City of
Santa Monica®

FAMILY CARE LEAVE OF ABSENCE REQUEST FORM

Section 1: For completion by the Employee

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 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 delay or denial of your FMLA request. 20 C.F.R. §§ 825.313. Please submit your completed form, no later than 15 calendar days from the date received, to Human Resources.

Employee Name: _____

Address: _____ Phone: _____

Department: _____ Supervisor: _____

Name of family member for whom you will provide care: _____

Relationship of family member to you: _____

If family member is your son or daughter, date of birth: _____

Leave Start Date: _____ Return to Work Date: _____

Describe the care you will provide to your family member: _____

_____

_____

I request a Family/Medical Leave for the following reasons (check one):

- ❑ A. Birth of a child and/or in order to care for such child.
- ❑ B. The placement of a child for adoption or foster care.
- ❑ C. In order to care for an immediate family member because such family member has a serious health condition.

  Check One: ☐ Child ☐ Spouse ☐ Parent ☐ Domestic Partner
  (Must submit "Medical Certification" within 15 days.)

- ❑ D. Care for an adult child who is incapable of self-care. (A child is "incapable of "self-care" if he/she requires active assistance or supervision to provide daily self-care in three or more of the activities of daily living or instrumental activities of daily living, such as: caring or grooming and hygiene, bathing, dressing and eating, cooking, cleaning, shopping, taking public transportation, paying bills, maintaining a residence, using telephones and directories, etc.)
- ❑ E. Employee's own serious health condition that makes the employee unable to perform the functions of his/her position.
- ❑ F. To assist son, daughter, spouse, or parent who is a member of the Armed Forces, including the National Guard or Reserves with a "qualifying exigency" related to covered active duty or a call to active duty status.

I understand that failure to return to work at the end of my leave period may be treated as absent without leave or job abandonment and subject to disciplinary action as outlined in the City of Santa Monica Municipal Code 2.04.330 unless an extension has been agreed upon and approved in writing by my department and/or Human Resources.

Employee's Signature: _____ Date: _____

Section 2: For Completion by the Health Care Provider

The employee listed above has requested leave under the FMLA to care for your patient. 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 patient needs leave. Please do **not** disclose the underlying diagnosis of the serious health condition involved. Please be sure to sign the form on the last page.

IMPORTANT NOTE: The California Genetic Information Nondiscrimination Act of 2011 (CalGINA) prohibits employers and other covered entities from requesting, or requiring, genetic information of an individual or family member of the individual except as specifically allowed by law. To comply with the Act, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information," as defined by CalGINA, includes information about the individual's or the individual's family member's genetic tests, information regarding the manifestation of a disease or disorder in a family member of the individual, and includes information from genetic services or participation in clinical research that includes genetic services by an individual or any family member of the individual. "Genetic Information" does not include information about an individual's sex or age.

Approximate date condition commenced: _____

Name of Patient: _____

Birth date of Patient: _____

If the patient is an adult child 18 years of age or older that the employee will be caring for, is the adult child incapable of self-care?

☐ Yes ☐ No

A child is "incapable of self-care" if he/she requires active assistance or supervision to provide daily self-care in three or more of the activities of daily living or instrumental activities of daily living, such as caring for grooming and hygiene, bathing, dressing and eating, cooking, cleaning, shopping, taking public transportation, paying bills, maintaining a residence, using telephone and directories, etc.

Probable duration of condition: _____

Will the patient be incapacitated for a single continuous period of time due to his/her serious health condition, including any time for treatment and recovery? ☐ Yes ☐ No

Patient Leave Start Date: _____ End Date of Incapacity: _____

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

If yes, explain the care needed by the patient: _____

_____

_____

Will it be medically necessary for the *employee* to take time off work for a single continuous period to provide care due to the serious health condition of your patient? ☐ Yes ☐ No

Care Start Date: _____ Care End Date: _____

Will it be medically necessary for the *employee* to take time off work to transport your patient to scheduled doctor appointments or to receive medical treatment administered by a health care practitioner or another provider of health services? ☐ Yes ☐ No

