



# RURALMETRO HUMAN RESOURCES Leave Request Form

**COMPLETE AND RETURN THIS FORM TO HUMAN RESOURCES WITHIN THREE (3) DAYS**

Name: \_\_\_\_\_ ID# \_\_\_\_\_ Date \_\_\_\_\_

Address: \_\_\_\_\_ Telephone/Pager Number: \_\_\_\_\_

\_\_\_\_\_ Supervisor Name: \_\_\_\_\_

\_\_\_\_\_ Telephone Number: \_\_\_\_\_

- I would like to notify you that I have a need to take a leave due to:
  - Birth of a child or the placement of a child for adoption or foster care (see the FMLA information on the following page).\*
  - A serious health condition that I need care for (see the FMLA information on the following page).\*
  - A serious health condition affecting the following family member for whom I need to provide care (see the FMLA information on the next page).\*
    - Spouse    Child    Parent
  - Personal Leave
  - Extension of FMLA leave (see the FMLA information on the next page).\*
  - Education
  - Military duty (military duty requires a copy of the orders to be given to supervisor).
  - Other (specify): \_\_\_\_\_

\* You will need to provide medical certification for this type of leave.

■ I will need this leave beginning on \_\_\_/\_\_\_/\_\_\_ and I expect to return on \_\_\_/\_\_\_/\_\_\_.

- If the leave is due to FMLA or a personal leave due to an employee's own serious health condition, the employee must first exhaust accrued sick time (or PTO) and STD and then vacation time to receive paid leave. If FMLA or personal leave is due to anything other than an employee's own serious health condition, the employee must use vacation(or PTO) time to receive paid leave. All remaining leave time is unpaid.
  - I intend to use \_\_\_\_\_ weeks/days sick/vacation/PTO/STD time as paid leave during my FMLA or personal leave (for my own medical condition).
  - I intend to use \_\_\_\_\_ weeks/days vacation/PTO time as paid leave during my FMLA leave or personal leave (not my own medical condition).
  - I understand I have no available paid time benefit for my FMLA or personal leave.





**RURALMETRO HUMAN RESOURCES**  
**Response to Request for**  
**Leave**

Date:

Employee Name: \_\_\_\_\_

ID# \_\_\_\_\_

Address: \_\_\_\_\_  
 \_\_\_\_\_

Phone # \_\_\_\_\_

On \_\_\_\_\_, you notified us of your need to take a leave due to:

- Employee's serious health condition (FML)
- Employee's serious health condition related to worker's compensation injury/illness (FWC)
- Employee's serious health condition related to state mandated disability (FSD)
- Serious health condition of employee's spouse, child, parent (FML)
- Birth/Placement of child for adoption/foster care (FML)
- Employee's medical condition (MED)
- Employee's medical condition related to worker's compensation injury/illness (MWC)
- Employee's medical condition related to state mandated disability (MSD)
- Extension of FMLA (MED)
- Personal reasons: education, paternity, placement child adoption/foster care, relocation, marriage, bereavement, jury duty over 30 days, extension of FMLA for family member (PER)
- Military (MIL)
- Long Term Disability (LTD)

You notified us that you need this leave beginning on \_\_\_\_\_ and that you expect leave to continue until or about \_\_\_\_\_.

The following provides important information about your leave request.

- Yes     No    1. You are approved to take the requested leave
- Yes     No    2. You are eligible for leave under the FMLA.
- Yes     No    3. This leave will be counted against your annual FMLA leave entitlement.
- Yes     No    4. You will be required to furnish medical certification of a serious health condition. **If required**, you must furnish certification by \_\_\_\_\_ (date must be at least 15 days after you are notified of this requirement), or we may delay the start of your leave until the certification is submitted. **Your requested leave period may be modified based on the medical determination provided by your health care provider.**
- Yes     No    5. You will be required to present a fitness-for-duty certificate from a licensed physician before being restored to employment. If such a certificate is required but not received, your return to work may be delayed until the certificate is provided. **continued**





# **RURALMETRO HUMAN RESOURCES**

## **Health Care Provider**

### **Certification<sup>1</sup>**

1. **Employee Name:** \_\_\_\_\_ **1A. Patient Name:** \_\_\_\_\_

2. The attached sheet describes what is meant by a "serious health condition" under the Family and Medical Leave Act. Does the patient's condition qualify under any of the categories described in the "serious health condition" section? If so, please check the applicable category:

- (a)  Hospital Care
- (b)  Absence Plus Treatment
- (c)  Pregnancy
- (d)  Chronic Conditions Requiring Treatments
- (e)  Permanent/Long-Term Conditions Requiring Supervision
- (f)  Multiple Treatments (Non chronic Conditions)
- (g)  None of the Above

3. Describe the medical facts that support your certification, including a brief statement on how the medical facts meet the criteria of one of these categories: \_\_\_\_\_  
\_\_\_\_\_

4. State the approximate date the condition commenced and its probable duration (and also the probable duration of the patient's present "incapacity," if different)<sup>2</sup>, and the date the employee may be able to return to work: \_\_\_\_\_  
\_\_\_\_\_

**(If leave is requested for a family member of an employee with a "serious health condition" please proceed to #9)**

5. Describe how the medical condition listed above makes the employee unable to perform his or her job. \_\_\_\_\_  
\_\_\_\_\_

6. (a)  It will be necessary for the employee to work only intermittently or on a less than full schedule as a result of the condition (including for multiple treatments described in item 6 below).

