Personnel Policy Bulletin

Number: 2009-1

Lancaster County

Date: February , 2009

Reference:	Title:
Family and Medical Leave Act of 1993 (FMLA) and 29 C.F.R. Part 825 Supercedes Personnel Policy Bulletin 2002-3	FAMILY AND MEDICAL LEAVE ACT

1. Purpose. The purpose of this policy is to define Lancaster County's procedure with regard to family and medical leave in accordance with the provisions of the Family and Medical Leave Act (FMLA) of 1993 and the federal regulations pertaining thereto.

2. Eligibility. Employees who have been employed for at least one year, and for at least 1,250 hours during the preceding 12-month period, are eligible for a total of 12 work weeks of FMLA leave per twelve month period.

3. Twelve-Month Period. The twelve month period for taking leave shall be measured forward from the first date an employee takes FMLA leave and shall expire twelve months thereafter.

4. Reasons for Leave. The 12 weeks of FMLA leave may be granted for the following reasons:

    a. For the birth and care of a newborn child of the employee;

    b. For placement of a child with the employee for adoption or foster care;

    c. To care for an immediate family member (spouse, child or parent) who has a serious health condition; or

    d. To take personal medical leave when the employee is unable to work because of a serious health condition.

    The entitlement to leave for the birth or placement of a child for adoption or foster care will expire 12 months from the date of the birth or placement.

5. General Information and Affect on County Paid Leaves.

    FMLA leave will be counted concurrently with other paid leaves (sick leave, personal holidays, vacation, injury leave, workers' compensation leave and/or catastrophic leave). Therefore, the 12 weeks of leave will be paid to the extent the employee has other paid leaves available. After all applicable paid leaves are exhausted, any remaining FMLA leave will be unpaid.

    In those cases where a husband and wife are both employed by the County and both are eligible for FMLA leave, they are limited to a combined total of 12 work weeks of leave during any 12-month period if the leave is taken: (1) for birth of the employee's child or to care for the child after birth; (2) for placement of a son or daughter with the employees for adoption or foster care, or to care for the child after placement; or (3) to

care for a parent with a serious health condition. If one spouse is ineligible for FMLA leave, the other spouse would be entitled to a full 12 weeks of FMLA leave. If the husband and wife both use a portion of the total 12 week FMLA leave entitlement for one of the purposes enumerated above, the husband and wife would each be entitled to the difference between the amount he or she has taken individually and 12 weeks of FMLA leave for a purpose other than those enumerated above. For example, if each spouse took 6 weeks of leave for the birth of a child, each could later use an additional 6 weeks due to a personal illness, to care for a sick child or to care for the other spouse. (See, 29 C.F.R. 825.202).

6. Intermittent/Reduced Schedule Leave. FMLA leave may be taken on an intermittent basis or to work a reduced schedule when (1) medically necessary to care for a seriously ill family member; or (2) because of the employee's own serious health condition. Intermittent or reduced schedule leave may be taken to care for a newborn or newly placed adopted or foster care child *only* with the County's approval. Only the amount of leave actually taken while on intermittent/reduced schedule leave may be charged as FMLA leave. Employees needing intermittent/reduced schedule leave for foreseeable medical treatment must work with their employers to schedule the leave so as not to unduly disrupt the employer's operations, subject to the approval of the employee's health care provider.

7. Serious Health Condition Defined. A serious health condition means an illness, injury, impairment, or physical or mental condition that involves either: (See, 29 C.F.R. 825.114 and 825.800).

   (1) any period of incapacity or treatment connected with inpatient care (i.e. an overnight stay) in a hospital, hospice, or residential medical-care facility, and any period of incapacity or subsequent treatment in connection with such inpatient care; or

   (2) continuing treatment by a health care provider which includes any period of incapacity (i.e. inability to work, attend school or perform other regular daily activities) due to:

   A. A health condition lasting more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also includes: (1) treatment two or more times, within 30 days of the first day of incapacity, unless extenuating circumstances exist, by or under the supervision of a health care provider; or (2) one treatment by a health care provider with a continuing regimen or treatment;

