PROCEDURE TO APPLY FOR MEDICAL LEAVE

Team Member Responsibilities:

- ☐ Complete and sign the *Request for Leave* form. This form should be faxed to LOAA at (704) 446-6624 no more than 30 days in advance and no later than 15 days from the start of your leave.
- ☐ Take the *Certification of Healthcare Provider* form to your healthcare provider to complete. This form should be turned in to LOAA no later than 22 days from the start date of your leave. This entire form must be completed and received for a leave to be approved.
- ☐ For maternity leave, an expected due date is acceptable to initiate the leave. Once the child is born, a revision to the leave date from the healthcare provider should be faxed to LOAA at (704) 446-6624.
- ☐ Updates to the *Certification of Healthcare Provider* form should be faxed to LOAA at (704) 446-6624 whenever extending beyond the original length of the leave.
- ☐ The *Fitness for Duty Certification to Return from Leave* form should be taken to the treating provider to complete prior to returning. This document is required prior to being allowed to return to work. LOAA requests it be faxed to (704) 446-6624 at least 3 days in advance.

Department Leader Responsibilities:

- Complete and sign the *Request for Leave* form if a team member is out unexpectedly and unable to complete the form.
- Instruct the team member to obtain a copy of the *Certification of Healthcare Provider* form and return it to LOAA no later than 15 days from the start date of the leave.
- Enter the team member's PTO and/or Absent Hours as requested by the team member and the appropriate pay code into the time keeping system.

My Leave Checklist:

- ☐ Complete *Request for Leave* form and fax to LOAA at (704) 446-6624
- ☐ Take *Certification of Healthcare Provider* form to treating provider
- ☐ Verify *Certification of Healthcare Provider* form has been completed and received by LOAA
- ☐ Obtain any missing information from the provider as requested by LOAA on the *Certification of Healthcare Provider* form
- ☐ If needed, contact LOAA about how to apply for Short Term Disability
- ☐ Submit any leave updates whenever changes occur to the original start date or length of leave
- ☐ Complete and send in the *Fitness for Duty Certification to Return from Leave* form prior to returning from your leave.

REQUEST FOR LEAVE

Team Member Name_____ **Team Member ID** _____
Last, First, Middle Initial (Please Print)

First Day Missed Work:___/___/____ **Expected Return Date:**____/___/____ **Team Member Date of Birth:**___/___/____

Teammates now have an option to receive communications via email. Please provide your email address if you choose to select this option, otherwise communications will be mailed to your home address. *Atrium Health e-mail accounts may not be used.*

Personal Email Address: _____

1. **Complete this form as soon as the need for a leave is known.**
2. **The completed form should be signed by the team member. The leader's signature is only required for Personal and Educational leaves. The completed and signed form should be faxed to Leave of Absence Administration (LOAA) at (704) 446-6624.**
3. **For a request of Family Leave or Medical Leave, complete the team member portion of the *Certification of Health Care Provider Form*, ask your health care provider to complete it, and forward it to LOAA within 15 days of the start of leave.**
4. **If the leave is unplanned, on the 4th missed consecutive scheduled work day, the leader should submit this form to LOAA on the team member's behalf.**
5. **Personal or Educational Leaves require the Departmental Vice President signature.**

Please refer to the Human Resources Policies on PeopleConnect for more information about your leave request. If you have questions, please contact LOAA at (704) 631-1500.

I understand that if eligible for 12 weeks of FMLA time, hours against my 12-week entitlement will be counted from the first day of leave.

Type: ☐ Intermittent (Periodically) ☐ Continuous (More than 3 consecutive scheduled work days)

*Type of Leave of Absence Requested: *Is this request related to a COVID-19 suspected or confirmed diagnosis (teammate or family member)* *Yes* *No*

☐ **Medical Leave:** An absence due to personal medical need.
  ☐ I plan to apply for Short-Term Disability

☐ **Maternity Leave**: An absence due to the birth of a child.
  ☐ I plan to apply for Short-Term Disability (Maternity

☐ Only) **Family Care Leave**
  - ☐ **Family Member:** An absence to care for a qualifying family member with a serious medical condition.
  - ☐ **Adoption/Foster Care:** An absence for the placement of a child with the team member for adoption/foster care.
  - ☐ **Birth of a Child:** Mother or father bonding time during 12 month period beginning at birth
  - ☐ **Qualifying Exigency:** An absence related to a family member's call to military service.
  - ☐ **Injured or Ill Current Servicemember:** An absence to care for a qualifying injured or ill current servicemember.
  - ☐ **Injured or Ill Veteran Servicemember:** An absence to care for a qualifying injured or ill veteran servicemember.

