

**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 under the 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: 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 <ul style="list-style-type: none">• 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: <ul style="list-style-type: none">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.

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