

# Procedure: 4.5.1p. (III.U.7)

## Family and Medical Leave Act Leave (FMLA)

**Revised:** July 20, 2021; January 1, 2020; April 16, 2019; September 15, 2015; May 21, 2009; and October 3, 2001.

**Last Reviewed:** September 21, 2022; and October 28, 2019.

**Adopted:** August 5, 1993.



### I. PURPOSE:

The Family and Medical Leave Act (FMLA) allows eligible employees to take job-protected leave for specific reasons. The maximum amount of leave an employee may use is twelve (12) or twenty-six (26) weeks within a twelve (12) month period depending on the reasons for the leave.

### II. RELATED AUTHORITY:

O.C.G.A. § 20-4-11 – Powers of Board.

O.C.G.A. § 20-4-14 – TCSG Established; Powers and Duties.

29 C.F.R. Part 825, Family and Medical Leave Act of 1993, Final Rule Published November 17, 2008.

### III. APPLICABILITY:

All work units and Technical Colleges are associated with the Technical College System of Georgia.

### IV. DEFINITIONS:

**Child (son or daughter):** a biological, adopted, or foster child, a stepchild, a legal ward, or a child of a person standing in loco parentis, who is either under age 18 or age 18 or older and incapable of self-care because of a mental or physical disability at the time that FMLA leave is to commence.

**Child (son or daughter) of a Covered Servicemember:** a biological, adopted, or foster child, a stepchild, a legal ward, or a child for whom the covered servicemember stood in loco parentis, regardless of age.

**Covered Servicemember:** is a member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list for a severe injury or illness that may render him/her medically unfit to perform the duties of the member's office, grade, rank, or rating.

**Covered Military Member:** the employee's spouse, son, daughter, or parent on active duty or call to active-duty status.

**Health Care Provider:** A Doctor of Medicine or osteopathy authorized to practice medicine or surgery (as appropriate) by the State in which the doctor practices or any other person determined by the Secretary of Labor to be capable of providing health care services.

a. Others capable of providing health care services include:

i. Podiatrists, dentists, clinical psychologists, optometrists, and chiropractors authorized to practice in the State and who are performing within the scope of their practice as defined in State Law;

ii. Nurse practitioners, nurse-midwives, clinical social workers, and physicians' assistants are authorized to practice under State law and perform within the scope

- of their practice as defined under State Law.
- iii. Christian Science Practitioners listed with the First Church of Christ, Scientist in Boston, Massachusetts. In these instances, the System Office or Technical College may require a second and/or third opinion by a non-Christian Scientist practitioner;
  - iv. any health care provider from whom the State of Georgia Health Benefit Plan will accept certification for the existence of a serious health condition to substantiate a claim for benefits; and,
  - v. a health care provider as defined above who practices in a country other than the United States and who is licensed to practice in accordance with the laws and regulations of that country.

**HIPAA:** Health Insurance Portability and Accountability Act.

**Immediate Supervisor:** an individual charged with developing performance plans and managing and accessing the performance of employee(s) in those work unit(s) under their span of control.

**Intermittent Leave:** leave taken in separate periods of time due to a single illness or injury.

**Need to Care For:** the physical and/or psychological care of a family member or covered servicemember in the following situations:

- a. The family member or covered service member is unable to care for their basic medical, hygiene, or nutritional needs, safety, or is unable to travel to the doctor, etc.
- b. The family member or covered service member receives inpatient or home care, and the employee is needed to provide beneficial psychological comfort and reassurance.
- c. An employee must substitute for others caring for the family member or make arrangements for changes in care, such as transfer to a nursing home.
- d. The family member is or covered servicemember's need for care is intermittent; or,
- e. an employee is needed only intermittently (e.g., other care is typically available, or care responsibilities are shared with another caregiver, etc.).

**Next of Kin:** is the nearest blood relative of a covered servicemember, other than the individual's spouse, parent, son, or daughter in the following order of priority: blood relatives who have been granted legal custody of the servicemember by court decree or statutory provisions; brothers and sisters; grandparents; aunts and uncles; and, first cousins, unless the servicemember has specifically designated, in writing, another blood relative as their nearest blood relative for Military Caregiver Leave.

**Parent:** a biological, adoptive, step or foster father or mother, or any other individual who stood in loco parentis to the employee when the employee was a son or daughter (as defined in the term "Child"). This term does not include parents "in law."

**Parent of a Covered Servicemember:** a biological, adoptive, step or foster father or mother, or any other individual who stood in loco parentis to the covered servicemember.

**Qualifying Exigencies:** include activities such as short-notice deployment, military events, arranging alternative childcare, making financial and legal arrangements, etc., related to deployment, rest and recuperation, counseling, and post-deployment debriefings.

**Reduced Schedule Leave:** a leave schedule that reduces the number of hours in an employee's established work week or a typical workday.

**Reviewing Manager:** a manager charged with reviewing the performance plans and evaluations

prepared by lower-level supervisor(s) in their direct line of supervision.

**Severe Health Condition:** is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility (i.e., inpatient care) or continuing treatment by a health care provider for a condition that prevents an employee from performing the functions of their job or prevents the qualified family member from participating in school or other daily activities. Subject to certain conditions, continuing treatment includes an incapacity of more than three consecutive, full calendar days and two visits to a health care provider within 30 days of the first day of incapacity or one visit to a health care provider and a continuing regiment of care; an incapacity caused by pregnancy or prenatal visits, a chronic condition, or permanent or long-term conditions; or absences due to multiple treatments.

**Spouse:** a husband or wife in a marriage recognized by the State in which it was entered. This includes common law marriages that are recognized in accordance with state law.

