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 the Benefits Coordinator at the Diocese Health Insurance Office by phone 815.399.4300, ext. 340 or email benefits@rockforddiocese.org) 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.

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 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.

Step Five: Scan and e-mail your completed paperwork to benefits@rockforddiocese.org 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.

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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 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

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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 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.

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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 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.

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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 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

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 requested)

(3) The medical certification must be returned by _____ (mm/dd/yyyy)
(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee's diligent, good faith efforts.)

(4) Employee's job title: _____ Job description ☐ is / ☐ is not attached.

Employee's regular work schedule: _____

Statement of the employee's essential job functions:

_____

(The essential functions of the employee's position are determined with reference to the position the employee held at the time the employee notified the employer of the need for leave or the leave started, whichever is earlier.)

SECTION II - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form. Your patient has requested leave under the FMLA. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of the employee. For FMLA purposes, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves **inpatient care** or **continuing treatment by a health care provider**. For more information about the definitions of a serious health condition under the FMLA, see the chart on page 4.

You also may, but are **not required** to, provide other appropriate medical facts including symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment. Please note that some state or local laws may not allow disclosure of private medical information about the patient's serious health condition, such as providing the diagnosis and/or course of treatment.

Employee Name: _____

Health Care Provider's name: (Print) _____

Health Care Provider's business address: _____

Type of practice / Medical specialty: _____

Telephone: _____ Fax: _____ E-mail: _____

PART A: Medical Information

Limit your response to the medical condition(s) for which the employee is seeking FMLA leave. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. **After completing Part A, complete Part B to provide information about the amount of leave needed.** Note: For FMLA purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

(1) State the approximate date the condition started or will start: _____ (mm/dd/yyyy)

(2) Provide your **best estimate** of how long the condition lasted or will last: _____

(3) Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

☐ **Inpatient Care**: The patient (☐ has been / ☐ is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): _____

☐ **Incapacity plus Treatment**: (e.g. outpatient surgery, strep throat)

Due to the condition, the patient (☐ has been / ☐ is expected to be) incapacitated for **more than** three consecutive, full calendar days from: _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy).

The patient (☐ was / ☐ will be) seen on the following date(s): _____

_____

The condition (☐ has / ☐ has not) also resulted in a course of continuing treatment under the supervision of a health care provider (e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment).

☐ **Pregnancy**: The condition is pregnancy. List the expected delivery date: _____ (mm/dd/yyyy).

☐ **Chronic Conditions**: (e.g. asthma, migraine headaches) Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

☐ **Permanent or Long Term Conditions**: (e.g. Alzheimer's, terminal stages of cancer) Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

☐ **Conditions requiring Multiple Treatments**: (e.g. chemotherapy treatments, restorative surgery) Due to the condition, it is medically necessary for the patient to receive multiple treatments.

☐ **None of the above**: If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed. Go to page 4 to sign and date the form.

Employee Name: _____

(4) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. (e.g., use of nebulizer, dialysis)

_____

PART B: Amount of Leave Needed

For the medical condition(s) checked in Part A, complete all that apply. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage.

(5) Due to the condition, the patient (☐ had / ☐ will have) **planned medical treatment(s)** (scheduled medical visits) (e.g.psychotherapy, prenatal appointments) on the following date(s): _____

_____

(6) Due to the condition, the patient (☐ was / ☐ will be) **referred to other health care provider(s)** for evaluation or treatment(s).

State the nature of such treatments: (e.g. cardiologist, physical therapy) _____

Provide your **best estimate** of the beginning date _____ (mm/dd/yyyy) and end date _____ (mm/dd/yyyy). for the treatment(s).

Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery (e.g. 3 days/week)

_____

(7) Due to the condition, it is medically necessary for the employee to work a **reduced schedule**.

Provide your **best estimate** of the reduced schedule the employee is able to work. From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy) the employee is able to work: (e.g., 5 hours/day, up to 25 hours a week)

_____

(8) Due to the condition, the patient (☐ was / ☐ will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.

Provide your **best estimate** of the beginning date _____ (mm/dd/yyyy) and end date _____ (mm/dd/yyyy). for the period of incapacity.

(9) Due to the condition, it (☐ was / ☐ is / ☐ will be) medically necessary for the employee to be absent from work on an intermittent basis (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, episodes of incapacity are estimated to occur _____ times per (☐ day ☐ week ☐ month) and are likely to last approximately _____ (☐ hours ☐ days) per episode.

Employee Name: _____

PART C: Essential Job Functions

If provided, the information in Section I question #4 may be used to answer this question. If the employer fails to provide a statement of the employee's essential functions or a job description, answer these questions based upon the employee's own description of the essential job functions. An employee who must be absent from work to receive medical treatment(s), such as scheduled medical visits, for a serious health condition is considered to be **not able** to perform the essential job functions of the position during the absence for treatment(s).

(10) Due to the condition, the employee (☐ was not able / ☐ is not able / ☐ will not be able) to perform **one or more** of the essential job function(s). Identify at least one essential job function the employee is not able to perform:

_____

Signature of Health Care Provider _____ Date: _____ (mm/dd/yyyy)

Definitions of a Serious Health Condition (See 29 C.F.R. §§ 825.113-.115)
Inpatient Care
• An overnight stay in a hospital, hospice, or residential medical care facility. • Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.
Continuing Treatment by a Health Care Provider (any one or more of the following)
Incapacity Plus Treatment: A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either: o Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or, o At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.
Pregnancy: Any period of incapacity due to pregnancy or for prenatal care.
Chronic Conditions: Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.
Permanent or Long-term Conditions: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.
Conditions Requiring Multiple Treatments: Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 15 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

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