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 – For an EMPLOYEE with a Serious Health Condition

Note: Failure to fully complete this form in full could result in an initial denial of FMLA leave or delay in approval of FMLA Leave for the employee. *The information sought relates only to the employee's condition for which they are taking FMLA leave. 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 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 medical leave due to your own serious health condition. 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#: _____

FAMILY MEDICAL LEAVE REQUEST FOR:

☐ **Continuous Medical Leave** *(For absences lasting or expected to last more than 3 consecutive scheduled work days or shifts)*
This leave is for: ☐ Birth of your child OR ☐ Placement of a child with you for adoption or foster care OR
☐ A Serious health condition that makes you unable to perform the essential functions of your job

☐ **Intermittent Leave** *(For occasional absences over a period determined by physician certification; each absence occasion cannot exceed 3 consecutive scheduled work days or shifts)*
This leave is for a serious health condition that makes you unable to perform the essential functions of your job

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 Other Medical Leave-No Benefits or a Personal Leave, but those types of leave do 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: Your patient listed in Section I has requested leave under 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. 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: _____

Fax:(_____)_____

Telephone: (_____)_____

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. Use the information provided in Section I to answer. If no job description is attached, answer these questions based on the employee's own description of his/her job functions

   Is the employee ABLE to perform ANY of his/her job functions due to the condition? ☐ No ☐ Yes

   If **NO**, identify the job functions the employee is unable to perform:

   _____

   _____

   _____

4. **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):

   _____

   _____

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PART B: AMOUNT OF CARE NEEDED:

1. Will the employee 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: _____

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

   ☐ No ☐ Yes If Yes, are the treatments or the reduced number of hours of work medically necessary? _____

   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, for date range: _____

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

   ☐ No ☐ Yes If Yes, is it medically necessary for the employee to be absent from work during the flare-ups? Please 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). **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

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

_____

_____

_____

_____

_____

_____

_____ _____

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

Submit all completed pages 1-3: 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**.