Diocese 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?

Step One: 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.

Step Two: Contact Misty Witt at the Diocese Benefits Department by phone 815.399.4300, ext. 340 or email mwitt@rockforddiocese.org) to begin your leave of absence request.

Step Three: Misty Witt 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.

Step Four: 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 Benefits Department 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 Benefits Department 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.

Step Five: Scan and e-mail your completed paperwork to mwitt@rockforddiocese.org or fax it to 815.997.5225.

After you have completed these steps, the Benefits Department 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.

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# Request for Family and Medical Leave of Absence

Employee _____

Work Location (Name and City) _____

Supervisor's Name and Signature _____

Last Day of Work _____ Anticipated Return to Work Date _____

Are you requesting a continuous block of time off or intermittent time off?

□ Continuous □ Intermittent

Type of leave you are requesting:

□ FMLA/my own medical condition
□ FMLA/medical condition of my parent, spouse or dependent child
□ FMLA/my pregnancy
□ FMLA/my spouse's pregnancy
□ FMLA/adoption or foster care placement
□ Non-FMLA/my medical condition
□ Leave of Absence for other reason
□ Leave of Absence for my military service
□ Leave of Absence for military service of family member
□ Leave of Absence for my domestic violence situation

I understand that if the reason for this requested leave is for a serious health condition, I must promptly submit medical verification.

I understand that to be eligible for an FMLA leave, I must have worked for the Diocese for the previous 12 consecutive months and worked at least 1,250 hours during that 12-month period, and the reason for the leave must be a reason that qualifies under the FMLA.

I understand this is a Request for FMLA leave, and I will be notified by my employer whether this leave is approved.

_____ _____
Employee Date

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# 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 Misty Witt at the Benefits Department via email mwitt@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 Benefits Department 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 Benefits Department 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 Benefits Department 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

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## 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

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## Authorization to Contact My Physician

The Benefits Department 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 Benefits Department permission to contact your health care provider for any needed information about the medical need for your leave of absence. The Benefits Department 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 Benefits Department. If you do not return documentation within the seven days, your leave request may be denied.

If you have any questions, please contact the Benefits Department at 815.399.4300, ext. 340.

_____

____ **Yes**, I give permission for the Diocese Benefits Department 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 Misty Witt via email mwitt@rockforddiocese.org or fax 815.997-5225.

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# AUTHORIZATION TO RETURN TO WORK FROM MEDICAL LEAVE OF ABSENCE

Date: _____

Employee Name: _____

Employee Date of Birth: _____

☐ Employee may return to work on _____ WITHOUT restriction.
(date)

☐ Employee may return to work on _____ WITH these restrictions until _____:
(date) (date)

- ☐ Sedentary/sit down work (with option to stand) 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) ☐0-5 ☐6-10 ☐11-25 ☐26-50 ☐> 50
- ☐ No prolonged or repetitive:
  - ☐ bending or stooping for _____ (time period)
  - ☐ walking or standing for _____ (time period)
  - ☐ climbing, kneeling or squatting for _____ (time period)
- ☐ No repetitive motion with _____ (specific body part)
- ☐ No over chest, above shoulder, or away from body work
- ☐ 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 Misty Witt at the Diocese's Benefits Department via email mwitt@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.

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# 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 Misty Witt in the Diocese's Benefits Department at mwitt@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 Benefits Department calling for clarification. By law, the employee must return this paperwork to the Diocese's Benefits Department within 15 days of the employee's receipt of the form. Please return the form to the employee or directly to Misty Witt in the Diocese's Benefits Department at mwitt@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 (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: 5/31/2018

## SECTION I: For Completion by the EMPLOYER

**INSTRUCTIONS to the EMPLOYER:** The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: _____

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

Employee's essential job functions: _____

_____

Check if job description is attached:

## SECTION II: For Completion by the EMPLOYEE

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

Your name: _____
First Middle Last

## SECTION III: For Completion by the HEALTH CARE PROVIDER

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

Provider's name and business address: _____

Type of practice / Medical specialty: _____

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

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

   **Mark below as applicable:**
   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
   ___No ___Yes. If so, dates of admission:

   _____

   Date(s) you treated the patient for condition:

   _____

   Will the patient need to have treatment visits at least twice per year due to the condition? ___No ___ Yes.

   Was medication, other than over-the-counter medication, prescribed? ___No ___Yes.

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
   ____No ____Yes. If so, state the nature of such treatments and expected duration of treatment:

   _____

2. Is the medical condition pregnancy? ___No ___Yes. If so, expected delivery date: _____

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

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

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

   _____

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

   _____

   _____

   _____

   _____

   _____

   _____

   _____

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___No ___Yes.

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

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ___No ___Yes.

   If so, are the treatments or the reduced number of hours of work medically necessary? ___No ___Yes.

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

   _____

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

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

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ____No ____Yes.

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

   _____

   _____

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

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

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

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

**Signature of Health Care Provider** **Date**

**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 20 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 Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**