

# 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 or 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 with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation 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 servicemember during a single 12-month period. A covered servicemember is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

## 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 one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

## 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;
- 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. Regulations 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](http://WWW.WAGEHOUR.DOL.GOV)



**ATTACHMENT A  
JEFFERSON COUNTY  
REQUEST FOR FAMILY/MEDICAL LEAVE**

1. Name \_\_\_\_\_ SS. # \_\_\_\_\_
  2. Position \_\_\_\_\_ Dept. \_\_\_\_\_  
Hire Date \_\_\_\_\_ Phone # \_\_\_\_\_
  3. Reason for requested leave:
    - a.  for the birth of my child, and to care for such child
    - b.  for the placement of a child with me for adoption or foster care
    - c.  to care for my spouse, child or parent with a serious health condition
    - d.  for my own serious health condition which has made me unable to perform my job functions
    - e.  because of a qualifying exigency arising out of the fact that my spouse, son or daughter, or parent is on active duty or call to active duty status in support of a contingency operation as an active duty service member or a member of the National Guard or Reserves; or
    - f.  because I am the spouse, son or daughter, parent, next of kin of a covered service member or a veteran with a serious injury or illness.
  4. Date on which you  wish to begin  began leave: \_\_\_\_\_
  5. Date of anticipated return to work: \_\_\_\_\_
  6. Are you requesting leave on an intermittent or reduced schedule?  Yes  No  
If yes, please give schedule or when you anticipate you will be unavailable for work.
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I understand that I must provide 30 days' advance notice for requesting FMLA leave when the leave is foreseeable.

I also understand that a Certification of Health Care Provider Form (Attachment C)/Certification of Health Care Provider Serious Injury or Illness of Covered Servicemember Form (Attachment C1) must be completed by my health care professional and returned within 15 days after I notify you of this leave. I understand that my leave may be delayed until I provide such certification from a physician. I understand that falsification of any document or failure to produce required certifications relating to leave will result in discipline, up to and including termination.

If my request for leave falls under 3e above, I understand a copy of the active duty orders or other documentation from the military certifying the covered military member is on active duty (or has been notified of an impending call to active duty) in support of a contingency operation should be submitted within 15 days after I notify you of this leave by completing the Certification of Qualifying Exigency Form (Attachment C2).

I hereby agree that while I am on leave I will continue to pay my share of dependent health insurance premiums unless I elect to discontinue such coverage. I also agree that if I fail to return to work at the end of the leave period, I will reimburse Jefferson County for the cost of health benefits provided by Jefferson County during my leave, unless I fail to return to work because of the continuation, recurrence or onset of a serious health condition or because of other circumstances beyond my control. If I am unable to return to work because of a serious health condition, I will provide medical certification from the appropriate health care provider stating that I am unable to perform the functions of my position on the date that my leave expired or that I was needed to care for a covered relation because he/she has a serious health condition on the date that my leave expired. Employees seeking to return to work after a leave because of their own serious illness (3.d) must furnish to the County a return-to-work release from the attending physician before being allowed to resume work.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Note: Nothing herein shall be construed as contradicting or superseding any portion of the FMLA or Jefferson County Policy. Any questions arising from use of this form should be directed to the Human Resources Director.

**ATTACHMENT B**  
**JEFFERSON COUNTY**  
**EMPLOYER NOTICE OF ELIGIBILITY/DESIGNATION OF FAMILY/MEDICAL LEAVE**

Date: \_\_\_\_\_

To: \_\_\_\_\_ SS# \_\_\_\_\_  
(Employee's Name)

Subject: Designation of Family/Medical Leave

**On \_\_\_\_\_, you notified us/we became aware of your need to take family/medical leave due to:**  
(date)

- a. the birth of a child, or the placement of a child for adoption or foster care; or
- b. a serious health condition that you need to care for; or
- c. a serious health condition affecting your o spouse, o child, o parent for which you are needed to provide care; or
- d. because of a qualifying exigency arising out of the fact that your o spouse, o son or daughter, or o parent is on active duty or call to active duty status in support of a contingency operation as an active service member or member of the National Guard or Reserves; or
- e. because you are the o spouse, o son or daughter, o parent, o next of kin of a covered service member or veteran with a serious injury or illness.