## **V. ATTACHMENTS:**

Attachment: 4.5.1p.a1. Leave Request Form

Attachment: 4.5.1p.a2. Child's Birth, Adoption, or Foster Care Form

Attachment: 4.5.1p.a3. Certification of Health Care Provider Form for Family Member's Serious Health Condition

Attachment: 4.5.1p.a4. Certification of Health Care Provider Form for Employee's Serious Health Condition

Attachment: 4.5.1p.a5. Certification for Serious Injury or Illness of Covered Servicemember for Military Family Leave

Attachment: 4.5.1p.a6. Certification of Qualifying Exigency for Military Family Leave

Attachment: 4.5.1p.a7. Notice of Eligibility and Rights and Responsibilities Form

Attachment: 4.5.1p.a8. FMLA Designation Notice

Attachment: 4.5.1p.a9. DOL Notice to Employees of Rights and Responsibilities under the FMLA

## **VI. PROCEDURE:**

### **A. General Provisions**

1. To be eligible for FLMA leave, an employee must
  - a. have worked at least 12 months for any State of Georgia agency, department, board, bureau, etc., in the preceding seven (7) years except for any break-in-service occasioned by the fulfillment of an employee's National Guard or Reserve military service obligation.
  - b. Have worked at least 1,250 hours for any State of Georgia agency, department, board, bureau, etc., during the twelve (12) months immediately preceding the date FMLA leave is to begin except that an employee returning from fulfilling their National Guard or Reserve military obligation shall be credited with the hours-of-service that could have been performed but for the period of military service in determining whether the employee worked the 1,250 hours of service.
2. FMLA leave may be taken for the following reasons:
  - a. Birth of a child or to care for/bond with a newly born child (up to 12 weeks).
  - b. Placement of a child with the employee for adoption or foster care (up to 12 weeks).
  - c. To care for an immediate family member (employee's spouse, child, or parent) with a serious health condition (up to 12 weeks).
  - d. An employee's serious health condition makes them unable to perform their job (up to 12 weeks).
  - e. To care for a covered service member with a severe injury or illness related to certain types of military service (up to 26 weeks).

- f. To manage qualifying exigencies arising because the employee's spouse, son, daughter, or parent is on active duty under a call or order to active duty in the Armed Forces (e.g., National Guard or Reserves) in support of a contingency operation (up to 12 weeks).
3. The maximum leave that may be taken in 12 months for all reasons is 12 weeks, except leave to care for a covered servicemember, which carries a maximum combined leave entitlement of 26 weeks. In these instances, leave for all other reasons cannot constitute more than 12 of these 26 weeks.
4. The TCSG and its associated Technical Colleges measure the 12-month period in which leave is taken by the "rolling" 12-month method, measured backward from the date of any FMLA leave with one exception. For leave to care for a covered service member, the TCSG and its Technical Colleges calculate the 12 months beginning on the first day the eligible employee takes FMLA to leave to care for a covered service member and ends 12 months after that date. FMLA leave for the birth or placement of a child for adoption, or foster care must be concluded within 12 months of the birth or placement.
5. When medically necessary, eligible employees may take FMLA to leave in a single block of time, intermittently (in separate blocks of time), or by reducing their regular work schedule when medically necessary for the serious health condition of the employee or immediate family member, or the injury or illness of a covered servicemember. Eligible employees may also take intermittent or reduced-scheduled leave for military qualifying exigencies. Employees who require intermittent or reduced-schedule leave must attempt to schedule their leave so that it will not unduly disrupt System Office or Technical College operations.
6. Employees must use any accrued paid leave concurrently with FMLA leave. When available, compensatory time (FLSA, Georgia, or holiday compensatory time) will be required. At the same time, on FMLA leave, available annual, sick, or personal leave will be used in accordance with related TCSG procedures governing the use of paid leave for all absences designated as family leave. Paid parental leave must be used concurrently with family leave taken for the same qualifying reasons. Employees elected to receive workers' compensation benefits for lost wages may take FMLA to leave without pay and will not be required to use paid leave.
7. The DOL Notice to Employees of Rights under the FMLA (Attachment: 4.5.1p.a9.) must be posted prominently so applicants and employees can readily see it. In addition, a copy of the notice should be provided to all newly hired employees.
8. In accordance with federal regulations, and as outlined in this procedure, the System Office and its associated Technical Colleges will inform an employee whether they are eligible for leave under the FMLA and designate all FMLA-protected leave. Upon returning from FMLA leave, an employee will typically be restored to their original job or an equivalent job with equivalent pay, benefits, and other employment terms and conditions.
9. The FMLA makes it unlawful for any employer to interfere with, restrain, or deny the exercise of any right provided under the FMLA or discharge or discriminate against any person for opposing any practice made unlawful by the FMLA or for involvement in any proceeding under or relating to the FMLA. Accordingly, the TCSG and its Technical Colleges encourage employees to bring any concerns or complaints about compliance with the FMLA to the System Office or Technical College Office of Human Resources.

10. Medical information obtained from an employee's serious health condition and all medical information gathered during employment with the System Office, or Technical College is confidential. Access to this information, which is housed separately from work-related documents collected during the scope of an individual's employment and retained in an employee's personnel file, is restricted to System Office/Technical College representatives having a legitimate business reason to view the materials.
11. Employees who fail to return to work as scheduled after FMLA leave will be subject to disciplinary action consistent with State Board policy.
12. An employee providing false or misleading information or intentionally omitting material information concerning an FMLA leave will be subject to disciplinary action consistent with State Board policy.

**B. Birth of a Child, Adoption, or Foster Care**

1. Family leave for a child's birth will begin when the child is born unless the mother is previously incapacitated.
2. Family leave for the placement or adoption of a child will begin on the date the employee's presence is needed for the placement process to begin or when the employee takes actual custody of the child.
3. Family leave taken for this reason must occur within 12 months from the date of birth or placement.
4. Spouses employed by a State of Georgia entity are entitled to a combined 12 weeks for bonding with a newborn or newly placed or adopted child.

**C. Serious Health Condition of an Employee or a Family Member**

1. Family leave for an employee's serious health condition will begin when the employee cannot perform the essential functions of their position. To qualify for family leave, an employee must have a serious health condition defined in this procedure and related rules and regulations.
2. Family leave for a family member's serious health condition will begin when the employee's presence is necessary to provide physical and/or psychological care for the family member. The employee's family member must have a serious health condition as defined in this procedure and related rules and regulations.
3. An employee requesting family leave for his or her serious health condition or the serious health condition of a family member must make a reasonable effort, subject to the approval of a health care provider, to schedule the treatment or supervision of the family member. Hence, so as not to unduly disrupt System Office or Technical College operations.
4. Spouses employed by a State of Georgia entity are entitled to a combined 12 weeks to care for a parent.