If yes, please indicate the estimated frequency of the *employee's* need to transport your patient to doctor's appointments or medical treatments, and the time required for each appointment, including any recovery period:

Begin Date: _____ End Date_____

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

Duration: _____ hours or _____ day(s) per appointment/treatment

Will it be medically necessary for the *employee* to work less than the his/her normal work schedule due to your patient's serious health condition? ☐ Yes ☐ No

If yes, please indicate the part-time or reduced work schedule the *employee* requires:

Reduced schedule start date: _____ Reduced schedule end date: _____

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

Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ☐ Yes ☐ No

During flare-ups, will the patient need care? ☐ Yes ☐ No

Begin Date: _____ End Date: _____

Based on 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 (ex: 1 episode every 3 months lasting 1-2 days):

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

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

A serious health condition is an illness, injury (including, by not limited to, on-the-job injury), impairment, or physical or mental condition that involves either (1) inpatient care (an overnight stay or the expectation of an overnight stay) in a hospital, hospice or resident medical care facility **or** (2) continuing treatment by a health care provider that involves (a)a period of incapacity of more than three consecutive calendar days and any subsequent treatment or period of incapacity relating to the same condition that also involves (i)treatment two or more times by a health care provider within the first 30 days of incapacity, or (ii) treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment; (b) a period of incapacity or treatment for a chronic serious health condition which requires periodic treatment by a health care provider, continues over an extended period of time and may cause episodic rather than a continuing period of incapacity; (c) a period of incapacity which is permanent or long term due to a condition where treatment may not be effective; or (d) a period of absence to receive multiple treatment for an injury or condition which would result in incapacity of more than three days if not treated.

Based on the information above, does the patient's condition meet the definition of a serious health condition?
☐ Yes ☐ No

Provider's name: _____

Provider's address: _____

Telephone: _____ Fax: _____

Signature of Health Care Provider: _____Date: _____

Date Human Resources received form: _____ Received by: _____

Completed forms can be returned to the patient directly or they may be faxed or mailed to the following:

City of Santa Monica
Human Resources
1685 Main Street
Santa Monica, CA 90401
Office: 310-458-8246

Fax:
310-656-5705

Email:
human.resources@smgov.net

City of
Santa Monica®

FAMILY AND MEDICAL LEAVE INFORMATION PACKET AND LEAVE OF ABSENCE FORM

Enclosed is an application for leave under the federal Family and Medical Leave Act (FMLA) and the California Family Rights Act (CFRA). Both laws provide that an eligible employee may take up to 12 weeks of unpaid leave in a 12-month period to care for a spouse, parent or child with a serious health condition, the employee's own serious health condition or to care for the employee's child after birth, or placement for adoption or foster care. Leave taken under these provisions can be on a continuous or intermittent basis.

In order to qualify for leave under the FMLA/CFRA, you must have been employed with the City of Santa Monica for 12 months prior to taking leave and have worked a minimum of 1250 hours in the preceding 12-month period.

As stated above, qualified employees have the right to take up to 12 weeks of leave in a 12-month period calculated as a rolling 12-month period measured backward from your first day of leave. During any periods of qualifying FMLA/CFRA leave, your health benefits must be maintained under the same conditions as if you had continued to work. You will be responsible for any employee contributions to your medical insurance. If you are on paid status, your contributions will continue to be deducted from your paycheck. If you enter unpaid status during any portion of your leave, a representative from the City's Benefits Unit will contact you to set up payment arrangements for your portion of the premiums. Generally, premium payments are due on the first of the month with a 30-day grace period. Failure to pay the employee portion of your health insurance premiums while on leave may result in your insurance coverage being cancelled. You will be notified in advance prior to any coverage being cancelled.

