

Miacese of Rockford

555 Colman Center Drive P.O. Box 7044 Rockford, IL 61125

FMLA LEAVE OF ABSENCE PAPERWORK

If you need a leave of absence, this packet contains all the leave paperwork you need to complete your request, as well as very important information on how to communicate with us during your leave of absence. Complete this paperwork and submit it when you become aware that you will need a leave of absence from work.

How do I apply for a Leave of Absence?

<u>Step One</u>: Notify your supervisor that you need a leave of absence and the reason why, and review the Diocese's Family and Medical Leave of Absence policy in the Employee Handbook, online.

<u>Step Two</u>: Contact the Benefits Coordinator at the Diocese Health Insurance Office by phone 815.399.4300, ext. 340 or email <u>benefits@rockforddiocese.org</u>) to begin your leave of absence request.

Step Three: The Benefits Coordinator will advise you on the appropriate paperwork to complete. To qualify for FMLA Leave you must have worked for the Diocese for at least 12 months and have worked 1250 hours during that 12 month period. If you do not meet this qualification you may consider requesting a Leave of Absence for Other Reason, and that policy is also in the Employee Handbook, online.

<u>Step Four</u>: Complete and turn in paperwork to finalize your leave request. Below is an explanation of the forms included in this packet:

- Request for Family and Medical leave of Absence Complete this form and submit it to the Benefits Department when you learn you need time off from work.
- FMLA Leave of Absence Acknowledgment Form This form ensures that you and the Diocese understand how your leave time will be handled.
- Leave of Absence Contact Form This form gives us your contact information, so we can contact you while you are on leave.
- Authorization to Contact My Physician This form applies if the reason for your leave of absence is because you have a medical condition, and it allows the Health Insurance Office to call your physician if there is something we don't understand on your paperwork.
- Authorization to Return to Work from Medical Leave of Absence This form applies when you have a medical condition, and it should be completed by your doctor when you are able to return to work with or without restrictions. This form should be returned to the Diocese's Health Insurance Office when you can return to work.
- Certification of Health Care Provider Form This form is completed by your doctor and provides information about your need for a leave and how long you will be off work. Have your doctor complete this form if you have a medical condition or if you are pregnant. Be sure to put your name at the top of page 1. If the reason for your leave is the medical condition of someone other than you, this form does not have to be completed.

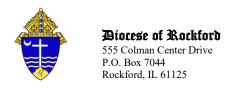
<u>Step Five</u>: Scan and e-mail your completed paperwork to <u>benefits@rockforddiocese.org</u> or fax it to 815.997.5225.

After you have completed these steps, the Health Insurance Office will review your paperwork and let you know if anything is missing. If there is nothing missing, we will review your leave request and let you know if it is approved or denied.



CATHOLIC DIOCESE OF ROCKFORD REQUEST FOR LEAVE OF ABSENCE

Employee:	Position:
Work Location:	City:
Supervisor's Name and Signature:	
Last Day of Work	Anticipated Return to Work Date
Are you requesting a continuous bloc	k of time or intermittent time off: Continuous Intermittent
Type of Leave requested:	
Leave for Qualifying Exigen Leave for Next of Kin Milita Family Bereavement Leave death of immediate family mevent affecting Employee's period Employee's period Employee's period Employee in the Employee in	endition ancy ition tion tion ealth condition 's Spouse wee, or Foster Care placement of Child with Employee cry regarding active military duty of parent, spouse, or child of Employee ry Service Member Line-of-Duty Serious Illness/Injury ember parenthood f Employee's child by Homicide or Suicide fiolence or Crime of Violence mployee's Spouse or Child called to active military duty
	yer on the medical verification and the continued need for accommodation.
Employee	Date
Approved by:	
Supervisor's Signature	Date



FMLA Leave of Absence Acknowledgement Form

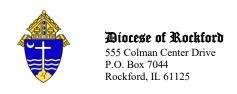
Your Name:	 	
Work Location (Name and City): _		 _

I am requesting FMLA Leave and have completed the appropriate paperwork. I will submit this paperwork to the Benefits Coordinator in the Health Insurance Office via email benefits@rockforddiocese.org or fax to 815.997.5225 within 15 days of my leave application.

I understand the following:

