CD-030900 Family Medical Leave of Absence	Issued: 11/05/93 Effective: 11/05/93	Reviewed: 09/29/23 Revised: 09/29/23
Alisha Tafoya Lucero, Cabinet Secretary		***Original Signed and Kept on File***

AUTHORITY:

Family and Medical Leave Act of 1993, P.L. 103-3 State Personnel Board Rule 1.7.7.12 NMAC.

REFERENCE:

A. U.S. Department of Labor Regulations, Title 29, Part 825, The Family and Medical Leave Act of 1993, https://www.dol.gov/agencies/whd/fmla/forms
B. New Mexico Corrections Department Policy *CD-030600*

PURPOSE:

To outline the conditions under which an employee may request time off, pursuant to the Family Medical and Leave Act (FMLA) for a limited period with job protection and no loss of accumulated service provided the employee returns to work as specified in this policy.

APPLICABILITY:

All New Mexico Corrections Department (NMCD) employees who meet established eligibility criteria.

FORMS:

A. **Application for Family and Medical Leave** form *(CD-030901.1)*
B. **Authorization to Release or Disclose Protected Health Information**(*CD-030901.3*)
C. **Release to Full Duty** (*CD-032301.1*)
D. **Doctor Visit/Modified Work Assignment** (*CD-032301.3*)
E. **Certification of Health Care Provider for Employee's Serious Health Condition** form WH-380E United States Department of Labor (4 Pages)
F. **Certification of Health Care Provider for Family Member's Serious Health Condition** form WH-380F United States Department of Labor (4 Pages)
G. **Certification of Qualifying Exigency For Military Family Leave** form WH-384 United States Department of Labor (3 Pages)
H. **Certification of Serious Injury or Illness of Covered Servicemember for Military Family Leave (Family and Medical Leave Act)** form WH-385 United States Department of Labor (4 Pages)

ATTACHMENTS:

Medical Certification Attachment *(CD-030901.A)* (2 Pages)

Posting of FMLA

1. Information about the FMLA will be provided to all employees by the Department by posting notices in conspicuous places throughout the NMCD.

2. Information concerning the FMLA will be included in handbooks or other publications that describe employee benefits or contain policies and practices that are of general interest to employees.

3. A copy of this policy will be included in the basic orientation materials for new employees.

DEFINITIONS:

A. *Eligible Employee*: An employee who has been employed by the State of New Mexico for at least twelve (12) months (which need not be consecutive) in total and who has worked at least 1,250 hours during the 12-month period, and actually performed work, or was on military leave at least 1,250 hours during the 12 months preceding the commencement of the leave.

B. *Family and/or Medical Leave of Absence (FML):* An approved absence available to eligible employees for up to **12 work-weeks per year** under one or more of the following circumstances: upon the birth of the employee's child; upon the placement of a child with the employee for adoption or foster care; when an employee is needed to care for a child, spouse, or parent who has a serious health condition; when the employee is unable to perform the functions of his or her position because of a serious health condition; when qualifying exigency occurs while the employee, the employee's child, spouse or parent is a member or a Reserve component or a retired member of the Regular Armed Forces or Reserves and is on active duty or on a Federal call to active duty.

C. *Health Care Provider*: A doctor of medicine or osteopathy, podiatrists, dentists, clinical psychologist, optometrists, chiropractors, nurse practitioners, nurse midwives authorized to practice in the State and performing within the scope of their practice as defined by State Law, Christian Science practitioners listed with the First Church of Christ Scientist in Boston, Massachusetts, and any other person determined by the Secretary of the U.S. Department of Labor to be capable of providing health care services. The definition also includes any health care provider from whom the state's group health plan's benefits manager will accept medical certification of the existence of a serious health condition.

D. *Involuntary Separation*: Involuntary removal of an employee from the classified service without prejudice as provided for in 1.7.10.13 NMAC.

E. *Qualifying Exigency*: A non-medical activity that is directly related to the covered military member's active duty or call to active duty status. For an activity to qualify as an exigency, it must fall within one of seven categories of activities to be mutually agreed to by the Department and the employee. The seven categories include:

   1. Short-notice deployment (leave permitted up to seven (7) days if the military member receives seven (7) or fewer days' notice of a call to active duty);
   2. Military events and related activities;

3. Certain temporary childcare arrangements and school activities (but not ongoing childcare);
4. Financial and legal arrangements;
5. Counseling by a non-medical counselor (such as a member of the clergy);
6. Rest and recuperation (leave permitted up to five days when the military member is on temporary rest and recuperation leave); or
7. Post-deployment military activities.

F. *Serious Health Condition*: An illness, injury, impairment of physical or mental condition that involves one of the following: 1) hospital care; 2) absence plus treatment; 3) pregnancy; 4) chronic conditions requiring treatments; 5) permanent long-term conditions requiring supervision; and, 6) multiple conditions or chronic conditions.