This leave  will begin  began on or about \_\_\_\_\_ and you expect the leave to continue until on or about \_\_\_\_\_.  
(date) (date)

You have a right under the FMLA for up to 12 workweeks of unpaid leave in a rolling 12-month period (unless you have paid leave available to you) for the reasons listed above (under a, b, c, and d).

For a serious injury or illness of a covered servicemember (military family leave) you have a right under the FMLA for up to 26 workweeks of unpaid leave in a 12-month period (unless you have paid leave available to you) for the reason listed above under e. For an eligible employee with a spouse, son, daughter, or parent on active duty as an active duty service member or call to active duty status in the National Guard or Reserves in support of a contingency operation you may use the 12 workweek leave entitlement to address certain qualifying exigencies.

Also, your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work, and you must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from leave. If you do not return to work following FMLA leave for a reason other than: (1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; or (2) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave.

This is to inform you that (check appropriate boxes; explain where indicated):

1. You are  eligible  not eligible for leave under the FMLA.

2. The requested leave o will o will not be counted against your annual FMLA leave entitlement.
3. You are required to furnish medical certification of a serious health condition and you must furnish this certification within 15 days after you are notified of this requirement or we may delay the commencement of your leave until the certification is submitted. If sufficient information is not provided in a timely manner, your leave may be denied.
4. In accordance with County policy, any useable accrued paid leave must be used first, in the following order during the 12 workweek or (26 workweek leave period to care for an injured or ill service member or a veteran who is undergoing medical treatment, recuperation or therapy for serious injury or illness that occurred any time during the five years preceding the date of treatment) leave period: 1) sick leave, 2) compensatory time, 3) vacation or 4) personal leave, where applicable. **An employee who is taking leave for the adoption or foster care of a child or military FMLA leave for a qualifying exigency must use all paid compensatory time, vacation and personal leave prior to being eligible for unpaid leave.** Once any paid leave is used up, the remainder of the 12 workweeks will be unpaid.
5. If you normally pay a portion of the premiums for your dependent’s health/dental insurance, and/or other optional benefits, these payments must continue during the period of FMLA leave. Your premium payments are due on regularly scheduled County paydays.
6. You will be required to present a fitness-for-duty certificate prior to being restored to employment. If such certification is not received, your return to work may be delayed until such certification is provided.
7. You are required to furnish us with periodic reports of your status and intent to return to work every 30 days while on FMLA leave.
8. You are required to furnish recertification every six (6) months in relation to a serious health condition.
9. Failure to comply with any of the above conditions may result in disciplinary action.

The above information has been reviewed with me and I agree to comply with the provisions herein.

Leave approved by: \_\_\_\_\_ Date  
(Department Head’s Signature)

\_\_\_\_\_  
Employee’s Signature

**ATTACHMENT C1**  
**JEFFERSON COUNTY**  
**CERTIFICATION OF HEALTH CARE PROVIDER**  
**Serious Injury or Illness of Covered Servicemember**  
**For Military Family Leave**  
**FAMILY AND MEDICAL LEAVE ACT**

**SECTION I: For Completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the Employee is Requesting Leave**

**INSTRUCTIONS to the EMPLOYEE or COVERED SERVICEMEMBER:** Please complete Section I before having Section II completed. The FMLA permits an employer to require that an employee submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a serious injury or illness of a covered servicemember. If requested by the employer, your response is required to obtain or retain the benefit of FMLA-protected leave. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to do so may result in a denial of an employee's FMLA request. 29 C.F.R § 825.310(f). The employer must give an employee at least 15 calendar days to return this form to the employer.

**SECTION II: For Completion by a UNITED STATES DEPARTMENT OF DEFENSE ("DOD") HEALTH CARE PROVIDER or a HEALTH CARE PROVIDER who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider**

**INSTRUCTIONS to the HEALTH CARE PROVIDER:** The employee listed on Page 2 has requested leave under the FMLA to care for a family member who is a member of the Regular Armed Forces, the National Guard, or the Reserves, or veteran (veterans illness that occurred any time during the five years preceding the date of treatment) 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. For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty that may render the servicemember medically unfit to perform the duties of his or her office, grade, rank, or rating.

A complete and sufficient certification to support a request for FMLA leave due to a covered servicemember's serious injury or illness includes written documentation confirming that the covered servicemember's injury or illness was incurred in the line of duty on active duty and that the covered servicemember is undergoing treatment for such injury or illness by a health care provider listed above. 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 employee is seeking leave.