- In order to be eligible for FMLA Leave I must have worked at least twelve (12) months for the Diocese and at least 1,250 hours during the twelve (12) months prior to my leave of absence.
- To obtain approval for FMLA Leave for my own medical condition, I must return the Certification form within fifteen (15) days of applying for FMLA Leave. My failure to return the "Certification" form within this fifteen (15) day period may result in the denial of my request for FMLA leave.
- I understand that if I am already absent from work due to my own medical condition at the time I receive the form, my failure to return the "Certification" form within fifteen (15) days will result in my absences being considered to be unapproved absences.
- I understand that if a portion of my leave is without pay and I have health insurance coverage through the Diocese for my dependents, I will be required to make premium payments during my leave for health insurance coverage of my dependents. Failure to make such payments may result in the termination of my dependent coverage.
- The period of my FMLA leave is treated as continued service for purposes of vesting and eligibility to participate in the Lay Pension Plan, but other benefits do not accrue during this period.
- If I am unable to return to work on the date that I have specified on the Request for FMLA Leave form or the Certification form, it is my responsibility to notify the Health Insurance Office and my immediate supervisor. I may be asked to supply physician documentation. If I choose not to return to work on this date or I am unable to do so, I must request and obtain approval of my continued absence from work, or I may be considered to voluntary resign my position without notice.
- If my FMLA Leave is exhausted and I choose to or am unable to return to work, I may request a Leave of Absence for Other Reason, according to Diocese policy. I acknowledge that it is my obligation to request and obtain a Leave of Absence for Other Reason after my FMLA Leave is exhausted and that my failure to do so will be considered as my voluntary resignation from employment without notice.
- If I am not eligible for this leave of absence, I may be eligible for a different type of leave with different eligibility requirements. I may be required to complete a different request form.
- I understand that it is my responsibility to cooperate in providing the Health Insurance Office with any missing information or clarification/verification of provided information as a condition of the processing of my leave request; and that my failure to cooperate with the Diocese and/or my supervisor in the submission of requested information may result in the denial of benefits for which I may otherwise be eligible.
- When returning to work from my own medical leave, I must submit to the Health Insurance Office a return to work report from the appropriate health care provider and my supervisor at least 2 business days prior to my return to work date; failure to do so may result in the delay of my return to work until such a return to work report has been provided.
- I acknowledge that if my absence from work is due to a work-related illness and/or injury covered by Worker's Compensation, my period of absence for that reason runs concurrently with that allowed by FMLA.
- I understand that my employer will use its best efforts to return me to the position I held prior to the approved leave of absence, but if it is not available, will place me in a substantially equivalent position.
- I understand and agree that if I elect not to return to work at the expiration of my approved leave of absence, my employer shall be entitled to recover from me personally the cost of premiums paid to maintain my and my dependent(s)', if applicable, group health plan coverage during the period of leave of absence.

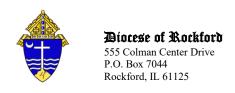
Employee Signature	Date



Leave of Absence Contact Information

The information on this form informs us how the Diocese can contact you regarding and during your leave of absence.

Employee:		
Work Location (name and city):		
Email address to reach you during your Leave of Absence:		
Home phone or cell number:		
Home address:		
Your Supervisor's name:		_
Employee Signature	Date	-



Authorization to Contact My Physician

The Health Insurance Office will review the physician certification form once it is submitted. Sometimes, we need additional information, authentication, or clarification to completely process your leave of absence request.

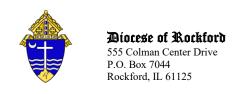
Marking **Yes** below gives the Health Insurance Office permission to contact your health care provider for any needed information about the medical need for your leave of absence. The Health Insurance Office will ask only about information related to the questions and related answers listed on the form.

Marking **No** below means that I am responsible for obtaining the needed information so that my leave application can be processed. I will take the paperwork back to the physician and get the required clarifications on the documentation within seven (7) business days of my notification.

Please Note: If you choose **No**, you will have seven (7) business days to obtain clarification and return the form to the Health Insurance Office. If you do not return documentation within the seven days, your leave request may be denied.

If you have any questions, please contact the Health Insurance Office at 815.399.4300, ext. 340.
Yes, I give permission for the Diocese Health Insurance Office to contact my physician for any
clarification or additional information needed.
No, I prefer to have paperwork returned to me for clarification/authentication from the physician.
I am aware that I will be responsible for returning the paperwork within seven (7) business days of
being asked to get the information.
Employee Name (please print):
Name and City of work location:
Employee Signature:
Date:

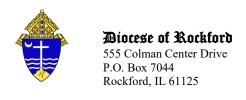
Please return this authorization form with your paperwork to the Benefits Coordinator via email benefits@rockforddiocese.org or fax 815.997-5225.



AUTHORIZATION TO RETURN TO WORK FROM MEDICAL LEAVE OF ABSENCE

Date:	
Employee Name:	
Employee Date of Birth:	
☐ Employee may return to work on(date	WITHOUT restriction.
☐ Employee may return to work on(date	with these restrictions until(date)
☐ Sedentary/sit down work (with option to stan	d) for (time period)
☐ Elevation of affected extremity as needed	
☐ May wear brace, immobilizer or splints	
☐ Requires use of elevator	
☐ Requires parking close to main entrance	
☐ One-handed duties	
☐ May not lift/pull/ carry more than (pounds)	$\square 0-5$ $\square 6-10$ $\square 11-25$ $\square 26-50$ $\square > 50$
☐ No prolonged or repetitive:	
☐ bending or stooping for	(time period)
☐ walking or standing for	(time period)
☐ climbing, kneeling or squatting for	
☐ No repetitive motion with	_ (specific body part)
$\hfill\Box$ No over chest, above shoulder, or away from	
☐ Other restrictions/comments:	
The Diocese will review the restrictions to see if	they can be accommodated.
Signature of Physician:	
Date:	

Note to Physician: Please send the completed form to the Benefits Coordinator in the Diocese's Health Insurance Office via email benefits@rockforddiocese.org or fax:815.997.5225 at least 2 business days before the expected return to work date. Call 815.399.4300, ext. 340 with questions.



