Family Medical Leave Act (FMLA)

no tricks...maybe treats

WHAT IS FMLA?

FMLA entitles eligible employees to take unpaid, job-protected leave for specified family and medical reasons with continuation of group health insurance coverage under the same terms and conditions as if the employee had not taken leave.

WHO IS ELIGIBLE?

An eligible employee is one who:

- Works for Greene County in a part-time or full-time position
- Has worked for Greene County for at least 12 months
- Has worked at least 1,250 hours during the 12 month period immediately preceding the leave

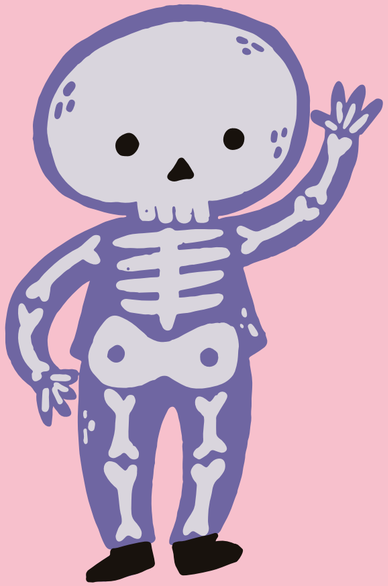
QUALIFYING LEAVE REASONS

- Birth and bonding of a son/daughter or placement of a son/daughter with you for adoption or foster care.
- To care for a spouse, son, daughter, or parent who has a serious health condition;
- For a serious health condition that makes you unable to perform the essential functions of your job.

SERIOUS HEALTH CONDITION

Illness, injury, impairment or physical or mental condition involving:

- Inpatient Care: Overnight stay in medical facility & any related treatment
- Continuing treatment by healthcare provider chronic conditions, pregnancy, permanent/long-term conditions, etc.



FAMILY MEMBER WITH SERIOUS HEALTH CONDITION

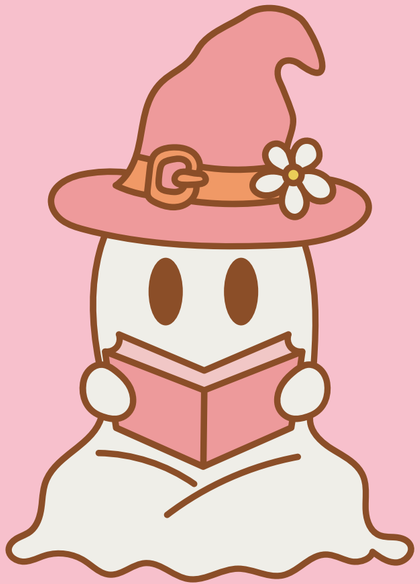
Parent: A biological, adoptive, step or foster father or mother, or loco parentis. Does not include in-laws.

Spouse: A husband or wife as defined or recognized in the state where the employee was married

Son or Daughter: a biological, adopted, or foster child, a stepchild, a legal ward, or a child of a person standing in loco parentis who is either under 18 years of age, or 18 or older and incapable of self-care because of a mental or physical disability.

BIRTH, ADOPTION OR PLACEMENT OF A CHILD

- Both parents are entitled to FMLA leave for the birth or placement of the child and/or to be with the child after the birth or adoption
- Employees may take FMLA leave before the actual birth, place mentor adoption
- Leave must be completed by the end of the 12-month period beginning on the date of the birth or placement



FMLA - UNPAID LEAVE

FMLA is not paid leave, but you can use your sick, vacation, personal and comp time to cover your leave.

You may also apply for Shared Leave.

SHARED LEAVE PROGRAM

- Once an employee has exhausted all of their accrued vacation, sick, personal days and compensatory time, they may apply for shared leave.
- The employee must be out on an approved FMLA leave.
- Shared leave must be approved by the Office Head or Elected Official and is NOT guaranteed.

THE FORMS

Confidential *Form A*
County of Greene, MO

FAMILY AND MEDICAL LEAVE ACT ("FMLA") REQUEST

Request must be made, if practicable, at least 30 days prior to the date of the requested leave is to begin.

Your completion of this Form means *only* that you have requested FMLA it *does not* mean that you are eligible for leave under the FMLA or that your request for leave has been approved.