**ATTACHMENT C1**  
**JEFFERSON COUNTY**  
**CERTIFICATION OF HEALTH CARE PROVIDER**  
**Serious Injury or Illness of Covered Servicemember**  
**FAMILY AND MEDICAL LEAVE ACT**

**For Completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the Employee is Requesting Leave:** (This section must be completed first before any of the below sections can be completed by a health care provider.)

**Part A: EMPLOYEE INFORMATION**

Name and Address of Employer (this is the employer of the employee requesting leave to care for covered servicemember): \_\_\_\_\_

Name of Employee Requesting Leave to Care for Covered Servicemember:

\_\_\_\_\_  
First Middle Last

Name of Covered Servicemember (for whom employee is requesting leave to care):

\_\_\_\_\_  
First Middle Last

Relationship of Employee to Covered Servicemember Requesting Leave to Care:

Spouse  Parent  Son  Daughter  Next of Kin

**Part B: COVERED SERVICEMEMBER INFORMATION**

(1) Is the Covered Servicemember a Current Member of the Regular Armed Forces, a veteran, the National Guard or Reserves?  Yes  No

If yes, please provide the covered servicemember's military branch, rank and unit currently assigned to:  
\_\_\_\_\_

Is the covered servicemember assigned to a military medical treatment facility as an outpatient or to a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients (such as a medical hold or warrior transition unit)?

Yes  No If yes, please provide the name of the medical treatment facility or unit:  
\_\_\_\_\_

(2) Is the Covered Servicemember on the Temporary Disability Retired List (TDRL)?  Yes  No

**Part C: CARE TO BE PROVIDED TO THE COVERED SERVICEMEMBER**

Describe the Care to Be Provided to the Covered Servicemember and an Estimate of the Leave Needed to Provide the Care:  
\_\_\_\_\_  
\_\_\_\_\_

**SECTION II: For Completion by a United States Department of Defense (“DOD”) Health Care Provider or a Health Care Provider who is either: (1) a United States Department of Veterans Affairs (“VA”) health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider. If you are unable to make certain of the military-related determinations contained below in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator). (Please ensure that Section I above has been completed before completing this section.) Please be sure to sign the form on the last page.**

**Part A: HEALTHCARE PROVIDER INFORMATION**

Health Care Provider’s Name and Business Address:

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Type of Practice/Medical Specialty: \_\_\_\_\_

Please state whether you are either: (1) a DOD health care provider; (2) a VA health care provider; (3) a DOD TRICARE network authorized private health care provider; or (4) a DOD non-network TRICARE authorized private health care provider: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_ Email: \_\_\_\_\_

**Part B: MEDICAL STATUS**

(1) Covered Servicemember’s medical condition is classified as (Check One of the Appropriate Boxes):

- (VSI) Very Seriously Ill/Injured** – Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)
- (SI) Seriously Ill/Injured** – Illness/Injury is of such severity that there is cause for immediate concern, but there is no imminent danger to life. Family members are requested at bedside. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)
- OTHER Ill/Injured** – a serious injury or illness that may render the servicemember medically unfit to perform the duties of the member’s office, grade, rank, or rating.
- NONE OF THE ABOVE** – (Note to Employee: If this box is checked, you may still be eligible to take leave to care for a covered family member with a “serious health condition” under § 825.113 of the FMLA. If such leave is requested, you may be required to complete an employer-provided form (Attachment C) seeking the same information.)

(2) Was the condition for which the Covered Service member is being treated incurred in line of duty on active duty in the armed forces?  Yes  No

(3) Approximate date condition commenced: \_\_\_\_\_

(4) Probable duration of condition and/or need for care: \_\_\_\_\_

(5) Is the covered servicemember undergoing medical treatment, recuperation, or therapy?  
 Yes  No If yes, please describe medical treatment, recuperation or therapy:

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**Part C: COVERED SERVICEMEMBER'S NEED FOR CARE BY FAMILY MEMBER**

(1) Will the covered servicemember need care for a single continuous period of time, including any time for treatment and recovery?  Yes  No  
If yes, estimate the beginning and ending dates for this period of time: \_\_\_\_\_

(2) Will the covered servicemember require periodic follow-up treatment appointments?  
 Yes  No If yes, estimate the treatment schedule: \_\_\_\_\_