**D. Military Caregiver Leave**

1. Employees who are the spouse, child (son or daughter), parent, or next of kin of a covered service member may use family leaves to care for family members who have sustained severe injuries or illnesses while on active duty. The employee must

meet all other eligibility requirements.

2. An eligible employee may take up to 26 work weeks of Military Caregiver Leave to care for a covered service member in 12 months. However, the rolling 12-month period may not coincide with the rolling 12-month period used for family leave for other qualifying reasons.
3. Military Caregiver Leave applies on a per-injury basis for each service member. Therefore, an eligible employee may take separate periods of leave for each covered service member and/or for each severe injury or illness of the same covered service member. However, no more than 26 workweeks of leave may be taken in any single 12-month period.
4. Within the single 12-month period, an eligible employee may take a combined total of 26 weeks of FMLA leave, including up to 12 weeks of leave for any other FMLA-qualifying reason (e.g., the birth of a child, the serious illness of a family member, a qualifying exigency, etc.). For example, during the "single 12-month period", an eligible employee may take up to 16 weeks of FMLA leave to care for a covered service member when combined with up to 10 weeks of FMLA leave to care for a newborn child.

#### **E. Qualifying Exigency Leave**

1. Employees who are the spouse, child (son or daughter), or parent of a covered military member called to active duty may take family leave for the following qualifying exigencies:
  - a. Short-notice deployment: to address any issue arising from short notice (within seven days or less) of an impending call or order to active duty.
  - b. Military events and related activities: to attend any official military ceremony, program, or event related to active duty or a call to active-duty status or to attend specific family support or assistance programs and information briefings.
  - c. Childcare and school activities: to arrange for alternative childcare; to provide childcare on an urgent, immediate need basis; to enroll a child in or transfer a child to a new school or daycare facility, or to attend meetings with staff at a school or daycare facility.
  - d. Financial and legal arrangements: to make or update various financial or legal arrangements; or to act as the covered military member's representative before a federal, State, or local agency in connection with service benefits.
  - e. Counseling: to attend counseling (by someone other than a health care provider) for the employee, the covered military member, or for a child or dependent, when necessary, as a result of duty under a call or order to active duty.
  - f. Rest and recuperation: to spend time with a covered military member on short-term, temporary rest and recuperation leave during deployment. Eligible employees may take up to five (5) days of leave for each instance of rest and recuperation.
  - g. Post-deployment activities: attend arrival ceremonies, reintegration briefings and events, and any other official ceremony or program sponsored by the military for up to 90 days following termination of the covered military member's active-duty status.



entirety and State whether the employee is eligible for family leave. If the employee is not eligible, all reasons why must be noted.

#### **H. Medical Certification (Employee or Family Member)**

1. When requesting FMLA leave, an employee must provide medical certification supporting the need for leave due to a severe health condition affecting an employee or their immediate family member within 15 calendar days of the System Office or Technical College's request to provide the certification.
2. If the certification is incomplete or insufficient, the System Office or Technical College must notify the employee in writing regarding what information is necessary to make the certification complete and sufficient and provide the employee with seven calendar days to cure any deficiencies (unless this time period is not practicable despite the employee's diligent, good-faith efforts).
3. If the deficiencies are not resolved, the System Office or Technical College may contact the employee's health care provider for verification and clarification. It is not permitted to obtain additional information beyond that required by the certification form. Contact may be made by the System Office, Technical College Human Resources Director/Coordinator, or other Human Resources representative. The employee's immediate supervisor is not permitted to engage in these discussions.
4. Suppose an employee fails to provide a complete certification. In that case, the System Office or Technical College may delay the commencement of leave, withdraw any designation of FMLA leave, or deny the leave and place the employee on leave without pay status consistent with State Board policy and State Personnel Board Rules.
5. An employee might be required to provide medical certification of their fitness for duty before returning to work if the leave was due to a severe health condition. The System Office or Technical College will require this certification to address whether an employee returning from a period of leave under these provisions can perform the essential functions of their position.
6. While an employee's permission is not needed to contact the healthcare provider purely for verification purposes, the System Office or Technical College must obtain the employee's authorization to clarify "individually identifiable" health information, consistent with HIPAA.

#### **I. Designation Notice**

1. Once the System Office or Technical College has sufficient information to determine whether the leave is FMLA-qualifying, the employee must be notified in writing of this decision within five business days using Attachment: 4.5.1p.a8., FMLA Designation Notice.
2. The Designation Notice must indicate this if an employee is required to provide a fitness-for-duty certificate from their health care provider before returning to work. In addition, a list of essential functions or a job description must be attached to the Designation Notice.
3. The designation notice need only be provided once for each qualifying reason during the 12 months.
4. The amount of leave (such as the number of hours, days, or weeks) to be counted against the FMLA entitlement must be specified if known at the time the System Office or

Technical College designates the leave as FLMA qualifying. If this is not possible when the designation is made, the System Office or Technical College must provide this information upon request by the employee. The leave notice amount must be written in writing no later than the following payday.

5. Suppose both military caregiver and the severe health condition of a family member leave apply. In that case, the System Office or Technical College must designate the leave as military caregiver leave to permit up to 26 weeks of leave.
6. Failure to provide required notice may constitute interference with, restraint of, or denial of the exercise of an employee's FMLA rights and subject the TCSG and its Technical Colleges to potential liability for compensation and benefits lost because of the violation.
7. The System Office or Technical College may retroactively designate leave, provided that the System Office or Technical College's failure to designate such leave promptly has not caused harm or injury to the employee. In all instances in which leave qualifies for FMLA protection, the System Office or Technical College and the employee may mutually agree to the retroactive designation.