☐ **Military Leave:** An absence needed by a team member who is inducted or enlists into the US Armed Forces, National Guard, or a reserve unit.

☐ **Workers' Compensation Covered Medical Leave:** A continuous or intermittent absence due to workplace injury or illness.

☐ **Personal Leave:** An absence for extraordinary personal reasons that PTO or other leaves listed above will not allow.
Note: The exact date of return should be listed under "expected return date" above. **(For a period of 31 to 90 days.)**

☐ **Educational Leave:** Job related courses leading to a degree in an area of specialty that will prove beneficial to *Atrium Health*.
Note: The exact date of return should be listed under "expected return date" above.

Leader Use (Check if applicable)

☐ The team member went out on an unplanned leave (4 or more consecutive work days) and was unable to complete this form.

☐ I notified the team member that the *Certification of Health Care Provider Form* must be turned in to LOAA within 15 days If the leave is approved for FMLA benefits, FMLA hours will be used.

☐ Spoke with_____ on_____. Leave of Absence Request Packet delivered per team member's request via (circle one) US mail, email, fax, hand delivery.

Team Member Signature	**Date**
Department Leader Name (Please Print) **Telephone Number/Pager**	**Date**
Department Leader Signature (Personal/Educational Leave ONLY)	**Date**
VP Signature (Personal/Educational Leave ONLY)	**Date**

CERTIFICATION OF HEALTH CARE PROVIDER FOR TEAMMATE'S SERIOUS HEALTH CONDITION (FAMILY AND MEDICAL LEAVE ACT)

SECTION I: For Completion by the EMPLOYER

Employer Name and Contact: Atrium Health Leave of Absence Administration

Leave of Absence Administration Phone Number: 704-631-1500 ; Fax: 704-446-6624

Teammate's Job Title: _____ **Regular Work Schedule:** _____

Teammate's Essential Job Functions: _____

_____

Check if job description is attached: ☐

SECTION II: For Completion by the TEAMMATE

INSTRUCTIONS to the TEAMMATE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614©(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your Name: _____
First Middle Last

Team Member Date of Birth: ____/____/____ **Team Member ID:** _____

Teammates now have an option to receive communications via email. Please provide your email address if you choose to select this option, otherwise communications will be mailed to your home address. *Atrium Health e-mail accounts may not be used.*

Personal Email Address: _____

Teammate's Job Title: _____ **Standard Work Hours Per Week:** _____

Regular Work Schedule

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start	____ AM/PM	____ AM/PM	____ AM/PM	____ AM/PM	____ AM/PM	____ AM/PM	____ AM/PM
End	____ AM/PM	____ AM/PM	____ AM/PM	____ AM/PM	____ AM/PM	____ AM/PM	____ AM/PM

Example:

	Sunday
Start	8 (AM)/PM
End	5 AM/(PM)

SECTION III: For Completion by the HEALTHCARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the 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 teammate is seeking leave. Please be sure to sign the form on the last page.

A job description containing the essential functions is available upon request and/or may be submitted to the extent necessary for clarification.

Team Member Name: _____
First Middle Last

Team Member Date of Birth: ____/____/____ **Team Member ID:** _____

Provider's Name and Business Address: _____

_____

Type of Practice/Medical Specialty: _____

Telephone: (____) _____ Fax: (____) _____

PART A: MEDICAL FACTS (must be completed in its entirety)

1. **Type of Leave Requested:** _____ **Intermittent (3 days of less)** _____ **Continuous (More than 3 consecutive days)**
2. **Begin Date of Leave:** ____/____/____ **Anticipated End Date of Leave:** ____/____/____
3. Approximate date condition commenced: ____/____/_____
   Probable duration of condition: _____
   Mark below as applicable:
   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ☐ Yes ☐ No
   If so, dates of admission: _____
   Date(s) you treated the patient for condition: _____
   Will the patient need to have treatment visits at least twice per year due to the condition? ☐ Yes ☐ No
   Was medication, other than over-the-counter medication, prescribed? ☐ Yes ☐ No
   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? ☐ Yes ☐ No
   If so, state the nature of such treatments and expected duration of treatment:

   _____

   _____
4. Is the medical condition pregnancy? ☐ Yes ☐ No If so, expected delivery date: _____
5. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the patient's essential functions or a job description, answer these questions based upon the patient's own description of his/her job functions.
   Is the patient unable to perform any of his/her job functions due to the condition: ☐ Yes ☐ No
   If so, identify the job functions the patient is unable to perform: _____

   _____
6. Describe other relevant medical facts, if any, related to the condition for which the patient 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 (must be completed in its entirety)

1. Will the patient be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ☐ Yes ☐ No

   If so, estimate the beginning and ending dates for the period of incapacity: Beginning_____Ending _____