Both laws require that an employee who is requesting leave provide the City with a minimum of 30 days' advance notice when the need for leave is foreseeable. In order to assess if your medical condition or that of your spouse, child or parent for whom you are requesting leave qualifies under FMLA or CFRA, you and the treating physician must complete the enclosed Medical Leave of Absence Request Form and return to Human Resources within 15 days. If applicable, a job description of your position has been included with this packet for you to provide to your physician to aid him or her in completing their portion of the leave of absence request form. Once received, you will be notified in writing by Human Resources staff as to whether or not your leave qualifies under the FMLA or CFRA. Failure to provide a complete and sufficient leave of absence request form may result in the delay or denial of your leave.

Upon your return from FMLA/CFRA leave, you will be reinstated to the same or equivalent job with the same pay, benefits, and terms and conditions of employment as you had prior to taking leave. Employees who are on a continuous leave of absence for their own serious health condition must obtain a release to return to work from his/her treating physician prior to returning to work.

While on leave, City policy requires that you use your accrued paid time off before entering into unpaid status. Please consult your bargaining unit's Memorandum of Understanding for your eligible benefits.

For more information or if you have additional questions, please contact Human Resources at 310-458-8246.

STATE OF CALIFORNIA **DEPARTMENT OF FAIR EMPLOYMENT AND HOUSING**

"NOTICE B"

FAMILY CARE AND MEDICAL LEAVE (CFRA LEAVE) AND PREGNANCY DISABILITY LEAVE

- Under the California Family Rights Act of 1993 (CFRA), if you have more than 12 months of service with us and have worked at least 1,250 hours in the 12-month period before the date you want to begin your leave, you may have a right to an unpaid family care or medical leave (CFRA leave). This leave may be up to 12 workweeks in a 12 month period for the birth, adoption, or foster care placement of your child or for your own serious health condition or that of your child, parent or spouse. The CFRA prohibits us from denying, interfering with, or restraining your exercise of these rights.

- Even if you are not eligible for CFRA leave, if disabled by pregnancy, childbirth or related medical conditions, you are entitled to take a pregnancy disability leave of up to four months, depending on your period(s) of actual disability. If you are CFRA-eligible, you have certain rights to take BOTH a pregnancy disability leave and a CFRA leave for reason of the birth of your child. Both leaves contain a guarantee of reinstatement to the same or to a comparable position at the end of the leave, subject to any defense allowed under the law.

- If possible, you must provide at least 30 days advance notice for foreseeable events (such as the expected birth of a child or a planned medical treatment for yourself or of a family member). For events which are unforeseeable, we need you to notify us, at least verbally, as soon as you learn of the need for the leave.

- Failure to comply with these notice rules is grounds for, and may result in, deferral of the requested leave until you comply with this notice policy.

- We may require certification from your health care provider before allowing you a leave for pregnancy or your own serious health condition or certification from the health care provider of your child, parent, or spouse who has a serious health condition before allowing you a leave to take care of that family member. When medically necessary, leave may be taken on an intermittent or a reduced work schedule.

- If you are taking a leave for the birth, adoption or foster care placement of a child, the basic minimum duration of the leave is two weeks and you must conclude the leave within one year of the birth or placement for adoption or foster care.

Taking a family care or pregnancy disability leave may impact certain benefits and your seniority date. If you want more information regarding your eligibility for a leave and/or the impact of the leave on your seniority and benefits, please contact:

Human Resources	(310) 458-8246
Employer's Contact Person	Telephone Number

EMPLOYEE RIGHTS AND 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 child birth;
- to care for the employee's child after birth, or placement for adoption or foster care;
- to care for the employee's spouse, son, daughter or parent, who has a serious health condition; or
- for a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain 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 service-member during a single 12-month period. A covered servicemember is: (1) a current 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 serious injury or illness*; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness.*

***The FMLA definitions of "serious injury or illness" for current servicemembers and veterans are distinct from the FMLA definition of "serious health condition".**

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 had 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 12 months, have 1,250 hours of service in the previous 12 months*, and if at least 50 employees are employed by the employer within 75 miles.

***Special hours of service eligibility requirements apply to airline flight crew employees.**

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 3 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. 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 so as not to 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 use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal 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 must comply with an employer's normal 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 also must 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 as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

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

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; and
- 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

An 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 which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulation 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

U.S. Department of Labor | Wage and Hour Division

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