WESLEY WOODS

# FMLA – Family/Medical Leave of Absence
# LEAVE OF ABSENCE REQUEST

## Types of Authorized Leave:

**FMLA:** Employees are eligible for FMLA leave if you have been employed with Wesley Woods for at least 12 months and have worked at least 1,250 hours over the past 12 months.

**Non-FMLA:** Regular employees who work at least 20 hours per week are eligible to request medical leave of absence for a serious health condition, which renders them unable to perform the essential functions of their jobs. This leave of absence applies to those employees **who are not FMLA eligible** as well as other employees who have exhausted their FMLA leave. **Employees with less than 12 months of service are eligible for this type of leave.**

## Required Amount of Notice for Leave Requests:

**Planned Leave:** A planned medical leave is a pre-arranged absence from work for a medical reason. Examples of planned leaves are scheduled surgeries, dental procedures, mental health treatment etc. Employees are encouraged to provide at least 15 days' notice for foreseeable/planned medical leave of absences. This allows for smoother scheduling and coverage of your responsibilities.

**Unforeseen Leave:** An unplanned medical leave is an unexpected absence from work due to a sudden illness, injury, or other medical emergency. Unlike planned medical leave, these situations arise without prior warning and require a quicker response. In these situations where leave is not foreseeable, employees must notify their supervisor as soon as practicable.

## Required Timeframe to Submit FMLA Packet and/or Doctor's Excuse:

**Planned:** Employees are encouraged to submit their FMLA request packet **at least 2 weeks in advance** from the start of their leave.

**Unforeseen:** For unforeseen leave, employees have up to 15 calendar days after the start of their leave to submit the completed FMLA documentation and/or submit a doctor's excuse. If documentation is not received within the 15 day calendar period, the leave will be considered **unauthorized**.

## Instructions for Submitting FMLA Packet

1. Complete the "Leave of Absence Request Form" and return it to your supervisor for their signature.
2. Have your health care provider complete the "Certification for Health Care Provider Form".
3. Your health care provider must send the completed form directly to the Human Resources Department via fax or email.

   **FAX: 404-947-5809**

   **OR**

   **EMAIL: HR@wesleywoods.org**

4. Once you have been released to return to work, you must have your healthcare provider to complete the "Return to Work Status Form". The form must be sent to the HR Department prior to your return. You will not be permitted to return to work without submitting this form.

WESLEY WOODS

# LEAVE OF ABSENCE REQUEST FORM

**Section I: To be completed by the EMPLOYEE:**
Please complete Section I of this form before providing it to your healthcare provider. To qualify for FMLA leave, you must submit a timely, complete, and sufficient medical certification that supports your request. This certification is required to confirm that your absence from work is due to a serious health condition. You have 15 calendar days from the start of your absence to return this completed form. Failure to provide a complete medical certification may result in the denial of your FMLA leave request.

**Employee's Name:** _____ **Manager's Name:** _____

**Employee ID:** _____ **Community:** _____

## CONTACT INFORMATION

**Phone Number:** _____ **Mailing Address:** _____

**Email Address:** _____

## DATES OF LEAVE REQUESTED

**Date Leave Begins:** _____ **Expected Return Date:** _____

**Is this a request for Intermittent FMLA or a reduced work schedule FMLA?** ☐ **YES** ☐ **NO**

## SELECT TYPE OF LEAVE REQUESTED

☐ **FMLA Personal Illness** – Requesting leave due to employee's own serious health condition

☐ **FMLA Parental** – Requesting leave due to the birth of a child, care for newborn child, or placement of a child with the employee for adoption or foster care.

☐ **FMLA Family** – Requesting leave to care for an immediate family member with a serious health condition (spouse, domestic partner, child or employee's parent). *NOTE:* Child is defined as a minor 18 years or younger or a child with a physical/mental disability that renders them incapable of self-care.

☐ **FMLA Military Caregiver** – Requesting leave to care for spouse, domestic partner, child, parent or nearest blood relative who has incurred a serious illness or injury while on active duty.

☐ **FMLA Military Qualifying Exigency** – Requesting due to a "qualifying exigency" for a spouse, domestic partner, child or parent who is on armed forces active duty or has been notified of an impending call or order to active duty.

☐ **Non-FMLA Leave of Absence** – Requesting leave due to employee's own serious health condition, educational training or other personal reasons. This leave must be requested by employees who have less than 1 year of service working with Wesley Woods, have not worked the required 1,250 hours or are otherwise not qualified for FMLA.

☐ **Military Leave of Absence** – Requesting leave of absence due to attending mandatory military training or service. A copy of military orders must be submitted to the Human Resources department.

**I certify that the information provided above is accurate to the best of my knowledge. I understand that any false or misleading statements may result in disciplinary action, up to and including termination. Additionally, I acknowledge that I may use accrued time off to receive pay while on FMLA leave.**

**Employee's Signature:** _____ **Date:** _____

**Manager's Signature:** _____ **Date:** _____

WESLEY WOODS

# Certification of Health Care Provider (FMLA)

**SECTION II: To Be Completed by the EMPLOYER:**

A job description listing the essential functions of the employee's job is attached. All medical certifications and documents associated with medical certifications are kept as confidential records in files separate from the personnel file.

