Family and Medical Leave Act (FMLA)

Leave of Absence Application – Caring for a FAMILY MEMBER with a Serious Health Condition

Note: Failure to fully complete this form could result in an initial denial of FMLA leave or delay in approval of FMLA Leave for the employee. *Where the need is foreseeable, an employee must provide at least 30 days advance notice of the need for leave, whenever possible. Otherwise leave applications must be submitted in full within 30 days of the start date of the leave (first missed shift).*

SECTION I: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section I before giving this form to your family member's medical provider to complete Section II. The FMLA permits CFCC to require that you submit a timely, complete, and sufficient medical certification to support a request for family leave due to the serious health condition of your family member. Your response is required to obtain or retain the benefit of FMLA protection. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. **You have 30 calendar days from the date your leave starts to return this form.**

IMPORTANT: In the case of an incomplete, vague or non-responsive medical certification, the HR Team may notify you in writing of the additional information/clarification that is necessary to complete the certification. **You then have fifteen (15) calendar days to provide the requested information.** If you fail to submit a complete and sufficient certification despite the opportunity to correct it, we may deny the FMLA leave.

Employee Name:	**Date:** **Phone:**
Employee ID#:	**Department:**
Position:	**Supervisor:**
Classification: ☐ **Faculty** ☐ **Staff**	**Contract Length:** ☐ **12-Months** ☐ **9-Months** ☐ **Other**
Regular Work Schedule:	**Average Hours Per Week:**
Full Name of Family Member:	**Care Needed for Family Member:**

FAMILY MEDICAL LEAVE REQUEST FOR:

☐ **Traditional Medical Leave** *(Continuous absence of four or more consecutive days off)*
This leave is for: ☐ Birth of my child OR ☐ Placement of a child with me for adoption or foster care OR
☐ A serious health condition affecting my ___ spouse, ___ child (up to age 18), ___ parent, for whom I will provide care

☐ **Intermittent Leave** *(occasional time off over a period determined by a physician certification, cannot exceed 3 consecutive scheduled work days)* to care for my ___ spouse, ___ child (up to age 18), ___ parent, for whom I will provide care.

☐ **Military Caregiver FMLA** *(may be approved for Traditional or Intermittent)* – If this is selected, please attach a copy of the military orders as supporting documentation (Section II Healthcare Certification may or may not be applicable).

Requested Leave Start Date:_____ **I plan to Return to Work on**: _____

***Sick Leave** – *You are required to use accrued Sick Time while on FMLA.*

You have a right under the FMLA for up to 12 weeks of unpaid leave in a 12 month period for the reasons listed above if you have completed one year of employment **and** have worked 1,250 hours in the prior 12 month period. Also, 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, terms and conditions of employment on your return from leave. If your leave exceeds 12 weeks, and you are on leave without pay status, you may be responsible for paying the full cost of your benefits (both employee and employer coverage). At that time, you may also be eligible for Short-Term Disability, but that does not offer job protection like the FMLA.

_____ _____

Employee's Signature ***Date***

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SECTION II: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient listed in Section I has requested leave under 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 do not provide information about genetic test, genetic services or the manifestation of disease or disorder in the employee's family members. Please be sure to sign & date the form on the last page. PLEASE PRINT CLEARLY

Patient Name: _____

Doctor's/Provider's Name: _____

Business address: _____

Type of practice/medical specialty: _____

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

PART A: MEDICAL FACTS (PLEASE PRINT CLEARLY FOR TIMELY PROCESSING)

1. Approximate date condition commenced: _____ Probable duration of condition:_____

   Date(s) you treated the patient for 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 Yes, dates of admission: _____

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

   ☐ No ☐ Yes

   Was medication prescribed (excluding over-the-counter medication)?

   ☐ No ☐ Yes

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?

   ☐ No ☐ Yes If Yes, state the nature of such treatments and expected duration of treatment:

   _____

2. Is the medical condition pregnancy?

   ☐ No ☐ Yes If Yes, expected delivery date: _____

3. **REQUIRED:** Describe the relevant medical facts, 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: 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

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

   ☐ No ☐ Yes If Yes, estimate the date range for the period of incapacity: _____

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2. During this time, will the patient need care?
☐ No ☐ Yes If yes, explain the care needed by the patient and why such care is medically necessary:
_____

_____

3. Will the patient require follow-up treatments, including any time for recovery?
☐ No ☐ Yes If 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 care needed by the patient and why such care is medically necessary: _____

_____

4. 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;

How many days per week?_____ From (start date): _____ Through (end date):_____

5. 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). **This information is REQUIRED and is only an "estimate" to determine if the specifics of the need fall under the criteria of Intermittent FMLA.**

MUST BE COMPLETED: Frequency: _____ times per _____ week(s) OR _____ month(s)

Duration: _____ hours OR _____ day(s) per episode

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

_____

_____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER. Print Clearly.

_____

_____

_____

_____ _____

Signature of Health Care Provider ***Date***

Submit all completed pages 1-3:
Fax to: **910-362-7259;** OR scan and e-mail to: **HR@CFCC.edu**;
OR mail to: CFCC Human Resources, 411 North Front St., Suite U-299, Wilmington, NC 28401.
For questions call HR at **910-362-7312**.