2. Will the patient need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the patient's medical condition? ☐ Yes ☐ No

   If so, are the treatments or the reduced number of hours of work medically necessary? ☐ Yes ☐ No

   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 part-time or reduced work schedule the patient needs, if any:

   _____hour(s) per day;_____days per week from_____through _____

3. Will the condition cause episodic flare-ups periodically preventing the patient from performing his/her job functions? ☐ Yes ☐ No

   Is it medically necessary for the patient to be absent from work during the flare-ups? ☐ Yes ☐ No

   If so, explain: _____

   _____

   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):

   Frequency:_____times per_____week(s)_____month(s)

   Duration:_____hour(s) or_____day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

Signature of Health Care Provider_____**Date**_____

Fax completed forms to (704) 446-6624 or call (704) 631-1500 with questions.

FITNESS FOR DUTY CERTIFICATION TO RETURN FROM LEAVE

Team Member Name_____ **Team Member ID** _____
Last, First, Middle Initial (Please Print)

Team Member Date of Birth: _____/_____/_____

A team member on a Medical Leave due to his/her own serious medical condition must present this release to Leave of Absence Administration prior to, or on the day, he/she returns to work. A team member may not work without this release.

TO: Health Care Provider

As a condition of return to work, the team member must have a medical clearance. This form must be completed by you, as his/her health care provider, before the team member is allowed to resume his/her job duties.

1. Team Member Name: _____
2. Team Member's Job Title: _____
3. Date of Last Medical Examination: _____
4. Date Team Member May Return from Leave: _____
5. Please indicate with a check mark the status of the team member's release for duty.

   _____ Full, unrestricted duty. (Skip question 6 and proceed to item 7.)

   _____ Modified duty. (Complete question 6 and 7.)

   _____ Not released for any type of duty. (Go to item 7.)

6. If you are releasing the team member to modified duty, please complete the following:
   a. Estimated date that team member will be able to return to full, unrestricted duty:_____.
   b. Date of your next medical evaluation of the team member:_____.
   c. Indicate the exact work restrictions which apply to the team member at this time using the chart on page 2 of this form.

Atrium Health has a Return to Work Program that provides our team members with work restrictions the opportunity to return to work in a reduced capacity. Our program is designed to allow our team member to safely perform modified or alternative work within their work restrictions while they recover. We promote an expeditious and productive return to work philosophy.

Is this team member a candidate for the Return to Work Program? ☐ **Yes** ☐ **No**

Complete this section if the team member is being released to modified duty.

Team Member Name_____ **Team Member ID** _____
Last, First, Middle Initial (Please Print)

☐ **None – Explain:** _____			
☐ Return to work no greater than_____hours/day			
☐ No lifting greater than_____pounds	☐ right	☐ left	☐ both
☐ No pushing/pulling greater than_____pounds	☐ right	☐ left	☐ both
☐ No reaching/working above shoulder	☐ right	☐ left	☐ both
☐ No work involving use of hand/arm	☐ right	☐ left	☐ both
☐ Sit down work only			
☐ No walking/standing over_____minutes/hours			
☐ No stooping ☐ No repeated bending ☐ No climbing ☐ No twisting, bending			
Other: _____			

Additional Comments/Notes:

_____

_____

_____

_____

_____

_____

7. I hereby certify that the foregoing facts are true and correct, and that this form is executed under penalty of perjury at_____, this_____day of_____,_____.
(List City and State) (month) (year)

ATTENDING PHYSICIAN:

Print or Type Name_____ Signature_____

Type of Practice/Medical Specialty: _____

Street Address_____ City / State_____ Zip Code _____

Phone #:_____ Fax #:_____ Date _____

MUST BE FURNISHED UNDER AUTHORITY OF LAW: SS# or Employer ID #_____

Fax completed form to (704) 446-6624 or call (704) 631-1500 with questions.

EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement
FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- for incapacity due to pregnancy, prenatal medical care or child birth;
- to care for the employee's child after birth, or placement for adoption or foster care;
- to care for the employee's spouse, son, daughter or parent, who has a serious health condition; or
- for a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements
Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness*; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness.*

***The FMLA definitions of "serious injury or illness" for current servicemembers and veterans are distinct from the FMLA definition of "serious health condition".**

Benefits and Protections
During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months*, and if at least 50 employees are employed by the employer within 75 miles.

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

Definition of Serious Health Condition
A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave
An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave
Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities
Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities
Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave i s not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers
FMLA makes it unlawful for any employer to:

- interfere with, restrain, or deny the exercise of any right provided under FMLA; and
- discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement
An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulation 29 C.F.R. § 825.300(a) may require additional disclosure.