Employee Name:_____ Employee No. _____

Department:_____ Title:_____Work Phone:_____

Home Email Address: _____Home Phone:_____

Supervisor:_____ Supervisor Phone:_____

Have you taken FMLA in the past 12 months? Yes ____ No ____

MY REQUEST FOR FMLA IS FOR ONE OF THE FOLLOWING REASONS

❑ **Birth of my child** (submit birth certificate or other proof of birth, if requested).
Expected/Actual Date of Birth:_____ Expected/Actual Start Date:_____ Expected Return Date:_____

❑ **Placement of child with me for adoption or foster care** (submit copy of legal record of placement, if requested).
Date of Placement:_____Leave Start Date:_____Expected Return Date:_____

❑ **Care for an immediate family member (__spouse __child __parent) with a serious health condition** (submit requested medical certification within 15 days, if requested).
Leave Start Date:_____ Expected Return Date:_____

❑ **My serious health condition** (submit requested medical certification within 15 days, if requested).
Leave Start Date:_____ Expected Return Date:_____

❑ **Military Leave** (submit requested medical certification within 15 days, if requested).
___ **Qualifying Exigency Leave** (__spouse __child __parent)
___ **Serious Injury or Illness of a Current Servicemember for Military Family Leave** (__spouse __child __parent __next of kin)
___ **Serious Injury or illness of a Veteran for Military Family Leave** (__spouse __child __parent __next of kin)
Leave Start Date:_____ Expected Return Date:_____

❑ **Proposed intermittent schedule, if applicable** (submit requested medical certification within 15 days). (Subject to management approval.)

I UNDERSTAND AND AGREE TO ALL OF THE FOLLOWING

- I have worked for Greene County for at least 12 months and 1250 hours in the previous 12 months.
- If it is determined the reason for any paid or unpaid leave time qualifies under FMLA, I will be required to use available paid sick, vacation, compensatory time or shared leave, if applicable, as part of my 12-week leave.
- This FMLA designated leave, if any, will count towards my entitlement of 12 weeks of FMLA leave within a 12-month period.
- Greene County may require medical certification, and if so, I will provide it within 15 days of the request.
- Upon my return from FMLA, I am entitled to restoration of my same or a substantially equivalent job.
- I may be required to provide a fitness-for-duty document from my health care provider prior to returning to work.
- My health care providers may provide information to Greene County for purposes of determining my eligibility for FMLA and determining any light duty restrictions.
- After 12 weeks of leave, if I do not return to work or contact my supervisor on or before my expected return, Greene County may assume that I have abandoned my job.
- If I fail to return to work after my leave for reasons other than my serious health condition, the serious health condition of a family member, or circumstances beyond my control, I will be required to reimburse the medical insurance premiums that Greene County paid while I was on leave.
- **By completing this Form, I understand that I have requested FMLA and that my completion of this Form *does not* mean that I am eligible for leave under the FMLA or that my request for leave has been approved. I will be notified separately of my eligibility for an approval of my request for leave.**

Signature of Employee _____ Date _____

Supervisor's Signature _____ Date _____

Certification of Health Care Provider for Employee's Serious Health Condition under the Family and Medical Leave Act

U.S. Department of Labor Wage and Hour Division

WHD WAGE AND HOUR DIVISION

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR. RETURN TO THE PATIENT.

OMB Control Number: 1235-0003
Expires: 6/30/2023

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. 29 U.S.C. §§ 2613, 2614(c)(3); 29 C.F.R. § 825.305. The employer must give the employee **at least 15 calendar days** to provide the certification. If the employee fails to provide complete and sufficient medical certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

SECTION I – EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, this form asks the health care provider for the information necessary for a complete and sufficient medical certification, which is set out at 29 C.F.R. § 825.306. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308.** Additionally, you **may not** request a certification for FMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care.

Employers must generally maintain records and documents relating to medical information, medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

(1) Employee name: _____
First Middle Last

(2) Employer name: Greene County- Fax 417-868-4811 Date: _____ *(mm/dd/yyyy)*
(List date certification requested)

(3) The medical certification must be returned by _____ *(mm/dd/yyyy)*
(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee's diligent, good faith efforts.)

(4) Employee's job title: _____ Job description (☐ is / ☐ is not) attached.
Employee's regular work schedule: _____
Statement of the employee's essential job functions: _____

(The essential functions of the employee's position are determined with reference to the position the employee held at the time the employee notified the employer of the need for leave or the leave started, whichever is earlier.)

SECTION II - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form. Your patient has requested leave under the FMLA. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of the employee. For FMLA purposes, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves *inpatient care* or *continuing treatment by a health care provider*. For more information about the definition of serious health condition under the FMLA, see the chart on page 4.

You may, but are **not required** to, provide other appropriate medical facts including symptoms or diagnosis of continuing treatment such as the use of specialized equipment. Please note that some [illegible] disclosure of private medical information about the patient's serious health condition [illegible] course of treatment.

Please contact Kami Johnson for the necessary paperwork.

THE STATS

FMLA Type	2017	2018	2019	2020	2021	2022	2023
Birth of a Child	7	5	6	13	10	17	18
Bonding with Child	12	20	15	12	22	16	15
Health Condition- Self	38	33	47	56	55	48	43
Health Condition- Spouse	2	5	2	2	8	7	6
Health Condition- Child	5	3	4	0	2	2	3
Health Condition- Parent	3	4	2	0	3	6	3
Placement of a Child	0	0	0	0	1	1	0
Totals:	**67**	**70**	**76**	**83**	**101**	**97**	**88**

QUESTIONS?