(i) The requirement in paragraphs (A)(1) and (2) of this section for treatment by a health care provider means an in-person visit to a health care provider. The first (or only) in person treatment visit must take place within seven days of the first day of incapacity; or

B. Pregnancy or prenatal care. A visit to the health care provider is not necessary for each absence; or

C. A chronic serious health condition which continues over an extended period of time, requires periodic visits (defined as at least twice a year) to a health care provider, and may involve occasional episodes of incapacity (e.g., asthma, diabetes). A visit to a health care provider is not necessary for each absence; or

D. A permanent or long-term condition for which treatment may not be effective (e.g., Alzheimer's, a severe stroke, terminal cancer). Only supervision by a health care provider is required rather than active treatment; or

E. Any absence to receive multiple treatments for restorative surgery or for a condition which would likely result in a period of incapacity of more than three days if not treated (e.g., chemotherapy or radiation treatments for cancer).

8. Health Care Provider Defined. Health care provider means (1) doctors of medicine or osteopathy authorized to practice medicine or surgery by the state in which the doctors practice; or (2) podiatrists, dentists, clinical psychologists, optometrists and chiropractors authorized to practice, and performing within the scope of their practice, under state law; or (3) nurse practitioners, nurse-midwives and clinical social workers authorized to practice, and performing within the scope of their practice, as defined under state law; or (4) Christian Science practitioners listed with the First Church of Christ, Scientist in Boston, Massachusetts; or (5) any health care provider recognized by the employer's group health care plan manager. (See, 29 C.F.R. 825.118).

9. Application for Leave. In all cases, an employee requesting leave must complete the attached "Application for Family or Medical Leave" and return it to the employee's department head for transmittal to the Personnel Director in the City/County Personnel Department. The completed application must state the reason for the leave and the starting and ending dates of the leave. The response to the request for family or

medical leave shall be provided to the employee within five business days after the employee gives notice of the need for leave.

10. Notice of Leave. An employee intending to take family or medical leave because of an expected birth or placement, or because of a planned medical treatment, must submit an application for leave at least 30 days before the leave is to begin. If leave is to begin within 30 days, an employee must give notice to his or her department head and to the City/County Personnel Department as soon as the necessity for the leave arises.

11. Medical Certification for Leave. An employee requesting leave based on a serious health condition of the employee or the employee's spouse, child or parent must have his/her health care provider complete a "Medical Certification Statement" form. Copies of the "Medical Certification Statement" forms may be obtained through the Personnel Department. The certification must state the date on which the health condition commenced, the probable duration of the condition, and the appropriate medical facts regarding the condition. If the employee is needed to care for a spouse, child or parent, the certification must so state along with an estimate of the amount of time the employee will be needed. If the employee has a serious health condition, the certification must state that the employee cannot perform the functions of his or her job.

    The employee shall have 15 calendar days to provide the completed Medical Certification Form. Failure to provide the Medical Certification Form within 15 calendar days of the request for leave may result in denial of FMLA leave. In the event the medical certification is incomplete or insufficient (vague, ambiguous, or non-responsive), the employee shall have 7 calendar days to cure any deficiency. Failure to cure the deficiencies may result in denial of FMLA Leave.

    The County may require employees to provide subsequent recertifications of the employee's continued need for leave, but not more often than every 30 days. The County may require, at its own expense, a second opinion from an independent health care provider. If there is a conflict between the two medical opinions, a third and binding medical opinion may be obtained at the County's expense.

12. Benefits Coverage During Leave. During a period of FMLA leave, an employee will be retained on the County's health and dental care plans under the same conditions that applied before leave was commenced. To continue health and dental coverage, the employee must continue to make any contributions that he or she made to the plan before taking leave. Failure of the employee to pay his or her share of the health or dental care monthly cost may result in loss of coverage.

If the employee fails to return to work after expiration of the leave, the employee will be required to reimburse Lancaster County for payment of health/dental care monthly costs incurred during the FMLA leave, unless the reason the employee fails to return is the presence of the serious health condition which prevents the employee from performing his or her job, or other circumstances beyond the control of the employee. (See, 29 C.F.R. 825.213(a)).

An employee is not entitled to any seniority or employee benefits that would have accrued if not for the taking of the leave. An employee who takes FMLA leave will not lose seniority or employment benefits that accrued before the date leave began. (See, 29 C.F.R. 825.215(d)(2)). However, an employee's seniority will be lost relative to other employees as their seniority accrues.

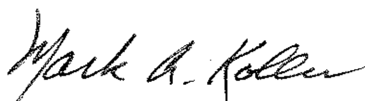
13. Restoration to Employment. Unless the employee is a "key employee", as defined by the Act, at the end of the FMLA leave, an employee will be restored to his or her old position or to a position with equivalent pay, benefits, and other terms and conditions of employment. Lancaster County cannot guarantee that an employee will be returned to his or her original job. A determination as to whether a position is an "equivalent position" will be made by Lancaster County. (See, 29 C.F.R. 825.214 and 825.215). A "key employee" is a salaried FMLA-eligible employee who is among the highest paid ten percent of all the employees employed by Lancaster County. (See, C.F.R. 825.217).

14. Return from Leave. An employee must complete a "Notice of Intention to Return to Work" form before he or she can be returned to active status. These forms may be obtained from the County Personnel Department. If an employee wishes to return to work prior to the expiration of a FMLA leave of absence, notification must be given to the employee's department head at least 2 working days prior to the employee's planned return.

15. Failure to Return from Leave. The failure of an employee to return to work upon the expiration of FMLA leave will be considered a resignation unless an extension is granted. An employee who has requested less than 12 weeks of FMLA leave may request an extension of FMLA leave by submitting a written request to the employee's department head setting forth the reasons for the extension, along with a current "Medical Certification Statement" form. This written request should be made as soon as the employee realizes that he or she will not be able to return at the expiration of the leave. In no circumstances will an extension beyond the 12-week period authorized pursuant to the FMLA be granted. However, Lancaster County will review business considerations and the individual circumstances involved to determine if additional

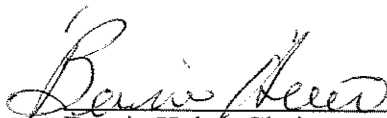
unpaid leave is available pursuant to the Americans with Disabilities Act of 1990, as amended.

16. Unlawful Acts. It is unlawful for any employer to interfere with, restrain, or deny the exercise of any right provided by the FMLA. It is also unlawful for an employer to discharge or discriminate against any individual for opposing any practice, or because of involvement in any proceeding related to the FMLA.



Mark A. Koller, Personnel Director

2-12-09
Date



Bernie Heier, Chairman
Board of County Commissioners

February 10, 2009
Date

COFMLA-2009-1.wpd

LANCASTER COUNTY
APPLICATION FOR FAMILY OR MEDICAL LEAVE

Name of Employee: ____
(Please Print Legibly)

Oracle Person Number: ________________________

Department: ____

Home Address: Street: ____

City: ___________________________ State: ____________ Zip: ___________

Start Date of Anticipated Leave: ____

Expected Date of Return to Work: ____

Reason for Leave (Mark One):

☐ A serious health condition that renders me unable to perform the essential functions of my job; or

☐ A serious health condition affecting my ☐ spouse, ☐ child, or ☐ parent for which I am needed to provide care; or

☐ The birth of a child, or the placement of a child with me for adoption or foster care.

Note: All leave requests must be accompanied by a verifying medical certification from a health care provider.

*I hereby authorize Lancaster County to contact my health care provider to verify the reason for my requested leave, or to authenticate and/or clarify any information contained in my medical certification statement concerning my requested family and medical leave.

*I understand that to maintain my health insurance benefits during this leave I must continue to pay my share of my health insurance as it comes due.

*I understand that failure to return to work at the end of my leave period may be treated as a resignation unless an extension has been agreed upon and approved in writing by Lancaster County.

Employee's Signature: ________________________________ Date: _______________

Approved By:

____ ________________________

Department Head or Designee Date

____ ________________________

Human Resources Director Date

Person # : ___________
Doc: MED

FAMILY & MEDICAL LEAVE
MEDICAL CERTIFICATION STATEMENT
(EMPLOYEE'S Own Serious Health Condition)
TO BE COMPLETED BY HEALTH CARE PROVIDER

HEALTH CARE PROVIDER: Please keep in mind this form is to be completed to reflect the period of time the employee is to be off work. Answer, fully and completely, all applicable parts. 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.

The Genetic Information Nondiscrimination Act of 2008 ("GINA") prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information,"as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

1. Name of employee: ____

2. Date condition began: _______________________ Or Date of Surgery: ____________________

3. Expected date of return to work due to this condition: ________________

   Or next scheduled appointment: _________________

4. a. The opposite page describes what is meant by a "serious health condition" under the Family and Medical Leave Act. Does the employee's condition qualify under any of the categories described. If so, please check the appropriate category.

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

   b. If you checked #2 in (a) above – Dates you have treated the patient for this condition:

   DATE: ____________________ DATE: ____________________

   DATE: ____________________ DATE: ____________________

5. Describe the medical facts that support your certification, including a brief statement as to how the medical facts meet the criteria of the category indicated above.

____

____

   a. If the condition is for pregnancy, please indicate expected due date for delivery: _____________

   b. If the condition is for pregnancy, please indicate how long **after** delivery the employee needs to remain off work: ____

6. Describe the regimen of treatment to be prescribed (Indicate the number of visits, general nature and duration of treatment, including referral to other provider for health services.)

   a. By primary health care provider: ____

   b. By another health care provider, if referred by you: __________________________________

FAMILY & MEDICAL LEAVE MEDICAL CERTIFICATION STATEMENT
(EMPLOYEE'S Own Serious Health Condition)
to Be Completed by Health Care Provider

7. Describe the employee's ability to work for this serious health condition. **(Answer the following after reviewing the essential functions of the employee's position, or, if none provided, after discussing with the employee.)**

   a. If medical leave is required for the employee's absence from work because of the employee's own serious health condition, is the employee able to work during this serious health condition?
   ______ YES ______ NO

   b. If able to perform some work, is the employee able to perform all of the essential functions of the employee's job?
   ______ YES ______ NO If no, list the essential functions the employee is *unable* to perform.

____

____

8. a. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced or intermittent schedule because of the employee's medical condition? ______ YES ______ NO

   b. Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period: ____________________________

   c. Estimate the part-time or reduced work schedule the employee needs, if any:
   _________ Hour(s) per day; ________ Days per week from ________ through _____________

   d. If the medical condition will cause episodic flare-ups preventing the employee from performing his/her job duties, estimate the following:

   Frequency: ______ times per ______ week(s) ______ month(s)

   Duration: ______ hours or ______ day(s) per episode

   e. If intermittent schedule is recommended, estimate the period of time needed for intermittent leave:

   From ____________________ through _____________________
   (Date) (Date)

____	____________________________________
Printed Name	Type of Practice
____	____________________________________
Signature of Health Care Provider Date	Telephone Number

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 [FN1] or subsequent treatment in connection with or consequent to such inpatient care.

2. **Absence Plus Treatment** A period of incapacity [FN1] of more than three consecutive calendar days (including any subsequent treatment or period of incapacity [FN1] relating to the same condition), that also involves:

(1) Treatment [FN2] two or more times by a health care provider, within 30 days of the first day of incapacity, unless extenuating circumstances exist, 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 [FN3] under the supervision of the health care provider. (i) The requirements of paragraphs 2.(1) and 2.(2) of this section for treatment by a health care provider means an in person visit to a health care provider. The first (or only) in person treatment visit must take place within seven days of the first day of incapacity.

3. **Birth of a Child/Pregnancy** Any period of incapacity due to pregnancy, birth of a child, or placement of a child for adoption or foster care, or for prenatal care.

4. **Chronic Conditions Requiring Treatments** A chronic condition which:

(1) Requires periodic visits (defined as at least twice a year) 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 [FN1] (e.g., asthma, diabetes, epilepsy, etc.).

5. **Permanent/Long-term Conditions Requiring Supervision** A period of incapacity [FN1] 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 [FN1] 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).

[FN1] "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.

[FN2] 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.