When a condition requires three consecutive days of incapacity plus two visits to a healthcare provider, the two visits to a health care provider must take place within thirty days of the commencement of the period of incapacity, and that the first visit must take place within seven (7) days of the commencement of the period of incapacity.

A serious health condition under the FMLA may also include a condition that requires three consecutive days of incapacity *plus* a regimen of continuing treatment. The first visit to the health care provider, which is part of the continuing treatment, is to occur within seven (7) days of the commencement of the period of incapacity and to qualify as a chronic serious health condition, the condition must require the employee to make at least two annual visits to a health care provider.

G. *Workweek*: An eligible employee is entitled to up to a total of 12 workweeks of leave, or 26 work-weeks in the case of military caregiver leave, and the total number of hours contained in those workweeks is necessarily dependent on the average hours the employee would have worked in the prior 12 months.

H. *Active Duty or A Call to Active Duty:* A federal call or order to active duty (State call to active duty does not qualify unless by order of the President of the United States) in support of a contingency operation pursuant to specific enumerated provisions of Section 688 of Title 10 of the United States Code, such active duty or call to active duty is only made to members of the National Guard or Reserve components or a retired member of the Regular Armed Forces or Reserve.

I. *Covered Service member*: A current member of the Armed Forces, National Guard or Reserves who is undergoing treatment, recuperation, is in outpatient status, or is otherwise on the temporary disabled list for a serious injury or illness.

J. *Military Caregiver Leave*: FML to care for a covered service member who has suffered serious injury or illness.

POLICY:

A. Eligible employees requesting a Family or Medical Leave shall be required to first take all accumulated sick leave, annual leave, compensatory time, and personal holidays as FML before being placed on unpaid FML leave. Sick leave must be exhausted before using other types of leave. Employee's may only use other forms of leave prior to sick leave with prior approval from the Division Director.

   Employees must follow the Department's procedures for requesting leave and calling in absences. Failure to do so may result in the time not being approved. In addition, if an employee simply calls in sick, does not follow the Department's call-in procedures, or does not provide sufficient information, the leave may not be designated as FMLA.

   Employees on FML are still subject to a furlough, reduction in force or reassignment that would have occurred otherwise had the employee been working.

B. The Department will require a health care provider's certification of a serious health condition to support a claim for leave for an employee's own serious health condition or to care for a seriously ill child, spouse or parent. For the employee's own medical leave, the certification must include a statement that the employee is unable to perform the essential functions of his or her position and an estimate of the amount of leave necessary. For leave to care for a seriously ill child, spouse or parent, the certification must include an estimate of the amount of time the employee is needed to provide care. The Department should request the certification at the time employee gives notice of leave or within five (5) business days thereafter. Once requested, it is the employee's responsibility to provide the Department with the medical certification within fifteen (15) calendar days.

   a. If the certification is incomplete or unclear, the employee has seven (7) additional calendar days to provide more complete information.

   b. If the certification is still insufficient, a leave management representative from central office human resources may contact the employee's health care provider for clarification or authentication of the employee's medical certification.

   c. The Human Resources Director may require a second opinion from a health care provider designated by the Human Resources Director. The Department will pay the cost of the second opinion, if required.

   d. If there is a difference between the medical certification and the second opinion, the Human Resources Director may require a third opinion from a mutually agreeable provider. The Department will pay the cost of the third opinion.

   e. NMCD may request recertification no more often than every 30-days and only in connection with an absence by an employee, unless the following sections apply. .

      - *More than 30 days* – if the medical certification indicates that the minimum duration of the condition is more than 30 days, an employer must wait until that minimum duration expires unless the following paragraph applies.

      - *Less than 30-days* – NMCD may request recertification in less than 30 days if:

- The employee requests an extension of leave
- The circumstances described in the previous certification have changed significantly (e.g., the duration or frequency of absence, the nature r the severity of the illness, complications).
- NMCD receives information that casts doubt upon the employee's stated reason for the absence or the continuing validity of the certification.

- **In all cases NMCD may request a recertification of a medical condition every six months in connection with an absence by the employee**.

f. All medical certifications and related information that describe the health or medical history or condition of the employee or family members must be handled as confidential medical information. Such information must be stored in a file separately from the personnel file.

g. When certification is requested, it is the employee's responsibility to provide the Department with timely, complete, and sufficient certification and failure to do so may result in delay or denial of FML until the certification is provided.

h. The employee should make reasonable effort to schedule the treatment so as not to disrupt unduly the employer's operations.

C. If medically necessary for a serious health condition of the employee or their spouse, child or parent, leave may be taken on an intermittent or reduced leave schedule. If leave is requested on this basis for planned treatment, the Department may transfer the employee to another position which better accommodates the leave requirements provided the employee qualifies for the position and has the same salary range and status. Upon completion of the planned treatment, the employee shall be returned to their original position.

D. A husband and wife who are both employed by the Department are entitled to a combined total of 12 workweeks during an eligibility year for a birth of a child or placement of a child for adoption or foster care. The combined limitation does not apply to leave taken by either spouse to care for the other who is seriously ill and unable to work, to care for a child with a serious health condition or for their own serious health condition.