#### **J. Recertification of Medical Conditions**

1. The System Office or Technical College Human Resources Director/Coordinator may require recertification (from the employee's health care provider) regarding the medical condition(s) that initially supported an employee's request for family leave for their use.
2. If the initial recertification indicates the severe health condition will have a minimum duration of more than 30 days, recertification may not be requested until the initial period has expired.
3. Recertification may be requested at reasonable intervals, but not more often than every 30 days, unless the employee requests an extension of leave; circumstances described by the previous certification have significantly changed (e.g., the duration of the illness, the nature of the illness, complications, etc.); or, the System Office or Technical College receives information that places doubt upon the continuing validity of the initial/most recent certification.
4. As with the initial certification, an employee has 15 calendar days to provide a requested certification. All requirements and consequences outlined in this Procedure will apply to requests for recertification. The employee will be responsible for all costs associated with the recertification, and no second or third opinions may be requested.
5. In instances in which the duration of an employee's condition is "lifetime" or "unknown," the System Office or Technical College may request a recertification every six months in conjunction with the employee's absence.

#### **K. Second or Third Medical Opinions**

1. Suppose the System Office or Technical College has reason to doubt the validity of a submitted medical certification. In that case, the employee may be required to obtain a second opinion at the expense of the System Office or Technical College. Pending receipt of the medical opinion, the employee is provisionally entitled to the benefits of the Act.
2. The System Office or Technical College may designate the health care provider to furnish the second opinion, provided the selected health care provider is not employed regularly by the System Office or Technical College.

3. Suppose the opinions of the employees and the System Office or Technical College's designated healthcare providers differ. In that case, the System Office or Technical College may require the employee to obtain certification from a third healthcare provider at the expense of the System Office or Technical College. The third opinion is binding.
4. The third health care provider must be designated or approved jointly by the System Office or Technical College and the employee. Both parties must act in good faith in reaching this determination. If the System Office or Technical College does not attempt, in good faith, to reach an agreement, the System Office or Technical College will be bound by the first certification. If the employee does not attempt, in good faith, to reach an agreement, the employee will be bound by the second certification.
5. The System Office or Technical College must provide the employee with a copy of the second and third medical opinions upon request. Requested copies must be provided within five business days unless extenuating circumstances prevent such action.
6. The System Office or Technical College must reimburse the employee for all reasonable expenses for obtaining the second and third medical opinion.
7. Unlike other medical certification forms, the System Office or Technical College may not require a second or third opinion or recertification of military caregiver-leave medical certifications.

#### **VII. RECORD RETENTION:**

Medically related documents associated with a short- or long-term leave/leave of absence (with or without pay) taken pursuant to the FMLA must be maintained in an employee's medical file for seven years after they depart from state employment. Other time and leave documents/records not kept in an employee's personnel file should be retained for three years after they depart from state employment.

**Attachment: 4.5.1p.a1. Technical College System of Georgia**

**FAMILY AND MEDICAL LEAVE ACT  
LEAVE REQUEST FORM**

Employee's Name: \_\_\_\_\_ Employee ID#: \_\_\_\_\_

Work Location: \_\_\_\_\_

Dates of Leave Requested: \_\_\_\_\_ through \_\_\_\_\_

**Reason for FMLA Leave (check all that apply):**

- Birth of a child and to care for the newly born child or placement of a child with the employee for adoption or foster care.
- To care for an immediate family member (employee's spouse, child, or parent) with a severe health condition
- Your serious health condition
- Because of a qualifying exigency arising out of the fact that your  spouse;  son or daughter;  or parent is on active duty or called to active-duty status in support of a contingency operation as a member of the National Guard or Reserves
- Because you are the  spouse;  son or daughter;  parent;  or next of kin of a covered servicemember with a serious injury or illness

**Type and Number of Hours of Leave Requested for The Purpose Identified Above (check all that apply, if available):**

- Annual Leave: \_\_\_\_\_ hours                      Unpaid family and medical leave
- Sick Leave: \_\_\_\_\_ hours                       Personal Leave: \_\_\_\_\_ hours
- 

To receive paid leave during all or part of an FMLA leave, employees must satisfy the State Board policy governing the use of leave and applicable State Personnel Board Rules.

Is intermittent leave or a reduced work schedule requested? If yes, explain why it is needed and the leave schedule proposed:

\_\_\_\_\_  
\_\_\_\_\_

**Intention To Return to Work When the Leave Ends (select one):**

- The employee will not be returning to work.
- However, the employee intends to return to work.

**Authorization, Certification, and Signatures:**

Who provided the information to complete the form (other than the employee)? \_\_\_\_\_

Name of the person who completed the form: \_\_\_\_\_ Date: \_\_\_\_\_

I certify that the above information is accurate and correct to the best of my knowledge. I understand that any misrepresentation concerning the above facts can result in the delivery of disciplinary action pursuant to the Positive Discipline Policy.

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Supervisor's Signature

\_\_\_\_\_  
Date

**Attachment: 4.5.1p.a2. Family and Medical Leave Act**

**Documentation of Child's Birth, Adoption, or Foster Care**

Employee's <del>Name</del>	Employee ID #:
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**For Birth of a Child:**

Physician/ Provider:	
Address:	
Phone No.:	
Mother's Name:	
<input type="checkbox"/> This is to certify that the mother named above is expected to give birth on:  _____ (date)	<input type="checkbox"/> This is to certify that the mother named above gave birth on:  _____ (date)
Health Care Provider's Signature: (No Stamp, Please)	Date:

**For Adoption/ Foster Care:**

Foster Care of Adoption Agency/ Attorney:	
Address:	
Phone No.:	
<input type="checkbox"/> This is to certify that the child will be placed for adoption with the employee named above on:  _____ (date)	<input type="checkbox"/> This is to certify that the child will be placed for foster care with the employee named above on:  _____ (date)
Child Placement Agency Representative/ Attorney Signature: (No Stamp Please)	Date:

**Attachment: 4.5.1p.a3.**

**Family and Medical Leave Act**

**CERTIFICATION OF HEALTH CARE PROVIDER FOR  
FAMILY MEMBER'S SERIOUS HEALTH CONDITION**

**Section I – For completion by the System Office or Technical College**

**INSTRUCTIONS:** The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Please complete Section I before giving this form to your employee. An employer may not ask an employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. The system office or Technical College must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of 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.

