient medical certification stating:


- (i.) the date on which the serious health condition commenced;
- (ii.) the probable duration of the condition; and
- (iii.) the appropriate medical facts within the knowledge of the health care provider regarding the condition.

In addition, for purposes of leave to care for a child, spouse, or parent, the certificate should give an estimate of the amount of time that the employee is needed to provide such care. For purposes of leave for an employee's illness, the certificate must state that the employee is unable to perform the functions of his or her position. In the case of certification for intermittent leave or leave on a reduced leave schedule for planned medical treatment, the dates on which such treatment is expected to be given and the duration of such treatment must be stated.

Extension to a leave must be granted in advance of the last day of the approved leave. The employee is responsible for seeking an extension in time for approval. Extensions will not be granted when sought on the last day of the approved date.

EFFECTIVE DATE: August 1, 1993

APPROVED BY:



ED PIPER, Ph.D.
CEO

REVIEW DATE: 1/97, 8/99, 8/01, 7/05

REVISION DATE: 05/98, 7/05

Certification of Health Care Provider
(Family and Medical Leave Act of 1993)

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



(When completed, this form goes to the employee, **Not to the Department of Labor.**)

OMB No.: 1215-0181
Expires: 07/31/07

1. Employee's Name

2. Patient's Name (If different from employee)

3. Page 4 describes what is meant by a "serious health condition" under the Family and Medical Leave Act. Does the patient's condition¹ qualify under any of the categories described? If so, please check the applicable category.

(1) _____ (2) _____ (3) _____ (4) _____ (5) _____ (6) _____, or None of the above _____

4. 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:

5. a. State the approximate **date** the condition commenced, and the probable duration of the condition (and also the probable duration of the patient's present **incapacity**² if different):

b. Will it be necessary for the employee to take work only **intermittently** or to **work on a less than full schedule** as a result of the condition (including for treatment described in Item 6 below)?

If yes, give the probable duration:

c. If the condition is a **chronic condition** (condition #4) or **pregnancy**, state whether the patient is presently incapacitated² and the likely duration and frequency of **episodes of incapacity**²:

¹ Here and elsewhere on this form, the information sought relates **only** to the condition for which the employee is taking FMLA leave.

² "Incapacity," for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom.

6. a. If additional **treatments** will be required for the condition, provide an estimate of the probable number of such treatments.

If the patient will be absent from work or other daily activities because of **treatment** on an **intermittent** or **part-time** basis, also provide an estimate of the probable number of and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any:

b. If any of these treatments will be provided by **another provider of health services** (e.g., physical therapist), please state the nature of the treatments:

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

7. a. If medical leave is required for the employee's **absence from work** because of the **employee's own condition** (including absences due to pregnancy or a chronic condition), is the employee **unable to perform work** of any kind?

b. If able to perform some work, is the employee **unable to perform any one or more of the essential functions of the employee's job** (the employee or the employer should supply you with information about the essential job functions)?
If yes, please list the essential functions the employee is unable to perform:

c. If neither a. nor b. applies, is it necessary for the employee to be **absent from work for treatment**?

8. a. If leave is required to **care for a family member** of the employee with a serious health condition, **does the patient require assistance** for basic medical or personal needs or safety, or for transportation?

b. If no, would the employee's presence to provide **psychological comfort** be beneficial to the patient or assist in the patient's recovery?

c. If the patient will need care only **intermittently** or on a part-time basis, please indicate the probable **duration** of this need:

Signature of Health Care Provider

Type of Practice

Address

Telephone Number

Date

To be completed by the employee needing family leave to care for a family member:

State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule:

Employee Signature

Date

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 incapacity² or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

(a) A period of incapacity² of **more than three consecutive calendar days** (including any subsequent treatment or period of incapacity² relating to the same condition), that also involves:

(1) **Treatment³ 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

(2) **Treatment** by a health care provider on **at least one occasion** which results in a **regimen of continuing treatment⁴** 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:

(1) 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;

(2) Continues over an **extended period of time** (including recurring episodes of a single underlying condition); and

(3) May cause **episodic** rather than a continuing period of incapacity² (e.g., asthma, diabetes, epilepsy, etc.).

5. Permanent/Long-term Conditions Requiring Supervision

A period of **Incapacity²** 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 stages 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 Incapacity² 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).

Note: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

³ 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.

⁴ 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.

Public Burden Statement

We estimate that it will take an average of 20 minutes 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 of information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, Department of Labor, Room S-3502, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE; IT GOES TO THE EMPLOYEE.

slow County Hospital Authority

Where People Care

Request for Family and/or Medical Leave of Absence

Name: _____

Date: _____

Department: _____

Job Title: _____

This letter is to notify you of my need to take leave under the Family and Medical Leave Act . The reason is:

- Birth of my child , or the placement of a child with me for adoption or foster care.
- A serious health condition that prevents me from performing the essential functions of my job.
- A serious health condition affecting my _____ spouse, _____ child, _____ parent who requires my care.

I request my leave to begin on: _____

I expect to return to work on or about: _____

Employee's Signature _____ Date _____

Manager's Signature _____ Date: _____

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REQUEST RECEIVED IN THE HUMAN RESOURCES DEPARTMENT ON _____

To: _____ Date: _____
(Employee)

From: HUMAN RESOURCES DEPARTMENT

Except as explained below, you are entitled under the Family and Medical Leave Act of 1993 to take up to 12 weeks of accrued and unpaid leave in a 12-month period for the reason stated above. Your health insurance benefits must be maintained during any period of leave under the same conditions that would exist if you continued to work. Upon your return from approved leave, you must be reinstated to the same or equivalent position with the same rate of pay, benefits, terms and conditions of employment. If you do not return to work at the end of your FMLA leave for reasons other than (a) the continuation, recurrence or onset of a serious health condition that would entitle you to FMLA leave; or (b) other circumstances beyond your control , you may be required to reimburse us for our share of the health insurance premiums paid on your behalf during your FMLA leave.

Please read the following statements carefully:

1. You are are not eligible for leave under the FMLA.
2. The leave you requested will be counted against your annual FMLA leave entitlement (480 hours).
3. You are required to furnish medical certification that a serious health condition exists. This certification must be furnished by (Date) _____, which is within 15 days of your receipt of this notice of the requirement. Be advised that the actual commencement date of your leave may be delayed until such time as medical certification is submitted.
4. You are required to substitute any accrued paid vacation leave for any part of the 12-week leave period. In the case of an employee's personal, serious illness, you are required to use accrued sick time for any part of the 12-week leave period before substituting accrued vacation time. Accrued sick and vacation time used will be considered part of the FMLA leave period and cannot be used to extend the leave beyond 12 weeks.
5. You are responsible for health insurance premium payments during your leave. While you are on paid leave, premiums will continue to be deducted. However, if your leave is unpaid, you must make timely payment arrangements through the Human Resources Department in order to keep your health coverage in force.
6. You are required to present a medical release form to Employee Health before you can return to work. You may not resume your duties without first reporting to Employee Health with a medical clearance.
7. (A) You are are not a "key employee" as defined in 825.218 of the FMLA Regulations. Restoration of a "key employee" to employment may be denied following FMLA leave on the grounds that such restoration will cause substantial and grievous economic harm to the organization.
(B). We have have not determined that restoring you to employment at the conclusion of FMLA will cause substantial and grievous economic harm to the organization (Ref: 825.219 FMLA Regulations).
8. If the circumstances of your leave change and you are able to return to work sooner than the date indicated on this form, you are required to notify Employee Health at least two working days in advance of the date you are released to return to work.
9. If the serious health condition recurs, you are required to furnish a new certification before additional leave will be approved.