E. When the need for leave is foreseeable, such as the birth or adoption of a child or planned medical treatment, employees must request FML thirty (30) days in advance or as soon as practicable. In the case of illness, the employee will be required to report periodically on their health status and intention to return to work.

F. The eligibility year used by the Department is the 12-month period measured forward from the date the employee first begins their FML. For the birth or adoption of a child, the eligibility year expires 12 months from the birth or placement of the child.

G. All requests for long-term (40 hours or more) sick leave usage will be evaluated to determine if the requests meet the requirements of the FMLA. If the request meets the requirements of the FML, the employee will have their leave so designated and the employee will be promptly notified in writing that they are being placed on FML and provided with a copy of this policy.

H. An employee who is entitled to take leave to care for a covered servicemember (Military Caregiver Leave) may be approved for up to a total of 26 weeks of leave during a single 12-month period as provided for in the FMLA. The single 12-month period is measured forward from the date an employee's leave to care to the covered service member begins.

I. In cases where an FML request is for a qualifying exigency, the Department will provide the employee with a copy of the **Certification of Qualifying Exigency For Military Family Leave** form WH-384 United States Department of Labor (3 Pages) to be completed by the employee. The completed form along with the documentation that the employee provides will be used to determine if the leave request qualifies and the length of the leave.

J. The time an employee spends performing "light-duty" work or performing modified duties in an Early Return to Work Program does not count towards an employee's FMLA leave.

K. Abuse of FMLA will be handled on a case-by-case basis and disciplinary action may be taken against the employee for each instance. All cases of abuse may result in a disciplinary action up to and including dismissal.

L. Discriminating against, interfering with, restraining, or denying the exercise of, or the attempt to exercise any FMLA right is strictly prohibited under the FMLA Regulations. These actions may be cause for disciplinary action up to and including dismissal.

AUTHORITY:

Policy *CD-030900*

PROCEDURES:

A. **Completion of Application for Family and Medical Leave** form *(CD-030901.1)*

1. An **Application for Family and Medical Leave** form *(CD-030901.1)* must be completed in detail, signed by the employee and submitted to their human resource office. If possible, the form should be submitted thirty (30) days in advance of the effective date of the leave. The form must be completed in its entirety and submitted to the Human Resource Bureau.

2. All requests for a Family or Medical Leave of Absence due to an employee's medical condition must be accompanied by health care provider **Certification of Health Care Provider for Employee's Serious Health Condition** form WH-380E or a **Certification of Health Care Provider for Family Member's Serious Health Condition** form WH-380F United States Department of Labor (4 Pages) for a family member's medical condition to support a claim for leave.

3. In cases where an FMLA leave is for a qualifying exigency, the employee should complete the **Certification of Qualifying Exigency For Military Family Leave** form WH-384 United States Department of Labor (3 Pages). The completed form along with the documentation that the employee provides will be used to determine if the leave request qualifies and the length of the leave. When certification is requested, it is the employee's responsibility to provide the Department with timely, complete, and sufficient certification and failure to do so may result in delay or denial of FMLA leave until the completed certification is provided.

4. In cases where an FMLA leave is for Military Caregiver Leave, the employee and an authorized military health care provider of the covered service member should complete the **Certification of Serious Injury or Illness of Covered Service member for Military Family Leave (Family and Medical Leave Act)** form WH-385 United States Department of Labor (4 Pages). The completed form along with the documentation that the employee provides will be used to determine if the leave request qualifies and the length of the leave. When certification is requested, it is the employee's responsibility to provide the Department with timely, complete, and sufficient certification and failure to do so may result in delay or denial of FMLA leave until the completed certification is provided.

B. Designation Notice:

1. A leave management representative from the Human Resources Bureau will provide a copy of the designation notice form WH-382 and a letter advising if the request has been approved, needs clarification or is denied to the employee, their supervisor and the respective HR.

2. Designation Notices that state that clarification or additional information is required the employee will have an additional 7 days to provide an updated certification. Failure to do so may result in a delay or denial of FMLA until the updated certification is provided.

C. Benefits Coverage During Leave:

1. During a period of family or medical leave, an employee will be retained on the Department's health plan (health and dental) under the same conditions that applied before leave commenced. To continue health coverage, the employee must continue to make contributions that they made to the plan before taking leave. Failure of the employee to pay their share of the health premium may result in loss of coverage.

2. If the FML includes paid leave and there is enough pay to cover the employee's share of the premium, the employee's share will be paid through payroll deduction. If the FML is unpaid, special arrangements must be made with the employee's payroll officer prior to the leave. Employees must make arrangements with their payroll officer to pay the employee's portion of the health plan prior to leaving on FML. Employees who are delinquent in paying their share of the health plan premium for more than thirty (30) days will cause the coverage to lapse.

