



Montgomery County Government
FMLA Request Coversheet
(Family and Medical Leave Act of 1993 as amended)

Name _____ Date _____

Current address _____

_____ Zip Code _____

Phone _____ Email Address _____

Date of Hire _____

Have you applied for FMLA in the previous 12 month? Yes No

If yes, what date? _____

If yes, what type? Self Family member Service member

Birth/Adoption Other _____

Is this a work related injury? Yes No If yes, date of injury: _____

Comments _____

Return all forms to:

Fax - (240) 777-5186

Email – fmla.information@montgomerycountymd.gov

OMS Office – 255 Rockville Pike suite 125 Rockville, MD 20850



Montgomery County Government
Employee Request for Family and Medical Leave (FMLA)

Date: _____

Supervisor Name _____

Employee Name _____

Department/Division _____

SUBJECT: Request for Family and Medical Leave (FMLA Leave)

I have worked for Montgomery County for a total of at least 12 months: [] Yes [] No [] Unsure

Is this a work related injury? [] Yes [] No If yes, date of injury: _____

I have worked for Montgomery County for at least 1040 hours, not including hours of paid leave, during the past 12 months: [] Yes [] No [] Unsure

FMLA Type

1. I need to take FMLA leave because of:

- [] the birth of a child, or the placement of a child with me for adoption or foster care;
[] a serious health condition that makes me unable to perform the essential functions of my job;
[] a serious health condition affecting my:
[] spouse [] domestic partner [] minor child [] adult child incapable of self-care [] parent;
[] to handle an exigency directly related to active duty status or a call to active duty of my:
[] spouse [] domestic partner [] son or daughter [] parent; or
[] to care for a servicemember with a serious injury or illness incurred in the line of duty while on active duty who is my: [] spouse [] domestic partner [] son or daughter [] parent [] next of kin

Amount of Leave

2. Please select if you will need this leave as a block of time, intermittently or both.

[] Block of time - beginning date _____ expected end date _____

[] Intermittently - (as needed basis). Approximate time needed per day/week/month: _____

FMLA Leave Types: Accrued annual leave, sick leave/family sick leave, personal leave, leave without pay or any combination.

I understand that the information contained in the Medical Certification must be completed in its entirety by my/my family member's healthcare provider. Submitting an incomplete Medical Certification will cause a delay in processing. Information such as frequency and duration of flare-ups, frequency of medical follow-ups/treatment and relevant medical facts must be completed in order to make a determination. Please review the Medical Certification to ensure the healthcare provider includes this information prior to submission. Keep in mind the duration and frequency are an estimate based on the patient's recent medical history and the healthcare provider's knowledge of the medical condition.

By signing, I am certifying to the information as well as authorizing the healthcare provider and/or the healthcare provider representatives to provide the FMLA Administrator, or any of its designees, all information, facts, and particulars which may be requested regarding the physical condition of, or treatment of me. A copy or fax of this form shall have the same effect as the original.

Employee Signature: _____ Contact phone _____



Montgomery County Government
Certification of Health Care Provider for
Family Member's Serious Health Condition
(Family and Medical Leave Act of 1993 as amended)

SECTION I: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section I before giving this form to your family member or his/her medical provider. The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave to care for a covered family member with a serious health condition to submit a timely, and complete certification providing sufficient facts to support the request for leave. Your response is required to obtain or retain the benefit of FMLA-protected leave. Failure to do so may result in a denial of your FMLA request. You have 15 calendar days to return this form to your supervisor.

Your name: _____
First Middle Last

Your department/division _____

Your job title: _____ Your regular work schedule: _____

Your supervisor: _____

Name of family member for whom you will provide care: _____
First Middle Last

Relationship of family member to you: _____

If family member is your son or daughter, date of birth: _____

Describe care you will provide to your family member and estimate leave needed to provide care:

Three horizontal lines for describing care and leave needed.

Employee Signature

Date

SECTION II: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. 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 patient needs leave. Page 4 provides space for additional information, should you need it. 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). Please be sure to sign the form on the last page.

Provider’s name and business address: _____

Type of practice / Medical specialty: _____

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

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

Probable duration of condition: _____

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: _____

Was medication, other than over-the-counter medication, prescribed? ___ Yes ___ No.

Will the patient need to have treatment visits at least twice per year due to the condition? ___ Yes ___ No.

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? ___ Yes ___ No. If yes, state the nature of such treatments and expected duration of treatment:

2. Is the medical condition pregnancy? ___ Yes ___ No. If yes, expected delivery date: _____

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs 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 CARE NEEDED: When answering these questions, keep in mind that your patient’s need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ___ Yes ___ No

Estimate the beginning and ending dates for the period of incapacity: _____

During this time, will the patient need care? ___ Yes ___ No

Explain the care needed by the patient and why such care is medically necessary:

5. Will the patient require follow-up treatments, including any time for recovery? ___ 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:

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

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery?

___ Yes ___ No

Estimate the hours the patient needs care on an intermittent basis, if any:

_____ hour(s) per day; _____ days per week from _____ through _____

Explain the care needed by the patient, and why such care is medically necessary: _____

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ___ Yes ___ No.

If yes, based upon the patient’s recent 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., Frequency: 1 time(s) per 2 month(s), Duration: 1-2 days per episode):

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

Duration: _____ hours or ___ day(s) per episode

Does the patient need care during these flare-ups? ___ Yes ___ No.

Explain the care needed by the patient, and why such care is medically necessary: _____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER

Signature of Health Care Provider

Date

NOTE: Submitting an incomplete Medical Certification will cause a delay in processing. Information such as frequency of medical follow-ups/treatment (if #6 is "Yes"), frequency and duration of flare-ups (if #7 is "Yes"), relevant medical facts and a current office visit date must be completed in order to make a determination. Keep in mind the duration and frequency are an estimate based on the patient’s recent medical history and the healthcare provider’s knowledge of the medical condition.

