

**LAKE COUNTY GOVERNMENT EMPLOYEE
APPLICATION FOR FAMILY MEDICAL LEAVE**

Please fill in all applicable sections. Failure to provide the requested information may result in denial or delay in your ability to receive approval.

Name: _____ **Department:** _____

Current Job Title: _____ **Supervisor's Name:** _____

Department Head (if different from Supervisor): _____

Current Home Address (Street, City, and Zip): _____

Start Date of Anticipated Leave: _____

Expected Date of Return: _____

Reason for Leave (Choose one):

- The birth of a child, or the placement of a child with you for adoption or foster care; or
- A serious health condition that makes you unable to perform the essential functions of your job: or
- A serious health condition affecting your Spouse, Child, Parent, for which you are needed to provide care.
- Because of any qualifying exigency arising out of the fact that your spouse, son, daughter, or parent is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation.
- A leave to care for a service member spouse, son, daughter, parent, or next of kin. This leave may provide an employee up to 26 weeks of leave during a 12-month period. This leave shall only be available during a single 12-month period.

*A full description of an employee's rights for leave under the Family & Medical Leave Act of 1993 can be found in the Employee Handbook or in the FMLA handout (available from the Human Resource office)

Have you received an approved FMLA leave in the past 12 months? Yes No

If Yes, what was the date that you returned to work from that leave? _____

I hereby authorize the Lake County Human Resources Consultant to contact my physician if necessary, to verify the need for my requested leave or for any other applicable information concerning my requested Family and Medical Leave.

I understand that a failure to return to work at the end of my leave period may be treated as a resignation unless an extension has been agreed upon and approved in writing by Lake County Government.

During an approved leave, I must use all sick/personal days, short term disability (if qualified), or compensatory time. I may use vacation days, if I choose, but I will not be required to do so.

Final approval or denial of leave will be made in writing. A copy will be provided to your Supervisor but will NOT include any specific information regarding the medical reason for the leave request.

Signature: _____ **Date:** _____

**ACKNOWLEDGEMENT OF INSURANCE RESPONSIBILITIES
WHILE ON PAID OR UNPAID LEAVE OF ABSENCE**

I, _____, hereby acknowledge that when I am on Family Medical Leave (either paid or unpaid, including short term disability) I am responsible for making payments to continue my insurance coverage. I understand the following to be the requirements:

1. Insurance payments must be received by the Insurance Office (Human Resource), Lake County, 2293 North Main St. Crown Point, IN 46307, on or before the 15th of each month in order to keep your insurance in force.

In the event that I am eligible for short-term disability payments, I authorize the aforementioned amount to be deducted from those payments in lieu of paying the employee contribution.

2. I am presently on the following type of coverage: (Circle Type)

A. Single- \$40.00/mo.

B. Family- \$75.00/mo.

3. I hereby acknowledge that the current monthly amount which I must pay for this insurance is _____ per month.
4. When I return to work as a full-time employee, I will notify the Lake County Human Resource Office (Insurance/Benefits) in writing so that they can activate the payroll deduction for my insurance.

Dated: _____ day of _____, 20_____

Employee's Name (Print)

Employee's Signature

CERTIFICATION RELATING TO CARE FOR AN EMPLOYEE'S SERIOUSLY ILL
FAMILY MEMBER

(If this section does not apply, please skip)

Name of Family Member: _____

Relation to Employee: _____

- | | Yes | NO |
|---|-----|-----|
| 1. Is inpatient hospitalization of family member required? | ___ | ___ |
| 2. Does the family member require the care of health provider that will last three or more days (excluding the flu, common cold, etc.)? | ___ | ___ |
| 3. Does (or will) the patient require assistance for medical, hygiene, nutritional needs, safety or transportation, safety or transportation? | ___ | ___ |
| 4. Would the care of the patient require the employee's presence/ assistance? (This may include psychological comfort.) | ___ | ___ |
| 5. Estimate the period of time care that is needed or the employee's presence would be beneficial: | | |

6. Will the Leave be taken for a period of time or intermittently (Please explain)?

Employee's Signature: _____

Date: _____

CHECKLIST FOR FAMILY & MEDICAL LEAVE REQUEST

- Completed Application **(Required)**
- Acknowledgement of Insurance Responsibilities while on Paid or Unpaid Leave of Absence **(Required)**
- Certification Relating to Care for An Employee's Seriously ILL Family Member (If Applicable)
- Certification of Health Care Provider **(Required)**

Once completed, return this application directly to the Insurance Office (Human Resource Dept.) for further processing.

You will be notified in writing as to whether or not your leave request has been approved.

**Certification of Health Care Provider for
Employee's Serious Health Condition
(Family and Medical Leave Act)**

U.S. Department of Labor
Wage and Hour Division



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

OMB Control Number: 1235-0003
Expires: 8/31/2021

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: 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. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to 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.

Employer name and contact: _____

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions: _____

Check if job description is attached: _____

SECTION II: For Completion by the EMPLOYEE

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

Your name: _____
First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b). Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

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

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

Probable duration of condition: _____

Mark below as applicable:

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

No Yes. If so, dates of admission:

Date(s) you treated the patient for condition:

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

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

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

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

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition: No Yes.

If so, identify the job functions the employee is unable to perform:

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

PART B: AMOUNT OF LEAVE NEEDED

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

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

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

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

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

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

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

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

Is it medically necessary for the employee to be absent from work during the flare-ups?
 No Yes. If so, explain:

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

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

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

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

A "Serious Health Condition" means an illness, injury impairment, or physical or mental condition that involves one of the following:

1. Hospital Care

Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity² or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

(a) A period of incapacity² of more than three consecutive calendar days (including any subsequent treatment or period of incapacity² relating to the same condition), that also involves:

- (1) Treatment³ two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or
- (2) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment⁴ under the supervision of the health care provider.

3. Pregnancy

Any period of incapacity due to pregnancy, or for prenatal care.

4. Chronic Conditions Requiring Treatments

A chronic condition which:

- (1) Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;
- (2) Continues over an extended period of time (including recurring episodes of a single underlying condition); and
- (3) May cause episodic rather than a continuing period of incapacity² (e.g., asthma, diabetes, epilepsy, etc.).

5. Permanent/Long-term Conditions Requiring Supervision

A period of incapacity² which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

6. Multiple Treatments (Non-Chronic Conditions)

Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity² of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), and kidney disease (dialysis).

This optional form may be used by employees to satisfy a mandatory requirement to furnish a medical certification (when requested) from a health care provider, including second or third opinions and recertification (29 CFR 825.306).

Note: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

³ Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

⁴ A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

Public Burden Statement

We estimate that it will take an average of 20 minutes 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 of information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, Department of Labor, Room S-3502, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE; IT GOES TO THE EMPLOYEE.