Certification of Healthcare Provider

To the Employee:

The next 4 pages must be completed by your doctor.

Your doctor should return the form to you or send the completed form to the Benefits Coordinator in the Diocese's Health Insurance Office at benefits@rockforddiocese.org or via fax 815. 997.5225.

To the Healthcare Provider:

Please complete this certification form as thoroughly and accurately as possible. This will avoid a representative from the Diocese's Health Insurance Office calling for clarification. By law, the employee must return this paperwork to the Diocese's Health Insurance Office within 15 days of the employee's receipt of the form. Please return the form to the employee or directly to the Benefits Coordinator in the Diocese's Health Insurance Office at benefits@rockforddiocese.org or via fax 815. 997.5225.

Thank you for your cooperation!

Also, please note:

Please do not provide any genetic information when responding to this request for medical information. "Genetic information" includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

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: 6/30/2023

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 re	quested)
(3) The medical certification	must be returned by			(mm/dd/yyyy)
(Must allow at least 15 cale	endar days from the date requeste	ed, unless it is not feasible despite the	employee's diligent, good faith effor	ts.)
(4) Employee's job title:			Job description is /	is not attached.
Employee's regular work	schedule:			
Statement of the employe	ee's essential job functions:			
,	the employee's position are dete ave or the leave started, whichev	rmined with reference to the position the reference to the position the reference to the position the reference to the position to	he employee held at the time the em	ployee notified the

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			
based upon your medical knowledge, e. information about the amount of leave regular daily activities due to the conditio tests, as defined in 29 C.F.R. § 1635.3(f) the employee's family members, 29 C.F.F. (1) State the approximate date the conditional conditions are considered as a second condition.	xperience, and examina needed. Note: For FML in, treatment of the cond), genetic services, as d. R. § 1635.3(b).	mployee is seeking FMLA leave. Your answers should be your best esti ation of the patient. After completing Part A, complete Part B to pro LA purposes, "incapacity" means the inability to work, attend school, or pe dition, or recovery from the condition. Do not provide information about ge defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disord (mm/dd/yyyy) or will last:	ovid erforn
(3) Check the box(es) for the questions b	elow, as applicable. For	all box(es) checked, the amount of leave needed must be provided in Par	rt B.
		cted to be) admitted for an overnight stay in a hospital, ng date(s):	
Incapacity plus Treatment: (e.g.			
consecutive, full calendar days fr	om:	expected to be) incapacitated for more than three _ (mm/dd/yyyy) to (mm/dd/yyyy). g date(s):	
		course of continuing treatment under the supervision of a than over-the-counter) or therapy requiring special equipment).	
Pregnancy: The condition is preg	nancy. List the expect	eted delivery date: (mm/dd/yyyy).	
Chronic Conditions: (e.g. asthm treatment visits at least twice per		Due to the condition, it is medically necessary for the patient to have	
		s, terminal stages of cancer) Due to the condition, incapacity is permanent health care provider (even if active treatment is not being provided).	
Conditions requiring Multiple T necessary for the patient to receive		otherapy treatments, restorative surgery) Due to the condition, it is medical	lly
None of the above: If none of the needed. Go to page 4 to sign and	` ,	re checked, (i.e., inpatient care, pregnancy) no additional information is	

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 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 / 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 for approximately for a days) per episode

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 mor	re of the	
essential job function(s). Identify at least one essential job function the employee is not ab	ole to perform:		
Cinn share of the all to Cons Branishan	Deter		
Signature of Health Care Provider	Date:	(mm/dd/yyyy)	
Definitions of a Serious Health Condition (See 29 C.F.R. §§ 825.113115)			
Inpatient Care			
 An overnight stay in a hospital, hospice, or residential medical care facility. Inpatient care includes any period of incapacity or any subsequent treatmen 	t in connection with the overn	ight stay.	
Continuing Treatment by a Health Care Provider (any one or more of the fo	llowing)		
Incapacity Plus Treatment : A period of incapacity of more than three consecutive treatment or period of incapacity relating to the same condition, that also involves	•	y subsequent	
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,			
 At least one in-person visit to a health care provider for treatment within results in a regimen of continuing treatment under the supervision of the provider might prescribe a course of prescription medication or therapy 	ne health care provider. For ex	cample, the health	
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 sasthma, migraine headaches. A chronic serious health condition is one which recupervised by the provider) at least twice a year and recurs over an extended peepisodic rather than a continuing period of incapacity.	quires visits to a health care p	rovider (or nurse	
Permanent or Long-term Conditions : A period of incapacity which is permaner treatment may not be effective, but which requires the continuing supervision of a disease or the terminal stages of cancer.			
Conditions Requiring Multiple Treatments: Restorative surgery after an accide likely result in a period of incapacity of more than three consecutive, full calendar			

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.

Employee Name: