

## Diocese of Owensboro

### Employee Request for Leave

#### Under the Family and Medical Leave Act (FMLA)

<b>Family Medical Leave Act (FMLA)</b>
--

The following forms must be completed by you and returned to the parish/bookkeeper/business manager or employer, to serve as your request for job protected time off under the Family Medical Leave Act (FMLA).

In addition, depending on the type of leave you are requesting you must complete the appropriate Department of Labor Forms - Certification for FMLA.

The Family Medical Leave Act (FMLA) entitles eligible employees to take up to 12 weeks of unpaid, job-protected leave for certain specific reasons. An employee must request the FMLA qualifying leave in writing by completing the “*Diocese of Owensboro Employee Request for Leave – FMLA*” and must document the reason for the leave. The pastor and the employer will determine if the days requested qualify as FMLA.

**To be eligible:**

- An employee must have worked at least 12 months for the Diocese.
- An employee must have worked at least 1,250 hours in the preceding twelve months, prior to the start of the FMLA leave.

When the leave is foreseeable, the employee should give their pastor or employer a 30-day notice and complete applicable FMLA paperwork.

**Eligible employees may take FMLA leave for the following reasons:**

- An employee’s birth of a child or in order to care for your child, or placement of a child for adoption or foster care - up to 12 weeks;
- An employee’s own serious health condition which renders an employee unable to perform the functions of their job - up to 12 weeks;
- An employee’s need to care for an immediate family member, which includes an employee’s spouse, child, or parent with a “serious health condition” - up to 12 weeks;
- An employee’s military active duty status, notification of an impending call, or order to active duty status - up to 26 weeks;
- An eligible employee is caring for a covered service member with a serious injury or illness if the employee is the spouse, son, daughter, parent, or next-of-kin of the service member – up to 26 weeks.

Any leave taken under one or more of these circumstances will be counted against the employee's total entitlement to FMLA leave for the leave year.

Employees who have a break in employment due to their military obligations shall be taken into consideration when determining whether an employee has been employed for 12 months or has the required 1,250 hours of service to qualify for FMLA.

Employees on FMLA will continue to receive the Diocese's employee benefits provided they meet the specific requirements of such benefit programs. The employee portion of the expense of these benefits will be the responsibility of the employee during their FMLA and self-pay payments should be submitted timely.

Sick Leave, paid or unpaid, may be designated as an FMLA leave by the employee and Sick Leave time off as FMLA leave shall run concurrently with the sick time off and is counted as FMLA leave.

Under FMLA, if sick time is available, it will be paid first, and once it is exhausted, the employee has the option to use available vacation time. After sick time (and elected vacation time) are used, the employee will then go into unpaid leave status.

A leave beyond 12 weeks (or 26 weeks if applicable) will not be granted except for extreme circumstances. Regular employees not eligible for FMLA may request from their pastor or employer an unpaid family emergency or medical leave.

The Diocese measures the 12-month period in which the leave is taken by the rolling 12 month period, measured backward from the date of any and all FMLA leave with one exception. For leave to care for a covered service member, or for the spouse, son, daughter, or parent of a covered service member, the 12-month period begins on the first day the employee takes FMLA leave to care for a covered service member and ends 12 months after that date. For leave to care for an eligible employee, the 12-month period begins on the first day the employee takes FMLA leave and ends 12 months after that date. FMLA for the birth or adoption of a child or foster care must be concluded within 12 months of the birth or placement.

If an employee requests FMLA leave due to a serious illness of their own, the employee may be required to furnish medical Certification that they are fit to resume work. Employees failing to provide the Return to Work Certification, when required, may not be permitted to resume work until it is provided.

Failure to return to work on the determined return to work day without prior approval of the pastor or employer will be considered a voluntary resignation by the employee.

Serious Health Condition means an illness, injury, impairment or physical or mental condition which involves:

Inpatient Care, meaning an overnight stay in a hospital, hospice or residential medical-care facility, including any period of incapacity (inability to work or perform regular daily activities) or any subsequent treatment in connection with such inpatient care; or

Continuing treatment by a health care provider, this includes:

- (1) A period of incapacity lasting more than three consecutive, full calendar days and any subsequent treatment of period of incapacity relating to the same condition, that also includes treatment two or more times by or under the supervision of a health care provider (in-person visits, the first within 7 days and both within 30 days of the first day of incapacity); or one treatment by a health care provider (an in-person visit within 7 days of the first day of incapacity) with a continuing regimen of treatment (Prescription medication, physical therapy); or
- (2) Any period of incapacity related to pregnancy or for prenatal care. A visit to the health care provider is not necessary for each absence; or
- (3) Any period of incapacity or treatment for a chronic serious health condition which continues over an extended period of time, requires periodic visits (at least twice per year) to a health care provider, and may involve occasional episodes of incapacity. A visit to a health care provider is not necessary for each absence; or
- (4) A period of incapacity that is permanent or long-term due to a condition for which treatment may not be effective. Only supervision by a health care provider is required, rather than active treatment; or
- (5) Any absence to receive multiple treatments for restorative surgery or for a condition that would likely result in a period of incapacity of more than three days if not treated.

**If you have any questions or concerns, feel free to contact your parish or employer.**

**Diocese of Owensboro**  
**Employee Request for Leave**  
**Family Medical Leave Act (FMLA)**

Date:-----

Parish or Employer Name\_\_\_\_\_

**This serves as my request for leave under the Family and Medical Leave Act. I am requesting leave for the following reason:**

\_\_\_\_\_ The birth of a child, placement of a child with me for adoption or foster care.

\_\_\_\_\_ A serious health condition of my own

\_\_\_\_\_ A serious health condition of my spouse/child/parent that requires my care.

\_\_\_\_\_ I am the spouse/son/daughter of a covered military member in active duty status, or has been notified of an impending call or order to active status

\_\_\_\_\_ I am the spouse/son/daughter/parent or next of kin of a covered service member with a serious injury or illness.

\_\_\_\_\_ I am the spouse/son/daughter/parent or next of kin of a covered service member under a call or in active duty and I must handle certain qualifying exigencies.

I understand that I must provide additional information if requested of me by my employer to support my reason for leave.

I would like for my FMLA leave to begin on\_\_\_\_\_, and I am requesting\_\_\_\_\_ days of leave or\_\_\_\_\_ weeks of leave or\_\_\_\_\_.

\_\_\_\_\_  
Employee printed name

\_\_\_\_\_  
Employee Signature

# EMPLOYEE RIGHTS UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION

## LEAVE ENTITLEMENTS

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;\* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

\*Special "hours of service" requirements apply to airline flight crew employees.

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

## BENEFITS & PROTECTIONS

## ELIGIBILITY REQUIREMENTS

## REQUESTING LEAVE

## EMPLOYER RESPONSIBILITIES

## ENFORCEMENT

For additional information or to file a complaint:

**1-866-4-USWAGE**

(1-866-487-9243) TTY: 1-877-889-5627

**[www.dol.gov/whd](http://www.dol.gov/whd)**

U.S. Department of Labor | Wage and Hour Division



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

**U.S. Department of Labor  
Wage 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 leave to care for a family member with a serious health condition to submit a medical certification issued by the family member'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](http://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 or employees' family members 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: \_\_\_\_\_ 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.)*

**SECTION II - EMPLOYEE**

Please complete and sign Section II before providing this form to your family member or your family member's health care provider. The FMLA allows an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of your family member. If requested by your employer, your response is required to obtain or retain the benefit of the FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). **You are responsible for making sure the medical certification is provided to your employer within the time frame requested, which must be at least 15 calendar days.** 29 C.F.R. §§ 825.305-825.306. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA leave request. 29 C.F.R. § 825.313.

- (1) Name of the family member for whom you will provide care: \_\_\_\_\_
- (2) Select the relationship of the family member to you. The family member is your:
- Spouse                       Parent                       Child, under age 18  
 Child, age 18 or older and incapable of self-care because of a mental or physical disability

Spouse means a husband or wife as defined or recognized in the state where the individual was married, including in a common law marriage or same-sex marriage. The terms "child" and "parent" include *in loco parentis* relationships in which a person assumes the obligations of a parent to a child. An employee may take FMLA leave to care for an individual who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave to care for a child for whom the employee has assumed the obligations of a parent. No legal or biological relationship is necessary.

Employee Name: \_\_\_\_\_

(3) Briefly describe the care you will provide to your family member: *(Check all that apply)*

- Assistance with basic medical, hygienic, nutritional, or safety needs  Transportation  
 Physical Care  Psychological Comfort  Other: \_\_\_\_\_

(4) Give your **best estimate** of the amount of leave needed to provide the care described: \_\_\_\_\_  
\_\_\_\_\_

(5) If a **reduced work schedule** is necessary to provide the care described, give your **best estimate** of the reduced schedule you are able to work. From \_\_\_\_\_ *(mm/dd/yyyy)* to \_\_\_\_\_ *(mm/dd/yyyy)*, I am able to work  
\_\_\_\_\_ *(hours per day)* \_\_\_\_\_ *(days per week)*.

Employee

Signature \_\_\_\_\_ Date \_\_\_\_\_ *(mm/dd/yyyy)*

### SECTION III - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form below. A family member of your patient has requested leave under the FMLA to care for your patient. 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 to care for a family member with a serious health condition. 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 definitions of a serious health condition under the FMLA, see the chart at the end of the form.

You also may, but are **not required** to, provide other appropriate medical facts including symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment. Please note that some state or local laws may not allow disclosure of private medical information about the patient’s serious health condition, such as providing the diagnosis and/or course of treatment.

Health Care Provider’s name: *(Print)* \_\_\_\_\_

Health Care Provider’s business address: \_\_\_\_\_

Type of practice / Medical specialty: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ E-mail: \_\_\_\_\_

#### **PART A: Medical Information**

Limit your response to the medical condition for which the employee is seeking FMLA leave. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. **After completing Part A, complete Part B to provide information about the amount of leave needed.** Note: For FMLA purposes, “incapacity” means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee’s family members, 29 C.F.R. § 1635.3(b).

(1) Patient’s Name: \_\_\_\_\_

(2) State the approximate date the condition started or will start: \_\_\_\_\_ *(mm/dd/yyyy)*

(3) Provide your **best estimate** of how long the condition lasted or will last: \_\_\_\_\_

(4) For FMLA to apply, care of the patient must be medically necessary. Briefly describe the type of care needed by the patient  
*(e.g., assistance with basic medical, hygienic, nutritional, safety, transportation needs, physical care, or psychological comfort)*.  
\_\_\_\_\_  
\_\_\_\_\_

Employee Name: \_\_\_\_\_

(5) Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

**Inpatient Care:** The patient ( has been /  is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): \_\_\_\_\_

**Incapacity plus Treatment:** (e.g. outpatient surgery, strep throat)

Due to the condition, the patient ( has been /  is expected to be) incapacitated for *more than three* consecutive, full calendar days from \_\_\_\_\_ (mm/dd/yyyy) to \_\_\_\_\_ (mm/dd/yyyy).

The patient ( was /  will be) seen on the following date(s): \_\_\_\_\_

The condition ( has /  has not) also resulted in a course of continuing treatment under the supervision of a health care provider (e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment)

**Pregnancy:** The condition is pregnancy. List the expected delivery date: \_\_\_\_\_ (mm/dd/yyyy).

**Chronic Conditions:** (e.g. asthma, migraine headaches) Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

**Permanent or Long Term Conditions:** (e.g. Alzheimer's, terminal stages of cancer) Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

**Conditions requiring Multiple Treatments:** (e.g. chemotherapy treatments, restorative surgery) Due to the condition, it is medically necessary for the patient to receive multiple treatments.

**None of the above:** If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed. Go to page 4 to sign and date the form.

(6) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. (e.g., use of nebulizer, dialysis) \_\_\_\_\_

### **PART B: Amount of Leave Needed**

For the medical condition(s) checked in Part A, complete all that apply. 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 if the benefits and protections of the FMLA apply.

(7) Due to the condition, the patient ( had /  will have) **planned medical treatment(s)** (scheduled medical visits) (e.g. psychotherapy, prenatal appointments) on the following date(s): \_\_\_\_\_

(8) Due to the condition, the patient ( was /  will be) **referred to other health care provider(s)** for evaluation or treatment(s).

State the nature of such treatments: (e.g. cardiologist, physical therapy) \_\_\_\_\_

Provide your **best estimate** of the beginning date \_\_\_\_\_ (mm/dd/yyyy) and end date \_\_\_\_\_ (mm/dd/yyyy) for the treatment(s).

Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery \_\_\_\_\_ (e.g. 3 days/week)



Employee Name: \_\_\_\_\_

- (9) Due to the condition, the patient ( was /  will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.

Provide your **best estimate** of the beginning date: \_\_\_\_\_ (mm/dd/yyyy) and end date \_\_\_\_\_ (mm/dd/yyyy) for the period of incapacity.

- (10) Due to the condition it, ( was /  is /  will be) medically necessary for the employee to be absent from work to provide care for the patient on an **intermittent basis** (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, episodes of incapacity are estimated to occur \_\_\_\_\_ times per ( day /  week /  month) and are likely to last approximately \_\_\_\_\_ ( hours /  days) per episode.

Signature of Health Care Provider \_\_\_\_\_ Date \_\_\_\_\_ (mm/dd/yyyy)

**Definitions of a Serious Health Condition (See 29 C.F.R. §§ 825.113-.115)**

**Inpatient Care**

- An overnight stay in a hospital, hospice, or residential medical care facility.
- Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.

**Continuing Treatment by a Health Care Provider (any one or more of the following)**

**Incapacity Plus Treatment:** A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either:

- Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or,
- At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.

**Pregnancy:** Any period of incapacity due to pregnancy or for prenatal care.

**Chronic Conditions:** Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.

**Permanent or Long-term Conditions:** A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.

**Conditions Requiring Multiple Treatments:** Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.

**PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT**

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 15 minutes for respondents 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 information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

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