3. Employees who fail to return to work after expiration of the FML leave must reimburse the Department for the payment of the health plan premiums unless the reason the employee fails to return is the presence of a serious health condition which prevents the employee from performing their job or for circumstances beyond the employee's control.

4. An employee on unpaid FML is not entitled to the accrual of any seniority or employment benefits that would have been accrued if not for the taking of the leave. An employee who takes family or medical leave will not lose seniority or employment benefits that accrued before the date the leave began. Employees on FML unpaid leave will NOT accrue leave.

D. Restoration to Employment:

1. Upon return from FML, an employee will be restored to their previous position or to a position with equivalent pay, benefits and other terms and conditions of employment.

2. Every effort will be made to restore the employee to their previous position but an equivalent position shall remain an option if the previous position is unavailable for any reason.

3. A health care provider must corroborate the employee's fitness for return to duty by providing written proof that the employee can perform all the essential functions of their

position. Failure to comply will delay reentry into a paid status.

a. Whenever a non-custody employee is on approved FML leave due to a personal serious health condition for thirty (30) days or more, a return-to-work statement will be required.

b. Whenever a custody employee is on approved FML leave due to a personal serious health condition for five (5) days or more, a return-to-work statement will be required.

4. If an employee wishes to return to work prior to the expiration of a family and medical leave absence, notification must be given to the employee's supervisor at least five (5) working days prior to the employee's planned return.

E. Failure to Return from Leave:

1. The failure of an employee to return to work upon the expiration of FML may result in an involuntary separation or subject the employee to discipline up to and including dismissal unless an extension is granted.

2. An employee, who requests an extension of FML for a valid reason, must submit a request for an extension to human resources as soon as the employee realizes that they will not be able to return, but in any event, before approved leave expires.

3. An eligible employee (and dependents) in the collective bargaining unit with chronic health conditions that may reasonably require frequent absences and charges to sick leave, may provide the NMCD with an annual certification.

NEW MEXICO CORRECTIONS DEPARTMENT

Application for Family or Medical Leave

Name: _____ Employee ID: _____

Current Address: _____

Phone Number: _____ Personal Email:

Direct Supervisor's Name: _____ Employee NMCD Email: _____

Start Date of Anticipated Leave: _____ Expected Date of Return to Work: _____

Intermittent or Continuous: _____

Reason for Leave (explain): _____

_____

Number of Sick Leave Hours: _____

Number of Annual Leave Hours: _____

Number of Unpaid Leave Hours: _____

Number of Compensatory Time Hours: _____

NOTE: *A leave request based on an employee's serious health condition, serious health condition of an employee's spouse, child, or parent, or for serious injury or illness of covered service member for Military Family Leave must be accompanied by a verifying medical certification from a physician.*

I hereby authorize the medical release/release of any information necessary to process the above request. I understand that failure to return to work at the end of my leave period may result in an involuntary separation or subject me to disciplinary action up to and including dismissal unless an extension has been agreed upon and approved in writing by the Corrections Department.

Signature: _____ Date: _____

Print and Sign or sign electronically

GINA Statement

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members. *In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information.* "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive service.

NEW MEXICO
CORRECTIONS DEPARTMENT
Secretary
Alisha Tafoya Lucero

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AUTHORIZATION TO RELEASE OR DISCLOSE PROTECTED HEALTH INFORMATION

This form is ***CONFIDENTIAL*** and will be maintained separate and apart from personnel files and will be kept for the duration of the individual's employment.

I, _____(Patient Name),

HEREBY AUTHORIZE _____

(Clinician Name) to release to the New Mexico Corrections Department medical information pertinent to the Family and Medical Leave Act ("FMLA") or non-FMLA medical leave requested in the attached document.

To any licensed physician, other licensed practitioner, hospital, clinic or other medically related facility, or United States Veteran Administration: I authorize you to release to the New Mexico Corrections Department the above-requested information to be used solely for the purpose of evaluating my request for FMLA or non-FMLA medical leave. This authorization shall be valid for a period 180 days after the date of my signature or earlier if revoked by my in writing to New Mexico Corrections Department. I hereby acknowledge that I have been informed of my right to receive a copy of this authorization request. I further acknowledge that I have been informed that if the medical information contained herein is not released, my medical leave may be denied.

_____ _____

Patient Signature Date

Form (*CD-032301.1*)
Revised 02/24/15

NEW MEXICO CORRECTIONS DEPARTMENT

Release to Full Duty

I have reviewed the ADA job description for the position of _____ and I am releasing _____ (employee name) to full duty, with no restriction, based on the physical demands of the position.

This release to full duty is effective Click here to enter a date. (Date)

_____
Physician's Name

_____
Physician's Signature

_____
Date

Form (*CD-032301.3*)
Revised 02/24/15

NEW MEXICO CORRECTIONS DEPARTMENT
RISK MANAGEMENT DIVISION

DOCTOR VISIT/MODIFIED WORK ASSIGNMENT (NON-WORK RELATED)

EMPLOYEE IS TO RETURN THIS COMPLETED FORM TO HIS/HER EMPLOYER AT THE CONCLUSION OF **EACH AND EVERY** DOCTOR VISIT

DATE: _____ EMPLOYER: _____

DOCTOR: _____ SOCIAL SECURITY #: _____

_____Is a State of New Mexico, Corrections Department employee. In order to accurately determine his or her working status, please complete the data below so that a determination may be made whether to return the employee to full duty or return the employee to a modified work assignment (light duty).