System Office/Technical College Contact Information: \_\_\_\_\_

**Section II: For completion by the Employee**

**INSTRUCTIONS to the EMPLOYEE:** Please complete Section II before giving this form to your family member or their 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 to care for a covered family member with a severe health condition. If requested by the system office or Technical College, 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. 20 C.F.R. § 825.313. You must be provided at least 15 calendar days to return this form—29 C.F.R. § 825.305(b).

Your name: \_\_\_\_\_  
First Middle Last

Name of a family member for whom you will provide care: \_\_\_\_\_  
First Middle Last

Relationship of family member to you: \_\_\_\_\_

If the family member is your son or daughter, their date of birth: \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Employee Signature

Date

**Section III: For completion by the Health Care Provider:**

**INSTRUCTIONS to the HEALTH CARE PROVIDER:** The employee listed above has requested leave under the FMLA to care for your patient. The answer, fully and completely, is all applicable parts below. Several questions seek a response regarding the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based on your medical knowledge, experience, and patient examination. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the patient needs to leave. Page 4 provides space for additional information should you need it. Please be sure to sign the form on the last page.

Provider's name and business address: \_\_\_\_\_

Type of practice/Medical specialty: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

**Part A – Medical Facts**

1. Approximate date condition commenced: \_\_\_\_\_

Probable duration of condition: \_\_\_\_\_

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?  Yes  No If so, dates of admission: \_\_\_\_\_

Date(s) you treated the patient for the condition:  
\_\_\_\_\_

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

Will the patient need treatment visits at least twice yearly due to the condition?  Yes  No

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

\_\_\_\_\_

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

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Part B – Amount of care needed**  
When answering these questions, keep in mind that your patient’s need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety, or transportation needs or the provision of physical or psychological care:

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

Estimate the beginning and ending dates for the period of incapacity: \_\_\_\_\_

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

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Will the patient require follow-up treatments, including any time for recovery?  Yes  No

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

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

\_\_\_\_\_

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery?  Yes  No

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

\_\_\_\_\_ hour(s) per day; \_\_\_\_\_ days per week from \_\_\_\_\_ through \_\_\_\_\_

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

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

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 six months (e.g., 1 episode every three months lasting 1-2 days):

Frequency: \_\_\_\_\_ times per \_\_\_\_\_ week(s) \_\_\_\_\_ month(s)

Duration: \_\_\_\_\_ hours or \_\_\_\_\_ day(s) per episode.

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

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

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**Additional Information:**  
**(Identify the question number with your additional answer.)**

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\_\_\_\_\_  
Signature of Health Care Provider  
(No Stamps, Please)

\_\_\_\_\_  
Date

**[Attachment: 4.5.1p.a4.]**

## **Family and Medical Leave Act**

### **CERTIFICATION OF HEALTH CARE PROVIDER FOR EMPLOYEE'S SERIOUS HEALTH CONDITION**

#### **Section I – For completion by the System Office or Technical College**

**INSTRUCTIONS:** 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 severe 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. An employer may not ask an employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Therefore, the system office or Technical College 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.

Employer name and contact: \_\_\_\_\_

Employee's job title: \_\_\_\_\_ Regular work schedule: \_\_\_\_\_

Employee's essential job functions: \_\_\_\_\_

Check if the 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 serious health condition. If requested by the system office or Technical College, 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. 20 C.F.R. § 825.313. It would be best if you were provided 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. The answer, fully and completely, all applicable parts. Several questions seek a response regarding the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based on your medical knowledge, experience, and patient examination. 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. 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, the dates of admission:

\_\_\_\_\_

Date(s) you treated the patient for the condition:

\_\_\_\_\_

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

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

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. Is the medical condition pregnancy?  Yes  No, If so, the 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 on the employee's description of their job functions.

Is the employee unable to perform any of their job functions due to the condition?  Yes  No

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

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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):

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### **Part B – Amount of Leave Needed**

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

If so, 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?  Yes  No

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

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

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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 and prevent the employee from performing their job functions?  Yes  No If so, explain:

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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 six months (e.g., 1 episode every three months lasting 1-2 days):

Frequency: \_\_\_\_\_ times per \_\_\_\_\_ week(s) \_\_\_\_\_ month(s)

Duration: \_\_\_\_\_ hours or \_\_\_\_\_ day(s) per episode.

**Additional Information:**  
**(Identify the question number with your additional answer.)**

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\_\_\_\_\_  
Signature of Health Care Provider

\_\_\_\_\_  
Date

(No Stamps, Please)

## Family and Medical Leave Act

### CERTIFICATION FOR SERIOUS INJURY OR ILLNESS OF COVERED SERVICEMEMBER FOR MILITARY FAMILY LEAVE

**INSTRUCTIONS:** The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a severe injury or illness of a covered servicemember to submit a certification providing sufficient facts to support the request for leave. An employer may not ask an employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. § 825.310. Therefore, the system office or Technical College must generally maintain records and documents relating to medical certification, 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 accordance with 29 C.F.R. § 1630.14(c)(1) if the Americans with Disabilities Act applies.

**Section I: For completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the Employee is Requesting Leave.**

**INSTRUCTIONS to the Employee or Covered Servicemember:** Please complete Section I before having Section II completed. The FMLA permits an employer to require that an employee submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a severe injury or illness of a covered servicemember. If requested by the system office or Technical College, your response is required to obtain or retain the benefit of FMLA-protected leave. 29 C.F.R. §§ 2613, 2614(c)(3). Failure to do so may result in denying an employee's FMLA request. 29 C.F.R. § 825.310(f). You must be provided at least 15 calendar days to return this form.

**Section II: For completion by a UNITED STATES DEPARTMENT OF DEFENSE ("DOD"), HEALTH CARE PROVIDER, or a HEALTH CARE PROVIDER who is either: (1) a United States Department of Veteran's Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider.**

**INSTRUCTIONS to the Health Care Provider:** The employee listed on Page 2 has requested leave under the FMLA to care for a family member who is a 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 severe injury or illness. For purposes of FMLA leave, a serious injury or illness is incurred in the line of duty on active duty that may render the servicemember medically unfit to perform the duties of his or her office, grade, rank, or rating.

