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TOWN OF ISLIP **OFFICE OF THE SUPERVISOR**

Department of Personnel and Labor Relations

TOWN HALL ● 655 Main Street ● Islip NY, 11751

Phone (631) 224-5520 ● Fax (631) 224-5771

Date: _____

I have received from the Personnel Department "Family and Medical Leave" papers along with an Explanation of Benefits.

Signed: _____

Printed Name:_____

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TOWN OF ISLIP
FAMILY AND MEDICAL LEAVES OF ABSENCE POLICY

Scope:

This policy is applicable to all requests for Family and Medical leaves of absences under the Family and Medical Leave Act of 1993(FMLA). Family and medical leave includes any accrued paid or unpaid leave which Town of Islip requires an employee to use as a part of a family leave or medical leave of absence. Any town policies regarding paid or unpaid leave or contractual leave provisions, whether paid or unpaid, that meet FMLA eligibility definition will count towards and are not in addition to FMLA leave.

Falsification of records and failure to correct records known to be false (even if true when given) are prohibited. Violation of this provision will result in discipline up to and including termination.

Eligibility:

To be eligible for FMLA benefits, an employee must have worked for the Town of Islip for at least a total of 12 months and at least 1,250 hours over a running 12 month period immediately preceding the commencement of the leave. Anyone out on workers compensation leave for 30 days or more or out on maternity leave will automatically be places on FMLA.

Leave Entitlement:

FMLA entitles eligible employees to take up to 12 weeks of paid (vacation, sick, personal, and ½ days) or unpaid job-protected leave in a twelve (12) month period for one or more of the following reasons: the birth of a child; the placement of a child for adoption or foster care; the care of an immediate family member (spouse, child or parent) with a serious health condition; or a serious health condition that makes the employee unable to work.

For purposes of this policy, “serious health condition” is an illness, injury, impairment or physical or mental condition that involves:

A. Any period of incapacity or treatment in connection with or consequent to impatient care (i.e. an overnight stay) in a hospital, hospice or residential medical care facility;

B. Any period of incapacity requiring absence from work, school or regular daily activities for more than three consecutive calendar days and any subsequent period of incapacity that involves continuing treatment by a health care provider; or

C. Continuing treatment by a health care provider for a chronic or serious health condition that, if not treated, would likely result in a period of incapacity of more than three calendar days; or for pregnancy or prenatal care.

For purposes of leave entitlement under this policy, the twelve (12) month period shall be calculated on a rolling basis, i.e. when an employee requests a leave under this policy the town will determine if the employee has been granted FMLA leave in the period of one (1) year immediately prior to application and the employee may be granted up to the difference between the twelve (12) week maximum and the leave already granted during the prior twelve (12) months.

Procedure:

An employee requesting either a family or medical leave under the FMLA must submit the written leave request, "Request for Family and Medical Leave", to the Personnel Office thirty (30) days before the date the leave is intended to begin. The town recognizes that unexpected emergencies can arise where it is not possible to provide as thirty (30) days' notice of the intended leave. In such situations, employees are expected to provide as much advance notice as is practicable. In some instances, advance notice might not be practical or possible.

Medical Certification:

In cases where an employee is requesting medical leave because of the employee's own serious health condition or that of a spouse, child or parent, the town will require the employee to submit written certification, "Certification of Health Care Provider" form issued by the U.S. Department of Labor, verifying the need for the leave. The town, at its own expense, may require the employee to receive a second opinion from a health care provider designated mutually agreed upon by the town and the employee. The third opinion will be binding on both parties.

Situation of Paid and Unpaid Leave:

An employee taking leave pursuant to FMLA will be required to use any paid vacation, personal and/or sick leave accrued prior to the medical leave or additional sick leave (including any half-pay leave) to which he/she is eligible under the terms of the labor contract for any of the 12 work weeks of medical leave set forth in this policy. The town policy for the remainder of the FMLA leave will be unpaid if the employee exhausts his/her accrued paid leave. The employee will be notified in writing that the vacation time, sick days or addition personal leave, sick leave for which he/she is eligible will be counted towards the twelve weeks of family leave. Paid leave shall be charged to an employee as follows:

1. Sick leave may only be substituted for leave taken for the employee's own serious health condition.

2. Family Leave for yourself – you must use all paid sick, vacation, half pay and personal leave in that order.

3. Family Leave for someone else – you must use all your paid vacation and personal leave.

Once the applicable paid leave is exhausted, an employee will be carried in an unpaid status for the remainder of the 12 week paid leave. Such leave will be counted towards an employee's FMLA entitlement.