**The employer is Wesley Woods Senior Living (WWSL). The contact person at WWSL for purposes of this certification is**

| Melissa Lawery | HR Manager | HR@wesleywoods.org | 404-689-3011 | 404-947-5809 |
|---|---|---|---|---|
| *Name* | *Title* | *Email* | *Phone Number* | *Fax* |

**SECTION III: To Be Completed by the HEALTH CARE PROVIDER:**

Your patient has requested leave under the Family and Medical Leave Act (FMLA). Please provide specific information about the health condition that requires the leave. When answering questions about the frequency or duration of the condition or treatment, please provide your best estimate based on your medical knowledge, experience, and examination of the patient. Please avoid using vague terms like "lifetime," "unknown," or "indeterminate," as these may not be sufficient to determine FMLA eligibility. ***Please be sure to sign and date this form.***

## PART A: MEDICAL FACTS

1 **Approximate date condition commenced:** _____

2 **Date(s) you treated the patient for the condition:** _____

3 **Probable duration of condition:** _____

4 **Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?**

☐ **YES** ☐ **NO**

**If yes, what are the dates of admission?**

_____

5 **Will the patient need to have treatment visits at least twice per year due to the condition?**

☐ **YES** ☐ **NO**

6 **Was medication (other than over-the-counter medication)**

☐ **YES** ☐ **NO**

7 **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 treatments and expected duration of treatment:**

_____

8 **Is this medical condition pregnancy?**

☐ **YES** ☐ **NO**

**If yes, state the expected delivery date:**

_____

9 **Describe other relevant facts, if any, related to the patient's condition that support the need for leave (e.g. symptoms, diagnosis, or any regimen of continuing treatment, including the use of specialized equipment).**

_____

_____

_____

**PART B: AMOUNT OF LEAVE REQUIRED**

**1 Will the employee be incapacitated for a single continuous period of time due to their medical condition, including any time for treatment and recovery?**

☐ **YES** ☐ **NO**

**If so, please estimate the beginning and ending dates for the period of incapacity:**

**2 If the patient is not the employee, will the patient need care during this time?**

☐ **YES** ☐ **NO**

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

**3 If the patient is the employee and will need to attend follow-up treatment appointments, work part-time or on a reduced work schedule because of the employee's medical condition, please state whether such treatments or reduced work hours are medically necessary:**

☐ **MEDICALLY NECESSARY** ☐ **NOT MEDICALLY NECESSARY**

**Please estimate the treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:**

**4 Please estimate the part-time or reduced work schedule the employee needs, if any:**

**_____Hours Per Day/Shift _____ Days Per Week From: _____ through _____**

**5 If the patient is the employee, will the condition cause episodic flare-ups periodically preventing the employee from performing his or her job functions?**

☐ **YES** ☐ **NO**

**Is it medically necessary for the employee to be absent from work during these flare-ups?**

☐ **MEDICALLY NECESSARY** ☐ **NOT MEDICALLY NECESSARY**

**Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of the 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) or _____ times per month**

**Duration:** **_____ hours or _____ days per episode**

**PART C: JOB FUNCTIONS (To be completed if the employee is the patient)**

**1 Use the attached job description to complete these responses. If no job description is attached, answer these questions based on the employee's description of the job functions. If the employee is unable to perform some or all of the job functions due to the condition, list the job functions they are unable to perform below:**

**Name of Hospital, Clinic or Practice:** _____ **Type of Practice / Medical Specialty:** _____

**Business Address:** _____

**Business Phone #:** _____ **Business Fax #:** _____

**Name of Provider** _____

_____ _____

**Signature of Health Care Provider** **Date**

WESLEY WOODS

# FITNESS FOR DUTY CERTIFICATION

*(Return to Work / Physician's Release)*

**Employee's Name:** _____ **Date:** _____

**Last 4 of SSN:** _____ **Community:** _____

**Employee ID:** _____ **Department:** _____

**SECTION IV: To be completed by the HEALTHCARE PROVIDER:**

Please complete Section V, fitness for duty certification, by providing the employee/patient's work capabilities, any restrictions, and the anticipated date of maximum medical improvement (MMI), if applicable. Your signature and contact information will confirm the employee's readiness for return to work or need for continued care. Please remit the completed form via email to Melissa.Lawery@wesleywoods.org or via fax to 404-947-5809.

## WORK STATUS

**Please select one of the following:**

☐ Unable to Work
☐ Returned to Regular Duty
☐ Return to Work with Restrictions (specified below)

## RESTRICTIONS

**Back:**

☐Sitting Only
☐ No lifting over _____ lbs
☐ No pushing/pulling over _____ lbs
☐ No prolonged sitting, standing, or walking for over _____ minutes
☐ Alternate sitting/standing every _____ (min/hr)
☐ Avoid bending/twisting at the waist
☐ Avoid kneeling/squatting
☐ No ladder or stair climbing

**Neck:**

☐ No constant neck flexion
☐ No overhead reaching

**Upper Extremities:**

☐ No use of _____(Left/Right) arm, finger, thumb, hand, or wrist
☐ No repetitive bending/twisting of _____ (left/right) arm or wrist
☐ No/limited reaching above shoulder level

**Other Restrictions:**

☐ No overtime
☐ Limited to _____ hours per day
☐ No driving
☐ No use of hazardous machinery
☐ No unprotected heights

**Lower Extremities:**

☐ Sitting position with foot/leg elevated
☐ Alternate sitting/standing, walk short distances
☐ Walk/stand for up to _____ hours per day
☐ No squatting/kneeling/climbing

## ADDITIONAL INFORMATION

| | | | |
|---|---|---|---|
| **Projected Maximum Medical Improvement (MMI) Date:** | | **Anticipated Permanent Partial Impairment (PPI) Rating:** | |
| **Follow-up Appointments Scheduled for the following dates:** | | | |

**Name of Hospital, Clinic or Practice:** _____ **Business Phone #:**

**Name of Provider:** _____

**Signature of Health Care Provider** **Date**