A complete and sufficient certification to support a request for FMLA leave due to a covered servicemember's serious injury, or illness includes written documentation confirming that the covered servicemember's injury or illness was incurred in the line of duty on active duty and that the covered servicemember is undergoing treatment for such injury or illness by a health care provider listed above. The answer, fully and completely, all applicable parts. Several questions seek a response regarding the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based on your medical knowledge, experience, and patient examination

. 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.

**Section I – For completion by the Employee and/or the Covered Servicemember for whom the Employee is Requesting Leave.**

(This section must be completed first before a health care provider can complete any of the below sections.)

**Part A - Employee Information**

Name and Address of Employer (this is the employer of the employee requesting leave to care for covered servicemember):

\_\_\_\_\_

Name of Employee Requesting Leave to Care for Covered Servicemember:

\_\_\_\_\_

First	Middle	Last
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Name of Covered Servicemember (for whom the employee is requesting leave to care):

\_\_\_\_\_

First	Middle	Last
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Relationship of Employee to Covered Servicemember Requesting Leave to Care:

- Spouse    Parent    Son    Daughter    Next of Kin

**Part B – Covered Servicemember Information**

1. Is the Covered Servicemember a current member of the Regular Armed Forces, the National Guard, or Reserves?  Yes  No

If yes, please provide the covered servicemember’s military branch, rank, and the unit currently assigned to:

\_\_\_\_\_

Is the covered servicemember assigned to a military medical treatment facility as an outpatient or to a unit established to provide command and control of Armed Forces members receiving medical care as outpatients (such as a medical hold or warrior transition unit)? Yes   No     

If yes, please provide the name of the medical treatment facility or unit: \_\_\_\_\_

\_\_\_\_\_

Attachment: 4.5.1p.a5.

2. Is the Covered Servicemember on the Temporary Disability Retired List (TDRL)?  Yes  No

**Part C – Care to be provided to the Covered Servicemember**

Describe the care to be provided to the Covered Servicemember and an Estimate of the leave needed to provide the care:

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**Section II: For completion by a United States Department of Defense (“DOD”) Health Care Provider or a Health Care Provider who is either: (1) a United States Department of Veterans Affairs (“VA”) Health Care Provider; (2) a DOD TRICARE Network Authorized Private Health Care Provider; or (3) a DOD Non-Network TRICARE Authorized Private Health Care Provider.**

**Suppose you cannot make sure of the military-related determinations in Part B. In that case, you can rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator).** (Please ensure that Section I above has been completed before completing this section.) Please be sure to sign the form on the last page.

**Part A – Health Care Provider Information**

Health Care Provider’s Name and Business Address:

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Type of Practice/Medical Specialty: \_\_\_\_\_

Please state whether you are either: (1) a DOD health care provider; (2) a VA health care provider; (3) a DOD TRICARE network authorized private health care provider; or (4) a DOD non-network TRICARE authorized private health care provider: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ E-mail: \_\_\_\_\_

**Part B – Medical Status**

1. A covered Servicemember's medical condition is classified as (check one of the appropriate boxes):
  - (VSI) Very Seriously Ill/Injured** – Illness/injury is of such severity that life is imminently endangered. Family members are requested at the bedside immediately. (Please note this is an internal DOD casualty assistance designation used by DOD health care 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 the bedside. (Please note this is an internal DOD casualty assistance designation used by DOD health care providers.)
  - Other Ill/Injured** – A severe 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 § 825.113 of the FMLA. If such leave is requested, you may be required to complete DOL FORM WH-380 or an employer-provided form seeking the same information.)

2. Was the condition for which the Covered Servicemember is being treated incurred in the line of duty on active duty in the armed forces?  Yes  No

3. Approximate date condition commenced: \_\_\_\_\_

4. Probable duration of the condition and/or need for care: \_\_\_\_\_

5. Is the covered servicemember undergoing medical treatment, recuperation, or therapy?  Yes  No

If yes, please describe medical treatment, recuperation, or therapy:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Part C – Covered Servicemember's Need for Care by Family Member**

1. Will the covered servicemember need care for a single continuous period of time, including any time for treatment and recovery? \_\_\_\_ Yes \_\_\_\_ No

If yes, estimate the beginning and ending dates for this period of time: \_\_\_\_\_

2. Will the covered servicemember require periodic follow-up treatment appointments?  Yes  No

Attachment: 4.5.1p.a5.

If yes, estimate the treatment schedule: \_\_\_\_\_

3. Is there a medical necessity for the covered servicemember to have routine care for these follow-up treatment appointments?  Yes  No

4. Is there a medical necessity for the covered servicemember to have periodical care other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of a medical condition)?  
 Yes  No

If yes, please estimate the frequency and duration of the periodical care:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Health Care Provider

\_\_\_\_\_  
Date

(No Stamps, Please)

**Attachment: 4.5.1p.a6.**

**Family and Medical Leave Act**

**CERTIFICATION OF QUALIFYING EXIGENCY  
FOR MILITARY FAMILY LEAVE**

**Section I – For completion by the System Office or Technical College**

**INSTRUCTIONS:** The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a qualifying exigency to submit a certification. Please complete Section I before giving this form to your employee. An employer may not ask an employee to provide more information than allowed under FMLA regulations, 29 C.F.R. § 825.309.

System Office or Technical College Contact Information: \_\_\_\_\_

\_\_\_\_\_

**Section II: For completion by the Employee**

**INSTRUCTIONS to the EMPLOYEE:** Please complete Section II fully and completely. The FMLA permits 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. Several questions in this section seek a response regarding the frequency or duration of the qualifying exigency. Be as specific as possible; terms such as "unknown" or "indeterminate" may not be sufficient to determine FMLA coverage. Your response is required to obtain a benefit under 29 C.F.R. § 825.310. While you are not required to provide this information, failure to do so may result in a denial of your request for FMLA leave. You must be provided at least 15 calendar days to return this form.

