

PROCEDURE TO APPLY FOR MILITARY LEAVE**Team Member Responsibilities:**

- Obtain a copy of the leave request form on PeopleConnect.
- Complete and sign *Request for Leave*. When possible, 30 days advance notice should be given. If leave is unexpected, leave forms must be submitted within 15 days of the start of your leave.
- Return the completed form to your department leader. Once your leader signs the form, fax it immediately to Leave of Absence Administration (LOAA) at (704) 446-6624 to initiate the leave.
- A copy of the covered military member's orders are required and completion of the *Certification of Qualifying Exigency* within 15 days unless unusual circumstances exist to justify a later date.

Department Leader Responsibilities:

- Verify completeness of the *Request for a Leave*.
- Sign the form and return it to the team member to submit to LOAA.
- Complete the team member's timesheet correctly. Code PTO hours as requested by the team member on the *Request for Leave*.
- Contact Workforce Relations to determine how to best staff the position.

My Leave Checklist:

- Complete *Request for Leave* form and fax to LOAA at (704) 446-6624.
- Provide LOAA with a copy of the covered military member's orders and completion of the *Certification of Qualifying Exigency*.
- Submit any leave updates whenever changes occur to the original start date or length of leave.
- Complete and send in the *Team Member Notification to Return from Military*.
- Family Care 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. *Carolinas HealthCare System 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 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 704-631-0262.

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:

- 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 Carolinas HealthCare System. **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 FOR SERIOUS INJURY OR ILLNESS OF A VETERAN FOR MILITARY CAREGIVER LEAVE (FAMILY AND MEDICAL LEAVE ACT)

Notice to the EMPLOYER

Employer Name and Contact: Carolinas HealthCare System Leave of Absence Administration

Leave of Absence Administration Phone Number: 704-631-0262 ; Fax: 704-446-6624

SECTION I: For Completion the TEAM MEMBER and/or the VETERAN for whom the team member is requesting leave

PART A: TEAM MEMBER INFORMATION

Name and Address of Employer (this is the employer of the team member requesting leave to care for a veteran):

Name of Team Member Requesting Leave to Care for a Veteran:

_____ **First** _____ **Middle** _____ **Last**

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

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

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. *Carolinas HealthCare System 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	<u>8</u> (AM/PM)
End	<u>5</u> AM/(PM)

PART B: VETERAN INFORMATION

Name of Veteran (for whom team member is requesting leave): _____
First Middle Last

Relationship of Team Member to Veteran: Spouse Parent Son Daughter Next of Kin
 (Please specify relationship: _____).

Date of the Veteran’s Discharge: _____

Was the veteran dishonorably discharged or released from the Armed Forces (including the National Guard or Reserves)? Yes No

Please provide the veteran’s military branch, rank and unit at the time of discharge:

Is the veteran receiving medical treatment, recuperation, or therapy for an injury or illness? Yes No

PART C: CARE TO BE PROVIDED TO THE VETERAN

Describe the care to be provided to the veteran and an estimate of the leave needed to provide the care:

SECTION II: For completion by: (1) a United States Department of Defense (“DOD”) health care provider; (2) a United States Department of Veterans Affairs (“VA”) health care provider; (3) a DOD TRICARE network authorized private health care provider; (4) a DOD non-network TRICARE authorized private health care provider; or (5) a health care provider as defined in 29 CFR 825.125.

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee named in Section I has requested leave under the military caregiver leave provision of the FMLA to care for a family member who is a veteran. For purposes of FMLA military caregiver leave, a serious injury or illness means an injury or illness incurred by the servicemember in the line of duty on active duty in the Armed Forces (or that existed before the beginning of the servicemember’s active duty and was aggravated by service in the line of duty on active duty in the Armed Forces) and manifested itself before or after the servicemember became a veteran, and is:

- (i) a continuation of a serious injury or illness that was incurred or aggravated when the covered veteran was a member of the Armed Forces and rendered the servicemember unable to perform the duties of the servicemember’s office, grade, rank, or rating; or
- (ii) a physical or mental condition for which the covered veteran has received a U.S. Department of Veterans Affairs Service Related Disability Rating (VASRD) of 50 percent or greater, and such VASRD rating is based, in whole or in part, on the condition precipitating the need for military caregiver leave; or
- (iii) a physical or mental condition that substantially impairs the covered veteran’s ability to secure or follow a substantially gainful occupation by reason of a disability or disabilities related to military service, or would do so absent treatment; or
- (iv) an injury, including a psychological injury, on the basis of which the covered veteran has been enrolled in the Department of Veterans’ Affairs Program of Comprehensive Assistance for Family Caregivers.

