Family and Medical Leave Act (FMLA)

Pender Memorial Hospital an affiliate of New Hanover Regional Medical Center

New Hanover Regional Medical Center

Leave of Absence Application – Caring for a FAMILY MEMBER with a Serious Health Condition

Note: Failure to fully complete this form could result in an initial denial of FMLA leave or delay in approval of FMLA Leave for the employee. *Where the need is foreseeable, an employee must provide at least 30 days advance notice of the need for leave, whenever possible. Otherwise leave applications must be submitted in full within 30 days of the start date of the leave (first missed shift).*

SECTION I: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section I before giving this form to your family member's medical provider to complete Section II. The FMLA permits NHRMC to require that you submit a timely, complete, and sufficient medical certification to support a request for family leave due to the serious health condition of your family member. Your response is required to obtain or retain the benefit of FMLA protection. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. **You have 30 calendar days from the date your leave starts to return this form.**

IMPORTANT: In the case of an incomplete, vague or non-responsive medical certification, the HR-Benefits Team may notify you in writing of the additional information/clarification that is necessary to complete the certification. **You then have ten (10) calendar days to provide the requested information.** If you fail to submit a complete and sufficient certification despite the opportunity to correct it, we may deny the FMLA leave.

Employee Full Name: _____Date: _____

Job Title: _____ Phone #:_____ EE ID#:_____

Full Name of Family Member: _____

Describe Care Needed for Family Member: _____

FAMILY MEDICAL LEAVE REQUEST FOR:

☐ **Continuous Leave** *(For absences lasting or expected to last more than 3 consecutive scheduled work days or shifts)*
This leave is for:

- ☐ A serious health condition affecting my ___ spouse, ___ child (up to age 18), ___ parent, for whom I will provide care

☐ **Intermittent Leave** (occasional time off over a period determined by a physician certification, cannot exceed 3 consecutive scheduled work days) to care for my ___ spouse, ___ child (up to age 18), ___ parent, for whom I will provide care.

☐ **Military Caregiver FMLA** (may be approved for Continuous or Intermittent) – If this is selected, please attach a copy of the military orders as supporting documentation (Section II may or may not be applicable).

Requested Leave Start Date:_____ **I plan to Return to Work on**: _____

***PDO** – *You are required to use all accrued PDO while on FMLA, not to exceed your FTE status. It is your responsibility to notify your timekeeper of your PDO distribution during your leave.*

You have a right under the FMLA for up to 12 weeks of unpaid leave in a 12 month period for the reasons listed above if you have completed one year of employment **and** have worked 1,250 hours in the prior 12 month period. Also, your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work. You must be reinstated to the same or an equivalent job with the same pay, benefits, terms, and conditions of employment on your return from leave. If your leave exceeds 12 weeks, your benefits will terminate at the end of that month and you will be offered to continue coverage at the full premium rate under COBRA. At that time, you may be eligible for a Personal Leave which not offer the same job protection as FMLA.

By applying for Intermittent FMLA, please be advised that should you have to miss a weekend shift due to your approved I-FMLA condition, that shift must be made up in a timely manner. You will need to speak with your supervisor for arrangements.

_____ _____

Employee's Signature ***Date***

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SECTION II: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed in Section I has requested leave under 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 may need help from the employee requesting leave. Please be sure to sign & date the form on the last page. PLEASE PRINT CLEARLY

Patient/Employee Name: _____

Doctor's/Provider's Name: _____

Business address: _____

Type of practice/medical specialty: _____

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

PART A: MEDICAL FACTS (PLEASE PRINT CLEARLY FOR TIMELY PROCESSING)

1. Approximate date condition commenced: _____ Probable duration of condition:_____

   Date(s) you treated the patient for 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 Yes, dates of admission: _____

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

   ☐ No ☐ Yes

   Was medication prescribed (excluding over-the-counter medication)?

   ☐ No ☐ Yes

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?

   ☐ No ☐ Yes If Yes, state the nature of such treatments and expected duration of treatment:

   _____

2. Is the medical condition pregnancy?

   ☐ No ☐ Yes If Yes, expected delivery date: _____

3. **REQUIRED:** Describe the relevant medical facts, 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 CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

1. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery?

   ☐ No ☐ Yes If Yes, estimate the date range for the period of incapacity: _____

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2. During this time, will the patient need care?
☐ No ☐ Yes If yes, explain the care needed by the patient and why such care is medically necessary:

_____

_____

3. Will the patient require follow-up treatments, including any time for recovery?
☐ No ☐ Yes If 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 care needed by the patient and why such care is medically necessary: _____

_____

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

Estimate the hours the patient needs care on an intermittent basis, if any: _____ hour(s) per day;

How many days per week?_____ From (start date): _____ Through (end date):_____

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

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). **This information is REQUIRED and is only an "estimate" to determine if the specifics of the need fall under the criteria of Intermittent FMLA.**

MUST BE COMPLETED: Frequency: _____ times per _____ week(s) OR _____ month(s)

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

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

_____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER. Print Clearly.

_____

_____

_____

_____ _____

Signature of Health Care Provider **Date**

Submit all pages 1-3 together: Fax to: **910-815-5969** or scanned and e-mailed to: HR.Benefits@nhrmc.org, or mailed to: HR-Benefits Team, PO Box 2318, Wilmington, NC 28401. For questions call the Benefits Hotline M-F – 8A-5P at **910-667-6000**.