Thank you for your cooperation in this matter.

_____ _____ _____
Human Resource Supervisor Agency/Division Phone

1. Diagnosis _____

_____

2. Was the employee released today? Yes ☐ No ☐
3. X-ray(s)? Today: Yes ☐ No ☐ Previously: Yes ☐ No ☐
4. Medication prescribed? Yes ☐ No ☐ Continued ☐
   Will medication affect job performance? Yes ☐ No ☐
5. Can employee return to normal duty at this time? Yes ☐ No ☐
6. If "No", can employee return to work on a limited/restricted basis? Yes ☐ No ☐
7. If "Yes" to #6, what restrictions?
   ☐ No reaching above shoulder ☐ No pushing/pulling
   ☐ No climbing of stairs or ladders ☐ No operation of machinery ☐ No lifting over _____
   ☐ No repetitive waist bending ☐ No kneeling/squatting ☐ Limited/no use of _____
   Other _____

   _____

   How long will restrictions last? Until next visit_____other date _____
8. When is next scheduled visit? _____
9. Other comments _____

   _____

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

U.S. Department of Labor
Wage and Hour Division

WAGE AND HOUR DIVISION

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

OMB Control Number: 1235-0003
Expires: 6/30/2026

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee'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.

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 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.)

(4) Employee's job title: _____ Job description ☐ is / ☐ is not attached.

Employee's regular work schedule: _____

Statement of the employee's essential job functions:

_____

(The essential functions of the employee's position are determined with reference to the position the employee held at the time the employee notified the employer of the need for leave or the leave started, whichever is earlier.)

SECTION II - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form. Your patient has requested leave under the FMLA. 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 due to the serious health condition of the employee. 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 on page 4.

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.

Employee Name: _____

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(s) 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) State the approximate date the condition started or will start: _____ (mm/dd/yyyy)

(2) Provide your **best estimate** of how long the condition lasted or will last: _____

(3) 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.

Employee Name: _____

(4) 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 FMLA coverage.

(5) 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): _____

_____

(6) 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)

_____

(7) Due to the condition, it is medically necessary for the employee to work a **reduced schedule**.

Provide your **best estimate** of the reduced schedule the employee is able to work. From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy) the employee is able to work: (e.g., 5 hours/day, up to 25 hours a week)

_____

(8) 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.

(9) Due to the condition, it (☐ was / ☐ is / ☐ will be) medically necessary for the employee to be absent from work 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.

Employee Name: _____

PART C: Essential Job Functions

If provided, the information in Section I question #4 may be used to answer this question. If the employer fails to provide a statement of the employee's essential functions or a job description, answer these questions based upon the employee's own description of the essential job functions. An employee who must be absent from work to receive medical treatment(s), such as scheduled medical visits, for a serious health condition is considered to be **not able** to perform the essential job functions of the position during the absence for treatment(s).

(10) Due to the condition, the employee (☐ was not able / ☐ is not able / ☐ will not be able) to perform **one or more** of the essential job function(s). Identify at least one essential job function the employee is not able to perform:

_____

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: o 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, o 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.

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 and Hour Division

WAGE AND HOUR DIVISION

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

OMB Control Number: 1235-0003
Expires: 6/30/2026

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.

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: o 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, o 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

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

Certification for Military Family Leave for Qualifying Exigency under the Family and Medical Leave Act

U.S. Department of Labor
Wage and Hour Division

WAGE AND HOUR DIVISION

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

OMB Control Number:
1235-0003 Expires: 6/30/2026

The Family and Medical Leave Act (FMLA) provides that eligible employees may take FMLA leave for a qualifying exigency while the employee's spouse, child, or parent (the military member) is on covered active duty or has been notified of an impending call or order to covered active duty. The FMLA allows an employer to require an employee seeking FMLA leave due to a qualifying exigency to submit a certification. 29 U.S.C. §§ 2613, 2614(c)(3). The employer must give the employee **at least 15 calendar days** to provide the certification. 29 C.F.R. § 825.305(b). If the employee fails to provide complete and sufficient certification, the employee's FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at 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, it asks the employee for the information necessary for a complete and sufficient qualifying exigency certification, which is set out at 29 C.F.R. § 825.309. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. § 825.309.**

(1) Employee name: _____
First *Middle* *Last*

(2) Employer name: _____ Date: _____ *(mm/dd/yyyy)*
(List date certification requested)

(3) This 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 all Parts of Section II and sign the form before returning it to your employer. The FMLA allows an employer to require that you submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a qualifying exigency. If requested by your employer, your response is required to obtain the benefits and protections of the FMLA**.** 29 C.F.R. § 825.309. Failure to provide a complete and sufficient certification may result in a denial of your FMLA leave request. A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes written documentation confirming a military member's covered active duty or call to covered active duty status. **You are responsible for making sure the certification is provided to your employer within the time frame requested, which must be at least 15 calendar days.** 29 C.F.R. § 825.313.

