

Appendix D to Part 825 - Prototype Notice: Employer Response to Employee Request for FMLA Leave (Form WH-381)

Employer Response to Employee Request for Family or Medical Leave
(Optional use form - see 29 CFR § 825.301)

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



(Family and Medical Leave Act of 1993)

(Date)

TO: _____
(Employee's Name)

FROM: _____
(Name of appropriate employer representative)

SUBJECT: Request for Family/Medical Leave

On _____, you notified us of your need to take family/medical leave due to:

- the birth of a child, or the placement of a child with you for adoption or foster care; or
- a serious health condition that makes you unable to perform the essential functions of your job; or
- a serious health condition affecting your spouse, child, parent, for which you are needed to provide care.

You notified us that you need this leave beginning on _____ and that you expect leave to continue until on or about _____.

Except as explained below, 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. Also, your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work, and you must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from leave. If you 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 you to FMLA leave; or (2) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave.

This is to inform you that: *(check appropriate boxes; explain where indicated)*

1. You are eligible not eligible for leave under the FMLA.
2. The requested leave will will not be counted against your annual FMLA leave entitlement.
3. You will will not be required to furnish medical certification of a serious health condition. If required, you must furnish certification by _____ *(insert date)* (must be at least 15 days after you are notified of this requirement) or we may delay the commencement of your leave until the certification is submitted.

4. You may elect to substitute accrued paid leave for unpaid FMLA leave. We will will not require that you substitute accrued paid leave for unpaid FMLA leave. If paid leave will be used, the following conditions will apply: *(Explain)*
- 5(a). If you normally pay a portion of the premiums for your health insurance, these payments will continue during the period of FMLA leave. Arrangements for payment have been discussed with you and it is agreed that you will make premium payments as follows: *(Set forth dates, e.g., the 10th of each month, or pay periods, etc. that specifically cover the agreement with the employee.)*
- (b) You have a minimum 30-day *(or, indicate longer period, if applicable)* grace period in which to make premium payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse, or, at our option, we may pay your share of the premiums during FMLA leave, and recover these payments from you upon your return to work. We will will not pay your share of health insurance premiums while you are on leave.
- (c) We will will not do the same with other benefits (e.g., life insurance, disability insurance, etc.) while you are on FMLA leave. If we do pay your premiums for other benefits, when you return from leave you will will not be expected to reimburse us for the payments made on your behalf.
6. You will will not be required to present a fitness-for-duty certificate prior to being restored to employment. If such certification is required but not received, your return to work may be delayed until certification is provided.
- 7(a). You are are not a "key employee" as described in § 825.218 of the FMLA regulations. If you are a "key employee," restoration to employment may be denied following FMLA leave on the grounds that such restoration will cause substantial and grievous economic injury to us.
- (b) We have have not determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic harm to us. *(Explain (a) and/or (b) below. See § 825.219 of the FMLA regulations.)*
8. While on leave, you will will not be required to furnish us with periodic reports every _____ *(indicate interval of periodic reports, as appropriate for the particular leave situation)* of your status and intent to return to work *(see § 825.309 of the FMLA regulations)*. If the circumstances of your leave change and you are able to return to work earlier than the date indicated on the reverse side of this form, you will will not be required to notify us at least two work days prior to the date you intend to report for work.
9. You will will not be required to furnish recertification relating to a serious health condition. *(Explain below, if necessary), including the interval between certifications as prescribed in § 825.308 of the FMLA regulations.)*

FAIR EMPLOYMENT & HOUSING COMMISSION
CERTIFICATION OF HEALTH CARE PROVIDER
(California Family Rights Act of 1993 (CFRA))

1. Employee's Name: _____

2. Patient's Name (If other than employee): _____

3. Date medical condition or need for treatment commenced
[NOTE: THE HEALTH CARE PROVIDER IS NOT TO DISCLOSE THE UNDERLYING DIAGNOSIS WITHOUT THE CONSENT OF THE PATIENT]:

4. Probable duration of medical condition or need for treatment: _____

5. The attached sheet describes what is meant by a "serious health condition" under both the federal Family and Medical Leave Act (FMLA) and the California Family Rights Act (CFRA). Does the patient's condition qualify under any of the categories described? If so, please check the appropriate category.

(1) (2) (3) (4) (5) (6)

6. If the certification is for the serious health condition of the employee, please answer the following:

Yes No

 Is employee able to perform work of any kind?
(If "No", skip next question.)

 Is employee unable to perform any one or more of the essential functions of employee's position? (Answer after reviewing statement from employer of essential functions of employee's position, or, if none provided, after discussing with employee.)

7. If the certification is for the care of the employee's family member, please answer the following:

Yes No

 Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation?

 After review of the employee's signed statement (See Item 10 below), does the condition warrant the participation of the employee? (This participation may include psychological comfort and/or arranging for third-party care for the family member.)

8. Estimate the period of time care needed or during which the employee's presence would be beneficial:

9. Please answer the following question only if the employee is asking for intermittent leave or a reduced work schedule.

Yes No

 Is it medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal work schedule in order to deal with the serious health condition of the employee or family member?

 If the answer to 9. is yes, please indicate the estimated number of doctor's visits, and/or estimated duration of medical treatment, either by the health care practitioner or another provider of health services, upon referral from the health care provider. _____

ITEM 10 IS TO BE COMPLETED BY THE EMPLOYEE NEEDING FAMILY LEAVE.
****TO BE PROVIDED TO THE HEALTH CARE PROVIDER UNDER SEPARATE COVER.

10. When family care leave is needed to care for a seriously-ill family member, the employee shall state the care he or she will provide and 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 work schedule:

11. Signature of health care provider:

Date: _____

12. Signature of Employee:

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 incapacity or subsequent treatment in connection with or consequent to such inpatient care.
2. Absence Plus Treatment
 - (a) 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:
 - (1) 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
 - (2) 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 [NOTE: An employee's own incapacity due to pregnancy is covered as a serious health condition under FMLA but not under CFRA.]
Any period of incapacity due to pregnancy, or for prenatal care.
4. Chronic Conditions Requiring Treatment
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 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 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 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), kidney disease (dialysis).