Your name: \_\_\_\_\_  
First Middle Last

Name of the covered military member on active duty or call to active-duty status in support of a contingency operation:

\_\_\_\_\_

First Middle Last

Relationship of a covered military member to you: \_\_\_\_\_

Period of covered military member's active duty: \_\_\_\_\_

A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes written documentation confirming a covered military member's active duty or call to active-duty status in support of a contingency operation. In addition, please check one of the following:

- A copy of the covered military member's active-duty orders is attached.
- Other documentation from the military certifying that the covered military member is on active duty (or has been notified of an impending call to active duty) in support of a contingency operation is attached.
- I have previously provided my employer with sufficient written documentation confirming the covered military member's active duty or call to active-duty status in support of a contingency operation.

**Part A – Qualifying reason for leave.**

1. Describe the reason you are requesting FMLA leave due to a qualifying exigency (including the specific reason you are requesting leave):

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2. A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes any available written documentation which supports the need for leave; such documentation may include a copy of a meeting announcement for informational briefings sponsored by the military, a document confirming an appointment with a counselor or school official, or a copy of a bill for services for the handling of legal or financial affairs. Available written documentation supporting this request for leave is attached. Yes  No  None available

**Part B – Amount of Leave Needed**

1. Approximate date exigency commenced: \_\_\_\_\_

Probable duration of exigency: \_\_\_\_\_

2. Will you need to be absent from work for a single continuous period of time due to the qualifying exigency?  Yes  No

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

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3. Will you need to be absent from work periodically to address this qualifying exigency?  Yes  No  
Estimate schedule of leave, including the dates of any scheduled meetings or appointments:

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Estimate the frequency and duration of each appointment, meeting, or leave event, including any travel time (i.e., one deployment-related meeting every month lasting 4 hours):

Frequency: \_\_\_\_\_ times per \_\_\_\_\_ week(s) \_\_\_\_\_ month(s)

Duration: \_\_\_\_\_ hours or \_\_\_\_\_ day(s) per event.

### Part C

If leave is requested to meet with a third party (such as to arrange for childcare, attend counseling, attend meetings with school or childcare providers, make financial or legal arrangements, to act as the covered 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), a complete and sufficient certification includes the name, address, and appropriate contact information of the individual or entity with whom you are meeting (i.e., either the telephone or fax number or email address of the individual or entity). This information may be used by the system office or Technical College to verify that the information contained on this form is accurate.

Name of Individual: \_\_\_\_\_ Title: \_\_\_\_\_

Organization: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

Describe nature of meeting: \_\_\_\_\_

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### Part D

I certify that the information I provided above is true and correct.

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date

**Attachment: 4.5.1p.a7.**

**Family and Medical Leave Act**

**NOTICE OF ELIGIBILITY AND  
RIGHTS & RESPONSIBILITIES**

**(For Completion by the System Office or Technical College)**

To be eligible for FMLA leave, an employee must have worked for any State of Georgia agency, department, etc. for at least 12 months and must have worked at least 1,250 hours in the 12 months preceding the leave.

TO: \_\_\_\_\_

FROM: \_\_\_\_\_

DATE: \_\_\_\_\_

**Part A - Notice of Eligibility**

On \_\_\_\_\_, you informed us that you needed leave beginning on \_\_\_\_\_ for:

- The birth of a child, care for the newborn child, or placement of a child with you for adoption or foster care.
- Your serious health condition
- Because you are needed to care for your  spouse;  child;  parent due to their serious health condition
- Because of a qualifying exigency arising out of the fact that your  spouse;  son or daughter;  
 The parent is on active duty or called to active-duty status in support of a contingency operation as a National Guard or Reserves member.
- Because you are the  spouse;  son or daughter;  parent;  next of kin of a covered Servicemember with a severe injury or illness.

This Notice is to inform you that you:

- Are eligible for FMLA leave (See Part B below for Rights and Responsibilities).
- Are **you** ineligible for FMLA leave because (only one reason needs to be checked, although you may not be eligible for other reasons):

- You have not met the FMLA's 12-month length of service requirement. However, as requested leave's first date, you will have worked approximately months towards this requirement.
- You have not met the FMLA's 1,250-hours-worked requirement.
- You do not work and/or report to a site with 50 or more employees within 75 miles.

If you have any questions, contact \_\_\_\_\_ or view the FMLA poster located in \_\_\_\_\_.

**Part B – Rights and Responsibilities for Taking FMLA Leave**

As explained in Part A, you meet the eligibility requirements for taking FMLA leave and still have FMLA leave available in the applicable 12-month period. **However, for us to determine whether your absence qualifies as FMLA leave, you must return the following information to us by**

\_\_\_\_\_.

(If a certification is requested, the system office or Technical College must allow at least 15 calendar days from receipt of this notice; additional time may be required in some circumstances.) If sufficient information is not provided in a timely matter, your leave may be denied. Please be advised that you must provide:

- Sufficient certification to support your request for FMLA leave. A certification form that contains the information necessary to support your request  is not enclosed. You must return the certification form within 15 calendar days of our request to provide the certification (additional time may be permitted in some circumstances). If you fail to do so, we may delay the commencement of your leave, withdraw any designation of FMLA leave, or deny the leave. If your leave is denied, your absence will be treated in accordance with applicable State Board policies relating to leave and time and attendance. Additionally, you may be subject to disciplinary action.
- Sufficient documentation to establish the required relationship between you and your family member.
- Other information needed: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- No additional information was requested.

**If your leave does qualify** as FMLA leave, you will have the following **responsibilities** while on FMLA leave (only checked blanks apply):

- Contact at \_\_\_\_\_ to make arrangements to continue to make your share of the premium payments on your health insurance to maintain health benefits while you are on unpaid leave. Your health insurance coverage may be impacted if premium payment(s) are not made promptly.

- Consistent with State Board Policy and applicable State Personnel Board Rules, you may use available **sick, annual, or personal leave** during your FMLA absence, or you may request placement on family leave without pay. While in a paid or unpaid leave status, your leave will be considered protected and count against your FMLA leave entitlement.
- While on leave, you will be required to furnish us with periodic reports of your status and intent to return to work every \_\_\_\_\_. (Indicate interval of periodic reports, as appropriate for the particular leave situation.)