Intermittent and Reduced Schedule Leave:

FMLA leave time may be taken intermittently (or on a reduced schedule basis) whenever the leave is medically necessary to care for a seriously ill family member, or because the employee is seriously ill or unable to work. Intermittent leave will not be granted after the birth of a healthy child, or placement of a healthy child for adoption or foster care. If the need for intermittent leave is foreseeable, based on planned medical treatment, the employee is responsible for scheduling the treatment in a matter that does not unduly disrupt the town's operations. Consequently, the employee must consult with the Commissioner or Department Head of his/her department before scheduling such leave. The town reserves the right to request that such leave be rescheduled. When an employee requests intermittent leave or reduced schedule leave, the town reserves the right to transfer the employee temporarily to an alternative position which better accommodates recurring periods of absence or a part-time schedule. The position to which the employee is transferred will be equivalent in pay and benefits to the one that the employee held prior to the transfer.

Recertification:

Employees who are on medical leave because of their own serious health condition or to take care of a spouse, child or parent with a serious health condition are required to submit to Personnel every six (6) months a written recertification o the need to remain on the leave. The town may request recertification on a more frequent basis if:

A. The employee requests an extension of leave; or
B. Changed circumstances occur regarding the illness or injury; or
C. the town receives information that casts doubt upon the continuing validity of the most recent certification; or
D. When an employee is unable to return to work after exhaustion of medical leave because of the continuation, recurrence or onset of a serious health condition thereby preventing the town from seeking reimbursement for group health premiums paid on the employee's behalf during a period of unpaid medical leave.

Return to Work Certification:

All employees taking medical leave to care for their own serious health condition may be required to submit to the Town Personnel Department an original copy of a fitness-for-duty certification signed by their health care provider before returning to work, stating that the employee is able to perform the essential functions of his or her position. The Personnel Department will provide a copy of such certification to the employee's Department Head.

Status of Benefits While on Leave:

While an employee is on medical or family leave pursuant to this policy, he/she will continue to be covered under town's group health, and other insurance plans in effect and so chosen by the employee, so long as the employee continues to pay the employee portion of the premium costs, if any. If paid leave is used for any portion of the family or medical leave, the employee's share of premiums, if any, will be deducted from the leave payments in accordance with the practice applicable to an employee not on leave.

At the time an employee begins unpaid family or medial leave he/she shall receive written instructions detailing the time and manner in which the employee premiums are to be paid. Failure to pay these premiums by the end of the grace period stated in the written instructions shall result in the loss of health, disability, life and other insurance coverage so chosen by the employee.

An employee who fails to return to work for at least 30 calendar days following the expiration of the unpaid family or medical leave shall be required to reimburse the town for the portion of the health care premiums paid by the town during the unpaid leave unless the employee can establish that the failure to return was due to the continuation, recurrence or onset of a serious health condition which meets the criteria for leave under this policy or was due to other circumstances beyond the employee's control.

Restoration of Benefits and Position at the Conclusion of Leave:

The employee on family or medical leave is not entitles to the accrual of any seniority or employment benefits during any period of leave except as expressly stated herein or as provided by law. At the conclusion of an employee's medical or family leave, the employee will be returned to the position that the employee held prior to leave. If that position is not available, the employee will be placed in a position that is equivalent in pay, conditions and other terms of employment as the employee's prior position. When the employee returns to active work following the family or medical leave, any benefits which have lapsed during the leave shall be reinstated as if the employee had remained actively employed during the leave except that the employee shall not accrue any additional benefits or seniority during the time of the leave (e.g., no accrual of more vacation time or sick days while on leave of absence). The number of calendar days taken as unpaid leave will be added to the employment anniversary date for purposes of calculating seniority, pay increases and other employment policies of the town.

Key Employees:

A key employee is a salaried, eligible employee who is among the highest paid ten percent of employees of the town. Subject to limitation of contract and/or state law, Town of Islip may refuse to reinstate key employees after using FMLA leave if it determines that substantial and grievous economic injury would result from reinstatement. If this determination is made, the employee will be notifies in writing and given an opportunity to end the leave and return to work. If the employee remains on leave, he or she will not have a right to be restored to employment. 1

Continuation of Leave:

An employee who wishes to take more leave than provided by this policy must leave pursuant to another Town of Islip leave policy, if any. The reinstatement of an employee, and the employee's right to continue group health coverage by only paying the employee's portion of the premiums (and any other benefit rights listed in this policy) are, however, protected only for the 12 work weeks of family and medical leave, unless otherwise provided by contract, policy or state law.