Probable duration: \_\_\_\_\_

(b) If the condition is a pregnancy or a chronic condition described in item 4, state whether the patient is presently incapacitated and the likely duration and frequency of episodes of "incapacity."<sup>2</sup>

\_\_\_\_\_

7. (a) If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments: \_\_\_\_\_

If the patient will be absent from work or other daily activities because of treatment on an intermittent or part-time basis, also provide an estimate of the probable number of and interval between such treatments: \_\_\_\_\_

actual or estimated dates of treatment, if known: \_\_\_\_\_

period required for recovery, if any: \_\_\_\_\_

<sup>1</sup>Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking FMLA leave.

<sup>2</sup>"Incapacity," for FMLA purposes is defined to mean inability to work, attend school, or perform other regular daily activities due to the serious health condition, treatment for it, or recovery from it.

(b) If any of these treatments will be provided by another provider of health services (e.g., physical therapist), please state the nature of the treatments: \_\_\_\_\_  
\_\_\_\_\_

(c) If a "regimen of continuing treatment" by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment): \_\_\_\_\_  
\_\_\_\_\_

8. (a) If medical leave is required for the employee's absence from work because of the employee's own condition (including absences due to pregnancy or a chronic condition), is the employee unable to perform work of any kind?  YES  NO

(b) If able to perform some work, is the employee unable to perform any of the essential functions of the employee's job (the employee or the employer should supply you with information about the essential job functions)?  YES  NO  
If yes, please list the essential functions the employee is unable to perform: \_\_\_\_\_  
\_\_\_\_\_

(c) If neither (a) nor (b) applies, is it necessary for the employee to be absent from work for treatment?  YES  NO

**(If leave is requested for an employee's own health condition, please skip to the Health Care Provider signature.)**

9. (a) If leave is required to care for a family member of the employee with a "serious health condition," does the patient require assistance for basic medical, personal, safety, or transportation needs?  YES  NO

(b) If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery?  YES  NO

(c) If the patient will need care only intermittently or part time, please indicate the probable duration of this need: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
PRINT NAME OF HEALTH CARE PROVIDER

\_\_\_\_\_  
TYPE OF PRACTICE

\_\_\_\_\_  
HEALTH CARE PROVIDER SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
TELEPHONE NUMBER

\_\_\_\_\_  
ADDRESS

\_\_\_\_\_  
FAX NUMBER

\_\_\_\_\_  
CITY, STATE, ZIP CODE

## Definition of a “Serious Health Condition”

A "Serious Health Condition" means an illness, injury, impairment, or physical or mental condition that involves one of the following:

**1. Hospital Care**

Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of "incapacity"<sup>2</sup> or subsequent treatment in connection with, or as a consequence of, such inpatient care.

**2. Absence Plus Treatment**

A period of "incapacity"<sup>2</sup> of more than three consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition) that also involves:

- a. "treatment"<sup>3</sup> two or more times by a health care provider, a nurse, or a physician's assistant under direct supervision of a health care provider or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or
- b. "treatment"<sup>3</sup> by a health care provider on at least one occasion that results in a "regimen of continuing treatment"<sup>4</sup> under the supervision of the health care provider.

**3. Pregnancy**

Any period of "incapacity"<sup>2</sup> due to pregnancy or for prenatal care.

**4. Chronic Conditions Requiring Treatment**

A chronic condition that:

- a. requires periodic visits for "treatment"<sup>3</sup> by a health care provider or nurse or physician's assistant under the direct supervision of a health care provider;
- b. continues over an extended period of time (including recurring episodes of a single underlying condition); and
- c. may cause episodic "incapacity"<sup>2</sup> rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

**5. Permanent/Long-Term Conditions Requiring Supervision**

A period of "incapacity"<sup>2</sup> that is permanent or long term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment from, a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

**6. Multiple Treatments (Non chronic Conditions)**

Any period of absence to receive multiple "treatments" (including any period of recovery from them) by a health care provider or a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury or for a condition that would be likely to result in a period of "incapacity"<sup>2</sup> of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), or kidney disease (dialysis).

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<sup>3</sup>"Treatment" includes examinations to determine if a serious condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

<sup>4</sup>A "regimen of continuing treatment" includes, for example, a course of prescription medication (such as an antibiotic) or therapy requiring special equipment to resolve or alleviate the serious health condition. A regimen of continuing treatment does not include taking over-the-counter medications such as aspirin, antihistamines, or salves, nor does it include bed rest, drinking fluids, exercise, or other similar activities that can be initiated without a visit to a health care provider.