A complete and sufficient certification to support a request for FMLA military caregiver leave due to a covered veteran’s serious injury or illness includes written documentation confirming that the veteran’s injury or illness was incurred in the line of duty on active duty or existed before the beginning of the veteran’s active duty and was aggravated by service in the line of duty on active duty, and that the veteran is undergoing treatment, recuperation, or therapy for such injury or illness by a health care provider listed above. 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 military caregiver leave coverage. Limit your responses to the veteran’s condition for which the employee is seeking leave.



(Please ensure that Section I has been completed before completing this section. Please be sure to sign the form on the last page and return this form to the employee requesting leave (See Section I, Part A above). **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.**)

PART A: HEALTH CARE PROVIDER INFORMATION

Health Care Provider's Name and Business Address:

Telephone: _____ Fax: _____ Email: _____

Type of Practice/Medical Specialty:

Please indicate if you are:

- a DOD Health Care Provider
- a VA Health Care Provider
- a DOD TRICARE Network Authorized Private Health Care Provider
- a DOD Non-Network TRICARE Authorized Private Health Care Provider
- Other Health Care Provider

PART B: MEDICAL STATUS

NOTE: If you are unable to make certain of the military-related determinations contained in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as, DOD Recovery Care Coordinator) or an authorized VA representative.

1. The Veteran's medical condition is:
 - A continuation of a serious injury or illness that was incurred or aggravated when the covered veteran was a member of the Armed Forces and rendered the servicemember unable to perform the duties of the servicemember's office, grade, rank, or rating.
 - A physical or mental condition for which the covered veteran has received a U.S. Department of Veterans Affairs Service Related Disability Rating (VASRD) of 50% or higher, and such VASRD rating is based, in whole or in part, on the condition precipitating the need for military caregiver leave.
 - A physical or mental condition that substantially impairs the covered veteran's ability to secure or follow a substantially gainful occupation by reason of a disability or disabilities related to military service, or would do so absent treatment.
 - An injury, including a psychological injury, on the basis of which the covered veteran is enrolled in the Department of Veterans' Affairs Program of Comprehensive Assistance for Family Caregivers.
 - None of the above.
2. Is the veteran being treated for a condition which was incurred or aggravated by service in the line of duty on active duty in the Armed Forces? Yes No
3. Approximate date condition commenced: _____
4. Probable duration of condition and/or need for care: _____
5. Is the veteran undergoing medical treatment, recuperation, or therapy for this condition? Yes No
If yes, please describe medical treatment, recuperation or therapy:

PART C: VETERAN'S NEED FOR CARE BY FAMILY MEMBER

“Need for care” encompasses both physical and psychological care. It includes situations where, for example, due to his or her serious injury or illness, the veteran is unable to care for his or her own basic medical, hygienic, or nutritional needs or safety, or is unable to transport him or herself to the doctor. It also includes providing psychological comfort and reassurance which would be beneficial to the veteran who is receiving inpatient or home care.

1. Will the veteran need care for a single continuous period of time, including any time for treatment and recovery? Yes No
If yes, estimate the beginning and ending dates for this period of time: Beginning _____ Ending _____

2. Will the veteran require periodic follow-up treatment appointments? Yes No
If yes, estimate the treatment schedule:

3. Is there a medical necessity for the veteran to have periodic care for these follow-up treatment appointments? Yes No

4. Is there a medical necessity for the veteran to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)? Yes No

If yes, please estimate the frequency and duration of the periodic care: _____

Signature of Health Care Provider

Date

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, in accordance with 29 U.S.C. 2616; 29 CFR 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 20 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 Ave., NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION;**

RETURN IT TO THE EMPLOYEE REQUESTING LEAVE (As shown in Section I, Part “A” above).



**TEAM MEMBER NOTIFICATION TO RETURN FROM MILITARY
FAMILY CARE LEAVE**

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

Team Member Date of Birth: ____/____/____

A team member on a Military Family Care Leave must present this release to Leave of Absence Administration prior to returning to work. A team member may not work without this release.

Date Team Member Will Return from Leave: _____

Signature Date Telephone Number

Fax completed form to (704) 446-6624 or call (704) 631-0262 to discuss leave.

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 is 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.