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1 The employer must decide on an individual basis which employees are considered key employees according to the criteria outlined above.

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REQUEST FOR FAMILY AND MEDICAL LEAVE

DEPARTMENT: _____ DATE: _____

NAME: _____

TITLE: _____ SS #: _____

(1) REASON FOR REQUESTING FMLA LEAVE:

_____ My own serious health condition renders me unable to perform the functions of my position.
_____ The birth of a child and in order to care for such a child.
_____ The adoption of a child or placement of a child for foster care.
_____ Serious health condition of your: child, spouse or parent.

(2) REQUEST LEAVE FROM THE TOWN

From: _____/_____/20_____ To: _____/_____/20_____

Total Number of Days: _____

(3) _____ Intermittent Leave

_____ Reduced Leave Schedule

_____ Continuous Leave (maternity, surgery)

(4) I understand that if the leave requested is for my own serious health condition of that of a family member, I must provide medical certification within 15 calendar days of completing this form and that my failure to do so will result in denial of my leave until such certification is provided. The medical certification must be submitted to Personnel.

(5) I understand that I may be required to submit additional certification at least once every 30 calendar days as requested by Personnel and that failure to comply with this request within 15 days may result in the Town of Islip denying continuation of my leave.

(6) If this leave is requested for the birth, adoption or placement of a foster child, I agree to provide the Town of Islip with the appropriate documentation substantiating such request within 15 calendar days of completing this form.

(7) I understand that this leave will be counted against my FMLA (Family and Medical Leave) entitlement.

(8) I understand that when taking FMLA leave, the Town of Islip will require that I use all applicable paid leave. Such paid leave will be counted against my annual Family and Medical leave entitlement for 12 weeks. Paid sick leave can only be used for employees' own illness or injury.

(9) If my leave request is for my own serious illness, I understand that I will be required to provide the Town of Islip with a certification from my health care provider that I am physically unable to return to work.

(10) I understand that when I return from FMLA leave, the Town of Islip will place me in the same position or an equivalent position to the one which I am presently employed.

(11) I understand that a fraudulent FMLA request will subject me to immediate dismissal.

(12) I acknowledge that I have received a copy of this form for my records.

_____ _____

Employee's signature Date

(If in an emergency situation, information received by:)

Name _____

Title_____ Date _____

REQUEST ACKNOWLEDGE/APPROVED/DENIED (Circle One)

_____ _____

Director of Personnel & Labor Relations Date

Certification of Health Care Provider for Family Member's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 2/28/2015

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees' family members, 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.

Employer name and contact: _____

_____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your family member or his/her medical provider. 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 denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Your name: _____
First Middle Last

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

Relationship of family member to you: _____

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

Describe care you will provide to your family member and estimate leave needed to provide care:

_____

_____

_____

_____ _____
Employee Signature Date

CONTINUED ON NEXT PAGE

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to 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 below. 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. Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address:_____

Type of practice / Medical specialty: _____

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

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
   ___No ___Yes. If so, dates of admission: _____

   Date(s) you treated the patient for condition: _____

   Was medication, other than over-the-counter medication, prescribed? ___No ___Yes.

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

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
   ____ No ____Yes. If so, state the nature of such treatments and expected duration of treatment:

   _____

   _____

2. Is the medical condition pregnancy? ___No ___Yes. If so, expected delivery date: _____

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

_____

_____

_____

_____

CONTINUED ON NEXT PAGE

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:

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

   Estimate the beginning and ending dates for the period of incapacity: _____

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

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

   _____

   _____

   _____

   _____

   _____

5. Will the patient require follow-up treatments, including any time for recovery? ___No ___Yes.

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   _____

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

   _____

6. 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; _____ days per week from _____ through _____

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

   _____

   _____

   _____

   _____

CONTINUED ON NEXT PAGE

7. 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):

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

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

   Does the patient need care during these flare-ups? ____ No ____ Yes.

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

   _____

   _____

   _____

   _____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Health Care Provider **Date**

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 20 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 Ave., NW, Washington, DC 20210.
DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.