**If the circumstances of your leave change and you are able to return to work earlier than the date indicated on this form, you will be required to notify us at least two workdays prior to the date you intend to report for work.**

**Information Regarding Family and Medical Leave**

**If your leave does qualify** as FMLA leave, you will have the following **rights** while on FMLA leave:

- You have a right under the FMLA for up to 12 weeks of unpaid leave in a “rolling” 12-month period measured backward from the date of any FMLA leave taken.
- You have a right under the FMLA for up to 26 weeks of unpaid leave in a single 12-month period to care for a covered servicemember with a serious injury or illness. This single 12-month period commenced on \_\_\_\_\_.
- Your health benefits must be maintained during any period of FMLA leave under the same conditions as if you continued to work, subject to conditions established by the State Health Benefit Plan.
- You will typically be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA-protected leave. (If your leave extends beyond the end of your FMLA entitlement, you do not have return rights under FMLA.)
- Consistent with State Board Policy, applicable State Personnel Board Rules, and the provisions of the Family Leave Procedure, you have the ability to use accrued annual leave, personal leave, or, as applicable, sick leave during an FMLA absence. If you do not meet the requirements for taking paid leave or paid leave is not available or has been exhausted, you will be placed on family leave without pay.

For a copy of conditions applicable to sick/annual/other leave usages, please refer to \_\_\_\_\_ available at \_\_\_\_\_.

Applicable conditions, if any, for the use of paid leave: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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**When the above information is obtained, we will inform you, within five business days, whether your leave will be designated as FMLA leave and counted towards your FMLA entitlement. If you have any questions, please do not hesitate to contact \_\_\_\_\_ at \_\_\_\_\_.**

**Attachment: 4.5.1p.a8.**

**Family and Medical Leave Act**

**DESIGNATION FORM**

**(For Completion by the System Office or Technical College)**

Leave covered under the Family and Medical Leave Act (FMLA) must be designated as FMLA-protected, and the employer must inform the employee of the amount of leave that will be counted against an employee's FMLA leave entitlement. To determine whether the leave is covered under FMLA, the system office or Technical College may request that the leave be supported by a certification. If the certification is incomplete or insufficient, the employee must be informed, in writing, what additional information is necessary to make the certification complete and sufficient.

TO: \_\_\_\_\_

FROM: \_\_\_\_\_

DATE: \_\_\_\_\_

We have reviewed your request for leave under the FMLA and any supporting documentation that you have provided. We received your most recent information \_\_\_\_\_ and decided:



- Your FMLA leave request is approved. All leave taken for this reason will be designated as FMLA leave (subject to the maximum amount of FMLA available to you).**

**The FMLA requires that you notify us as soon as practicable if the dates of your scheduled leave change or are extended, or were initially unknown. Based on the information you have provided thus far; we are providing the following information regarding the amount of time that will be counted against your leave entitlement:**

- Provided there is no deviation from your anticipated leave schedule, the following number of hours, days, or weeks will be counted against your leave entitlement: \_\_\_\_\_.
- Because the schedule of the leave you will need is uncertain, it is not possible to provide the hours, days, or weeks that will be counted against your FMLA entitlement at this time. You have the right to request this information once in a 30-day period (if leave was taken in the 30-day period.).

**Please be advised (check if applicable):**

- You have requested to use sick, annual, and/or personal leave during your FMLA leave. All such leave taken will count against your FMLA leave entitlement.
- You have requested to be placed on family leave without pay during this absence, and all time spent in this employment status will count against your FMLA leave entitlement.
- You will be required to present a fitness-for-duty certificate to be restored to employment. If such certification is not timely received, your return to work may be delayed until certification is provided. Should you not return this certification as requested, you may no longer be entitled to reinstatement under FMLA. A list of the essential functions of your position or a copy of your job description  is  not  attached. If attached, the fitness-for-duty certification must address your ability to perform these functions.



**Additional information is needed to determine if your FMLA leave request can be approved:**

- The certification you provided is not complete and sufficient to determine whether your leave should be considered FMLA-qualifying. Therefore, unless it is not practical to do so under the particular circumstances of your absence (despite your diligent, good faith efforts), you must provide the following information no later than \_\_\_\_\_ (provide at least seven calendar days). Failure to follow through as requested may result in denying your leave.

\_\_\_\_\_  
\_\_\_\_\_  
(Specify information needed to make the certification complete and sufficient.)

- We are exercising our right to have you obtain a second or third opinion medical certification at our expense. Further detail will be provided at a later time.



- Your FMLA leave request is Not Approved.
- The FMLA does not apply to your leave request.
- You have exhausted your FMLA leave entitlement in the applicable 12-month period.

**EMPLOYEE RIGHTS & RESPONSIBILITIES  
UNDER THE FAMILY AND MEDICAL LEAVE ACT**

**Basic Leave Entitlement**

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care, or childbirth.
- To care for the employee's child after birth, or placement for adoption or foster care.
- To care for the employee's spouse, son or daughter, or parent who has a serious health condition; or
- A serious health condition makes the employee unable to perform the employee job.

**Military Family Leave Entitlements**

Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address particular qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging alternative childcare, addressing specific financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status, or is on the temporary disability retired list.

**Benefits and Protections**

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee has continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

**Eligibility Requirements**

Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

**Definition of Serious Health Condition**

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than three consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. In addition, other conditions may meet the definition of continuing treatment.

**Use of Leave**

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment to not unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

**Substitution of Paid Leave for Unpaid Leave**

Employees may choose, or employers may require using accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's typical paid leave policies.

**Employee Responsibilities**

Employees must provide 30 days' advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days' notice is not possible, the employee must provide notice as soon as practicable and generally comply with an employer's routine call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees must also inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

**Employer Responsibilities**

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required and the employee's rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave is designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. Likewise, the employer must notify the employee if the employer determines that the leave is not FMLA-protected.

**Unlawful Acts by Employers**

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

**Enforcement**

Any employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination or supersede any State or local law or collective bargaining agreement that provides more extraordinary family or medical leave rights.

**FMLA section 109 (29 U.S.C. § 2619) requires FMLA-covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.**



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