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.



For additional information:
1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627
WWW.WAGEHOUR.DOL.GOV

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



WHD Publication 1420 · Revised February 2013

What triggers an FMLA Leave qualifying event?

**How do I know if I have a medical absence that qualifies for FMLA leave?
What is considered a serious health condition?**

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either:

1. an overnight stay in a medical care facility
2. 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 5 or more consecutive calendar days combined with at least two visits to a health care provider or one (1) 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.

Under the FMLA, a [serious health condition](#) is an illness, injury, impairment or physical or mental condition that involves *inpatient care* (defined as an overnight stay in a hospital, hospice or residential medical care facility; any overnight admission to such facilities is an automatic trigger for FMLA eligibility) or *continuing treatment* by a health care provider. Examples include the following:

Continuing treatment by a health care provider that results in an incapacity (inability to work, attend school or participate in other daily activities) of more than three consecutive calendar days with either two or more in-person visits to the health care provider within 30 days of the date of incapacity OR one in-person visit to the health care provider with a regimen of continuing treatment, such as prescription medication, physical therapy, etc. In either situation, the first visit to the health care provider must occur within seven days of the first date of incapacity. Examples include pneumonia, surgery or broken/fractured bones.

Chronic conditions that require periodic visits to a health care provider, continue over an extended period of time and may cause episodic rather than continuing periods of incapacity of more than three days. Examples of chronic conditions include asthma, diabetes and epilepsy.

Incapacity for pregnancy or prenatal care (any such incapacity is FMLA-protected regardless of the period of incapacity). For example, a pregnant employee may be unable to report to work due to severe morning sickness.

Permanent or long-term conditions such as Alzheimer's, severe stroke or terminal disease.

Conditions requiring multiple treatments and recovery from treatments, such as cancer, severe arthritis and kidney disease.

Treatment for substance abuse by a health care provider or by a provider of health care services on referral by a health care provider.

Serious health condition means an illness, injury, impairment, or physical or mental condition that involves either:

Inpatient care (*i.e.*, an overnight stay) in a hospital, hospice, or residential medical-care facility, including any period of incapacity (*i.e.*, inability to work, attend school, or perform other regular daily activities) or subsequent treatment in connection with such inpatient care; **or** Continuing treatment by a health care provider, which includes:

(1) A period of incapacity lasting more **than five consecutive full calendar days**, and any subsequent treatment or 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 (*i.e.*, 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 (*i.e.*, an in-person visit within 7 days of the first day of incapacity) with a continuing regimen of treatment (*e.g.*, 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 a 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 absences 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.



FMLA Annual Recertification Notice MEMORANDUM

SUBJECT: Family and Medical Leave Act (FMLA) Recertification Request

If you currently have a FMLA certification for yourself or family member on file and you will continue to have a FMLA qualifying event for the next leave year (to include work related injuries or illness) your FMLA medical certification applications must be resubmitted. **Your FMLA leave certification must be submit after your first (1st) absence due to an FMLA qualifying absence.**

Under MCG Personnel Regulation **Section 19-4 and Section 1-34 FMLA Leave is on a calendar year cycle.** Although you may have submitted an application mid or late in the prior year you are required to resubmit an application at the beginning of each calendar/leave year. In accordance with the MCGEO Collective Bargaining Agreement, Article 45 and MCG Personnel regulations section 19, "The leave year begins with the first full payroll period of a calendar year and ends with the payroll period in which December 31 falls".

Based on the above, we request that you submit a FMLA medical certification application from your healthcare provider. Your medical certification must be completed by the healthcare provider who is treating you or your family member for the medical condition. You have fifteen (15) calendar days from the date of receipt of your FMLA Leave packet to submit your FMLA recertification application to the OHR OMS. There are 3 methods to submit your application and to obtain FMLA leave forms: At the OMS office at 255 Rockville Pike Suite 125, fax to 240 777-5186, via email at fmla.information@montgomerycountymd.gov. When your information has been received you will and your department will receive notification (email) of your FMLA application status once it has been received and processed.

If you need a FMLA leave application for either yourself or a family member, please contact your immediate supervisor or the FMLA office at 240 777-5137. FMLA packets and information are also available online at the county website under departments, human resources, occupational medical. <http://www.montgomerycountymd.gov/ohr/oms/oms.html>

If you fail to submit your FMLA packet after an absence due to an FMLA qualifying event, it will result in your absences being counted under normal departmental attendance policy and deeming you ineligible for leave protected under FMLA until your information is received and processed.

For more information, questions, and concerns you can contact the FMLA office at 240-777-5137 or fmla.information@montgomerycountymd.gov.

Thanks for your time and cooperation.



U.S. Department of Labor
Wage and Hour Division
(February 2013)

Fact Sheet #28G: Certification of a Serious Health Condition under the Family and Medical Leave Act

MEDICAL CERTIFICATION

If the employer requests medical certification, the employee is responsible for providing a *complete and sufficient certification*, **within 15 calendar days** after the employer's request. The employee is responsible for paying for the cost of the medical certification and for making sure the certification is provided to the employer.

If the certification is incomplete or insufficient, the employer must give the employee a written notice stating what additional information is necessary to make the certification complete and sufficient. The employee must provide the additional information to the employer **within seven calendar days**, in most circumstances.

- A certification is considered “incomplete” if one or more of the *applicable* entries on the form have not been completed.
- A certification is considered “insufficient” if the information provided is vague, unclear, or non-responsive.