(3) Is there a medical necessity for the covered servicemember to have periodic care for these follow-up treatment appointments?  Yes  No

(4) Is there a medical necessity for the covered servicemember to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)?  
 Yes  No If yes, please estimate the frequency and duration of the periodic care:

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**Printed Name of Health Care Provider:** \_\_\_\_\_

**Signature of Health Care Provider:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**ATTACHMENT C2  
JEFFERSON COUNTY  
CERTIFICATION OF QUALIFYING EXIGENCY  
FOR MILITARY FAMILY LEAVE  
FAMILY AND MEDICAL LEAVE ACT**

Employer Name: \_\_\_\_\_  
\_\_\_\_\_

Contact Information: \_\_\_\_\_

**NOTE: Use of Sick Leave for the purpose of a Qualifying Exigency is not permitted.**

**SECTION II: For Completion by the EMPLOYEE**

**INSTRUCTIONS to the EMPLOYEE:** Please complete Section II fully and completely. The FMLA permits an employer to require that you submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a qualifying exigency. Several questions in this section seek a response as to the frequency or duration of the qualifying exigency. Be as specific as you can; terms such as “unknown,” or “indeterminate” may not be sufficient to determine FMLA coverage. Your response is required to obtain a benefit. 29 C.F.R. § 825.310. While you are not required to provide this information, failure to do so may result in a denial of your request for FMLA leave. Your employer must give you at least 15 calendar days to return this form to your employer.

Your Name: \_\_\_\_\_  
                    First                                    Middle                                    Last

Name of covered military member on active duty or call to active duty status in support of a contingency operation:

\_\_\_\_\_

First                                    Middle                                    Last

Relationship of covered military member to you: \_\_\_\_\_

Period of covered military member’s active duty: \_\_\_\_\_

A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes written documentation confirming a covered military member’s active duty or call to active duty status in support of a contingency operation. Please check one of the following:

- A copy of the covered military member’s active duty orders is attached.
- Other documentation from the military certifying that the covered military member is on active duty (or has been notified of an impending call to active duty) in support of a contingency operation is attached.
- I have previously provided my employer with sufficient written documentation confirming the covered military member’s active duty or call to active duty status in support of a contingency operation.

**Part A: QUALIFYING REASON FOR LEAVE**

1. Describe the reason you are requesting FMLA leave due to a qualifying exigency (including the specific reason you are requesting leave):

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2. A completed and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes any available written documentation which supports the need for leave; such documentation may include a copy of a meeting announcement for informational briefings sponsored by the military, a document confirming an appointment with a counselor or school official, or a copy of a bill for services for the handling of legal or financial affairs. Available written documentation supporting this request for leave is attached.

Yes    No    None Available

**Part B: AMOUNT OF LEAVE NEEDED**

1. Approximate date exigency commenced: \_\_\_\_\_

Probable duration of exigency: \_\_\_\_\_

2. Will you need to be absent from work for a single continuous period of time due to the qualifying exigency?    No    Yes

If so, estimate the beginning and ending dates for the period of absence:

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3. Will you need to be absent from work periodically to address this qualifying exigency?

No    Yes

Estimate schedule of leave, including the dates of any scheduled meetings or appointments:

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Estimate the frequency and duration of each appointment, meeting, or leave event, including any travel time (i.e., 1 deployment-related meeting every month lasting 4 hours):

Frequency: \_\_\_\_\_ times per \_\_\_\_\_ week(s) \_\_\_\_\_ month(s)

Duration: \_\_\_\_\_ hours \_\_\_\_\_ day(s) per event.

**Part C:**

If leave is requested to meet with a third party (such as to arrange for childcare, to attend counseling, to attend meetings with school or childcare providers, to make financial or legal arrangements, to act as the covered military member's representative before a federal, state, or local agency for purposes of obtaining, arranging or appealing military service benefits, or to attend any event sponsored by the military or military service organizations), a complete and sufficient certification includes the name, address, and appropriate contact information of the individual or entity with whom you are meeting (i.e., either the telephone or fax number or email address of the individual or entity). This information may be used by your employer to verify that the information contained on this form is accurate.

Name of Individual: \_\_\_\_\_ Title: \_\_\_\_\_

Organization: \_\_\_\_\_

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

Telephone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

Email: \_\_\_\_\_

Describe nature of meeting: \_\_\_\_\_

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**Part D:**

I certify that the information I provided above is true and correct.

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date