[FN3] 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.

Person # : ___________
Doc: PERS

FAMILY & MEDICAL LEAVE — MEDICAL CERTIFICATION STATEMENT
(FAMILY MEMBER'S Serious Health Condition)
TO BE COMPLETED BY HEALTH CARE PROVIDER

INSTRUCTIONS TO THE HEALTH CARE PROVIDER: Answer, fully and completely, all applicable parts below. 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 patient needs leave.

1. Name of employee: ______________________________

2. Name of patient: First ____________________ Last ____________________

   Relation to employee: ______________________________

3. Date condition began: ______________________________

4. Expected duration of the condition: ______________________________

5. Is the medical condition pregnancy? ______ NO ______ YES If so, expected delivery date: ____________________

6. a. The opposite page describes what is meant by a "serious health condition" under the Family and Medical Leave Act. 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) _____, or None of the above _____.

   b. If you checked #2 in (a) above – Dates you have treated the patient for this condition:

   DATE: ____________________ DATE: ____________________ DATE: ____________________

7. Describe the medical facts that support your certification, including a brief statement as to how the medical facts meet the criteria of the category indicated above. ______________________________

   ____

   ____

8. Does the patient require assistance for basic medical or personal needs or safety, or for transportation? _____ NO ____ YES

   If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery? ______ NO ______ YES

9. Estimate the period of time care is needed or the employee's presence would be beneficial. ____________________

   ____

10. 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; _________ days per week; from ________________ through ________________.

11. Explain the care needed by the patient, and why such care is medically necessary: ____________________

    ____

____
Printed Name of Health Care Provider

____
Type of Practice

____
Signature of Health Care Provider

____
Telephone Number

____
Date

____
Address

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. (Attach additional pages if necessary.)

____
Employee's Signature

____
Date

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1. **Hospital Care** Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity [FN1] or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment A period of incapacity [FN1] of more than three consecutive calendar days (including any subsequent treatment or period of incapacity [FN1] relating to the same condition), that also involves:

(1) Treatment [FN2] two or more times by a health care provider, within 30 days of the first day of incapacity, unless extenuating circumstances exist, 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 [FN3] under the supervision of the health care provider. (i) The requirements of paragraphs 2.(1) and 2.(2) of this section for treatment by a health care provider means an in person visit to a health care provider. The first (or only) in person treatment visit must take place within seven days of the first day of incapacity.

3. Birth of a Child/Pregnancy Any period of incapacity due to pregnancy, birth of a child, or placement of a child for adoption or foster care, or for prenatal care.

4. Chronic Conditions Requiring Treatments A chronic condition which:

(1) Requires periodic visits (defined as at least twice a year) 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 [FN1] (e.g., asthma, diabetes, epilepsy, etc.).

5. Permanent/Long-term Conditions Requiring Supervision A period of incapacity [FN1] 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 [FN1] 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).

[FN1] "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.

[FN2] 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.

[FN3] 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.

LANCASTER COUNTY
NOTICE OF INTENTION TO RETURN FROM LEAVE

This form is to be completed by your health care provider no more than one week prior to your scheduled return to work and must be submitted to your department head at least 2 working days prior to your planned return.

Name of Employee: ____
(Please Print Legibly)

Oracle Person Number: ________________________

Supervisor: ____

Date Leave Commenced: ____

Date of Planned Return: ____

I understand that my restoration to employment is subject to the following conditions:

1. Where leave was granted based upon my own serious health condition, as a condition of restoration to my employment, I must provide a written certification from my health care provider stating that I am able to resume working.

2. Every attempt will be made to restore me to my original position. If my original position is unavailable, I understand I will be placed in an equivalent position with equivalent pay and benefits.

3. I understand that as an employee returning from family and medical leave I may not be entitled to accrual of any seniority or employment benefits during the period of leave.

Employee's Signature: ________________________________ Date: ________________

FITNESS FOR DUTY CERTIFICATION OF HEALTH CARE PROVIDER

I have examined said employee and can certify that she/he is fully able to resume working

on ________________________.
Return to Work Date

______________________________________ ______________________________
Health Care Provider's Signature Date