(1) Provide the name of the military member on covered active duty or call to covered active duty status:

_____
First *Middle* *Last*

(2) Select your relationship of the military member. The military member is your:

☐ Spouse ☐ Parent ☐ Child, of any age

Spouse means a husband or wife as defined or recognized in the state where the individual was married, including 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 for a qualifying exigency related a military member who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave for a qualifying exigency related a military member for whom the employee has assumed the obligations of a parent. No legal or biological relationship is necessary.

Employee Name: _____

PART A: COVERED ACTIVE DUTY STATUS

Covered active duty or call to covered active duty in the case of a member of the Regular Armed Forces means duty during the deployment of the member with the Armed Forces to a foreign country. Covered active duty or call to covered active duty in the case of a member of the Reserve components means duty during the deployment of the member with the Armed Forces to a foreign country under a Federal call or order to active duty in support of a contingency operation pursuant to: Section 688 of Title 10 of the United States Code; Section 12301(a) of Title 10 of the United States Code; Section 12302 of Title 10 of the United States Code; Section 12304 of Title 10 of the United States Code; Section 12305 of Title 10 of the United States Code; Section 12406 of Title 10 of the United States Code; chapter 15 of Title 10 of the United States Code; or, any other provision of law during a war or during a national emergency declared by the President or Congress so long as it is in support of a contingency operation. 10 U.S.C. § 101(a)(13)(B).

An employer may require the employee to provide a copy of the military member's active duty orders or other documentation issued by the military which indicates that the military member is on covered active duty or call to covered active duty status, and the dates of the military member's covered active duty service. **This information need only be provided to the employer once, unless additional leave is needed for a different military member or different deployment**.

(3) Provide the dates of the military member's covered active duty service: _____

(4) Please check one of the following and attach the indicated written document to support that the military member is on covered active duty or call to covered active duty status:

- ☐ A copy of the military member's covered active duty orders
- ☐ Other documentation from the military indicating that the military member is on covered active duty or has been notified of an impending call to covered active duty, such as official military correspondence from the military member's chain of command
- ☐ I have previously provided my employer with sufficient written documentation confirming the military member's covered active duty or call to covered active duty status

PART B: APPROPRIATE FACTS

Under the FMLA, leave can be taken for a number of qualifying exigencies. 29 C.F.R. § 825.126(b). Complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes available written documentation which supports the need for leave such as a copy of a meeting announcement for informational briefings sponsored by the military, a document confirming the military member's Rest and Recuperation leave, or other documentation issued by the military which indicates that the military member has been granted Rest and Recuperation leave, or a document confirming an appointment with a third party (*e.g.*, a counselor or school official, or staff at a care facility, a copy of a bill for services for the handling of legal or financial affairs). Please provide appropriate facts related to the particular qualifying exigency to support the FMLA leave request, including information on the type of qualifying exigency and any available written documentation of the exigency event.

(5) Select the appropriate **Qualifying Exigency Category** and, if needed, provide additional information related to the event:

- ☐ Short notice deployment (*i.e.,* deployment within seven or fewer days of notice)
- ☐ Military events and related activities *(e.g., official ceremonies or events, or family support and assistance programs):*

  _____
- ☐ Childcare related activities for the child of the military member *(e.g., arranging for alternative childcare):*

  _____

Employee Name: _____

- ☐ Care for the military member's parent *(e.g., admitting or transferring the parent to a new care facility):*

  _____

- ☐ Financial and legal arrangements related to the deployment *(e.g., obtaining military identification cards)*
- ☐ Counseling related to the deployment (*i.e.*, counseling provided by someone other than a health care provider)
- ☐ Military member's short-term, temporary Rest and Recuperation leave (R&R) (leave for this reason is limited to 15 calendar days for each instance of R&R)
- ☐ Post deployment activities *(e.g., arrival ceremonies, or reintegration briefings and events):* _____

  _____

- ☐ Any other event that the employee and employer agree is a qualifying exigency: _____

  _____

(6) **Available written documentation** supporting this request for leave is (☐ attached / ☐ not attached / ☐ not available).

PART C: AMOUNT OF LEAVE NEEDED

Provide information concerning the amount of leave that will be needed. Several questions in this section seek a response as to the frequency or duration of the qualifying exigency leave needed. Be as specific as you can; terms such as "*unknown"* or *"indeterminate"* may not be sufficient to determine FMLA coverage.