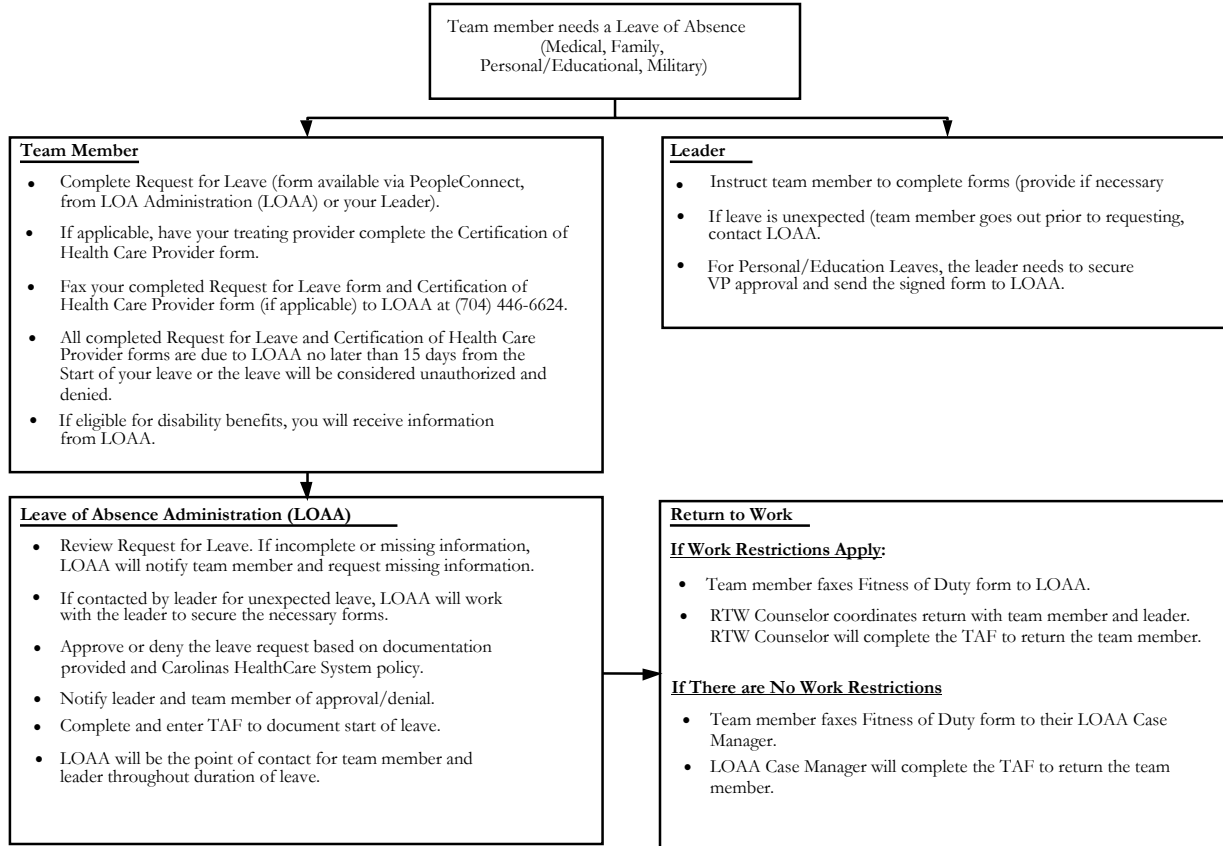
Enforcement

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 disclosures.

APPLYING FOR LEAVE OF ABSENCE



Additional Information/Responsibilities

Continuous Medical or Family Care Leave

Team Member:

- Send updated Fitness for Duty form as required by LOAA (at least every 30 days.)
- Contact LOAA and provide Fitness for Duty form to begin return to work process.
- Contact disability carrier if applicable.

Leader:

- Record FMLA hours on time sheet (Code 395).
- Obtain release from LOAA before allowing team member to return to work.

LOAA:

- Track hours and notify leader when position can be posted.
- Complete TAF to Term or move to appropriate cost center after leave time has been exhausted.
- Maintain contact with team member during leave.
- Provide leader with updates as needed.
- Refer to Transition Services as needed.

Intermittent Medical or Family Care Leave

Team Member:

- Send updated Fitness for Duty forms as required by LOAA (at least every 30 days).
- Notify leader when time off should be counted towards approved intermittent leave.

Leader:

- Record FMLA hours on time sheet (Code 395).
- Document team member's given reason for each episode of absence via Notification Form and record on A & C record.

LOAA:

- When contacted by leader, verify if position can be posted and complete TAF if necessary.
- Provide leader with updates as needed.