(7) List the approximate date exigency started or will start: _____ *(mm/dd/yyyy)*

(8) Provide your best estimate of how long the exigency lasted or will last:

From _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*

(9) Due to a qualifying exigency, I need to work a **reduced schedule**. Provide 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 _____

(e.g., 5 hours/day, up to 25 hours a week)

(10) Due to a qualifying exigency, I will need to be absent from work for a **continuous period of time**. Provide your **best estimate** of the beginning and ending dates for the period of absence:

From _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*

Employee Name: _____

(11) Due to a qualifying exigency, I will need to be absent from work on an **intermittent basis** (periodically).

Provide your **best estimate** of the frequency (how often) and duration (how long) of each appointment, meeting, or leave event, including any travel time.

Over the next 6 months, absences on an **intermittent basis** are estimated to occur: _____ times per (☐ day / ☐ week / ☐ month) and are likely to last approximately _____ (☐ hours / ☐ days) per episode.

(12) My leave is due to a qualifying exigency that involves **Rest and Recuperation leave** (R & R) of the military member (leave for this reason is limited to 15 calendar days for each instance of R & R leave).

List the dates of the military member's R &R leave:

From _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*

PART D: THIRD PARTY INFORMATION

If applicable, please provide information below that may be used by your employer to verify meetings or appointments with a third party related to the qualifying exigency. Examples of meetings with third parties include: arranging for childcare or parental care, to attend non-medical counseling, to attend meetings with school, childcare or parental care providers, to make financial or legal arrangements, to act as the military member's representative before a federal, state, or local agency for purposes of obtaining, arranging or appealing military service benefits, or to attend any event sponsored by the military or military service organizations. This information may be used by your employer to verify that the information contained on this form is accurate.

Individual *(e.g., name and title)* or Entity / Organization: _____

Address: _____

Telephone: (___) _____ Fax: (___) _____ E-mail: _____

Describe purpose of meeting: _____

Employee Signature _____ **Date** _____ *(mm/dd/yyyy)*

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

Certification for Serious Injury or Illness of a Current Servicemember for Military Caregiver Leave under the Family and Medical Leave Act

U.S. Department of Labor
Wage Hour Division

WAGE AND HOUR DIVISION

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

OMB Control Number: 1235-0003
Expires: 6/30/2026

The Family and Medical Leave Act (FMLA) provides that eligible employees may take FMLA leave to care for a covered servicemember with a serious illness or injury. The FMLA allows an employer to require an employee seeking FMLA leave for this purpose to submit a medical certification. 29 U.S.C. §§ 2613, 2614(c)(3). The employer must give the employee **at least 15 calendar days** to provide the certification. If the employee fails to provide complete and sufficient 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.

SECTION I - EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, it asks the health care provider for the information necessary for a complete and sufficient medical certification. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. § 825.310. Recertifications are not allowed for FMLA leave to care for a covered servicemember. Where medical certification is requested by an employer, an employee may not be held liable for administrative delays in the issuance of military documents, despite the employee's diligent, good-faith efforts to obtain such documents.** An employer requiring an employee to submit a certification for leave to care for a covered servicemember **must** accept as sufficient certification invitational travel orders (ITOs) or invitational travel authorizations (ITAs) issued to any family member to join an injured or ill servicemember at the servicemember's bedside. An ITO or ITA is sufficient certification for the duration of time specified in the ITO or ITA.

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) This 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 and/or CURRENT SERVICEMEMBER

Please complete all Parts of Section II before having the servicemember's health care provider complete Section III. The FMLA allows an employer to require that an employee submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a serious injury or illness of a covered servicemember. If requested by your employer, your response is required to obtain or retain the benefit of FMLA-protected leave.

PART A: EMPLOYEE INFORMATION

(1) Name of the current servicemember for whom employee is requesting leave: _____

Employee Name: _____

(2) Select your relationship to the current servicemember. You are the current servicemember's:

☐ Spouse ☐ Parent ☐ Child ☐ Next of Kin

Spouse means a husband or wife as defined or recognized in the state where the individual was married, including 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 a covered servicemember 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 covered servicemember for whom the employee has assumed the obligations of a parent. No biological or legal relationship is necessary. "Next of kin" is the servicemember's nearest blood relative, other than the spouse, parent, son, or daughter, in the following order of priority: (1) a blood relative as designated in writing by the servicemember for purposes of FMLA leave, (2) blood relatives granted legal custody of the servicemember, (3) brothers and sisters, (4) grandparents, (5) aunts and uncles, and (6) first cousins.

PART B: SERVICEMEMBER INFORMATION AND CARE TO BE PROVIDED TO THE SERVICEMEMBER

(3) The servicemember (☐ is / ☐ is not) a current member of the Regular Armed Forces, the National Guard or Reserves. If yes, provide the servicemember's military branch, rank and unit currently assigned to: _____

_____

(4) The servicemember (☐ is / ☐ is not) assigned to a military medical treatment facility as an outpatient or to a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients, such as a medical hold or warrior transition unit. If yes, provide the name of the medical treatment facility or unit: _____

(5) The servicemember (☐ is / ☐ is not) on the Temporary Disability Retired List (TDRL).

(6) Briefly describe the care you will provide to the servicemember: *(Check all that apply)*

☐ Assistance with basic medical, hygienic, nutritional, or safety needs

☐ Psychological Comfort ☐ Physical Care

☐ Transportation ☐ Other: _____

(7) Give your **best estimate** of the amount of leave needed to provide the care described: _____

_____

(8) If a reduced work schedule is necessary to provide the care described, give your **best estimate** of the reduced work 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).*

SECTION III - HEALTH CARE PROVIDER

Please provide your contact information, complete all Parts of this Section fully and completely, and sign the form below. The employee listed at Section I has requested leave under the FMLA to care for a family member who is a current member of the Regular Armed Forces, the National Guard, or the 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. Note: For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty in the Armed Forces or that existed before the beginning of the member's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces that may render the servicemember medically unfit to perform the duties of the servicemember's office, grade, rank, or rating. "Need for care" includes both physical and psychological care. It includes situations where, for example, due to his or her serious injury or illness, the servicemember is not able to care for his or her own basic medical, hygienic, or nutritional needs or safety, or needs transportation to the doctor. It also includes providing psychological comfort and reassurance which would be beneficial to the servicemember who is receiving inpatient or home

care. A complete and sufficient certification to support a request for FMLA leave due to a current servicemember's serious injury or illness includes written documentation confirming that the servicemember's injury or illness was incurred in the line of duty on active duty or if not, that the current servicemember's injury or illness 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 that the current servicemember is undergoing treatment for such injury or illness by a health care provider listed above.

PART A: HEALTH CARE PROVIDER INFORMATION

Health Care Provider's Name: *(Print)* _____

Health Care Provider's business address: _____

Type of practice/Medical specialty: _____

Telephone: (___) _____ Fax: (___) _____ E-mail: _____

Please select the type of FMLA health care provider you are:

- ☐ DOD health care provider
- ☐ VA health care provider
- ☐ DOD TRICARE network authorized private health care provider
- ☐ DOD non-network TRICARE authorized private health care provider
- ☐ Health care provider as defined in 29 C.F.R. § 825.125

PART B: MEDICAL INFORMATION

Please provide appropriate medical information of the patient as requested below. Limit your responses to the servicemember's condition for which the employee is seeking leave. If you are unable to make some of the military-related determinations contained below, you are permitted to rely upon determinations from an authorized DOD representative, such as a DOD recovery care coordinator. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. §1635.3(e).

(1) Patient's Name: _____

(2) List the approximate date condition started or will start: _____ *(mm/dd/yyyy)*

(3) Provide your **best estimate** of how long the condition will last: _____

(4) The servicemember's injury or illness: *(Select as appropriate)*

- ☐ Was incurred in the line of duty on active duty.
- ☐ Existed before the beginning of the servicemember's active duty and was aggravated by service in the line of duty on active duty.
- ☐ None of the above.

(5) The servicemember (☐ is / ☐ is not) undergoing medical treatment, recuperation, or therapy for this condition.
If yes, briefly describe the medical treatment, recuperation or therapy: _____

Employee Name: _____

(6) The current servicemember's medical condition is classified as: *(Select as appropriate)*

☐ **(VSI) Very Seriously Ill/Injured** Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately. *Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.*

☐ **(SI) Seriously Ill/Injured** Illness/injury is of such severity that there is cause for immediate concern, but there is no imminent danger to life. Family members are requested at bedside. *Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.*

☐ **OTHER Ill/Injured** A serious injury or illness that may render the servicemember medically unfit to perform the duties of the member's office, grade, rank, or rating.

☐ **NONE OF THE ABOVE.** *Note to Employee: If this box is checked, you may still be eligible to take leave to care for a covered family member with a "serious health condition" under 29 C.F.R. § 825.113 of the FMLA. If such leave is requested, you may be required to complete DOL FORM WH-380-F or an employer-provided form seeking the same information.*

PART C: AMOUNT OF LEAVE NEEDED

For the medical condition checked in Part B, complete all that apply. Some 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.

(7) Due to the condition, the servicemember will need care for a **continuous period of time**, including any time for treatment and recovery. Provide your **best estimate** of the beginning date _____ *(mm/dd/yyyy)* and end date _____ *(mm/dd/yyyy)* for this period of time.

(8) Due to the condition, it is medically necessary for the servicemember to attend **planned medical treatment** appointments (scheduled medical visits). Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery _____ *(e.g. 3 days/week)*

(9) Due to the condition, it is medically necessary for the servicemember to receive care on an **intermittent basis** (periodically), such as the care needed because of episodic flare-ups of the condition or assisting with the servicemember's recovery. Provide your **best estimate** of how often (frequency) and how long (the duration) the intermittent episodes will likely last.

Over the next 6 months, intermittent care is 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)*

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 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 THE COMPLETED FORM TO THE DEPARTMENT OF LABOR. RETURN IT TO THE PATIENT.