NEW YORK POWER AUTHORITY	EP:	3.3
	REVISION:	11
EMPLOYEE POLICY	DATE:	1/15/09

PLEASE REFER TO THE PORTION OF THE EMPLOYEE POLICIES ENTITLED DISCLAIMERS WHERE YOU WILL FIND A STATEMENT, WHICH PERTAINS TO ALL EMPLOYEE POLICIES, INCLUDING THIS ONE.

FAMILY & MEDICAL LEAVE ACT (FMLA)

1.1 This policy applies to all employees at all NYPA sites and offices and provides guidelines for qualifying leaves under the Family and Medical Leave Act ("FMLA"). The Notice to Employees of Rights under the FMLA (WHD Publication 1420) ("Notice") is found in Attachment 1 and fully incorporated into this policy. The policies and guidelines stated in this FMLA policy shall be subject to such other terms and conditions as are provided in the FMLA and its regulations.

ELIGIBILITY FOR FAMILY MEDICAL LEAVE ACT ("FMLA")

2.1 To be eligible for FMLA leave, an employee must have been employed with the Authority for at least 12 months and have worked at least 1,250 hours during the previous 12 months.

2.2 Type of Leaves Covered Under the FMLA:

1) Employee Medical Leave ("EML") (see Section 4) - for an employee's "serious health condition" (see attached Notice) that makes the employee unable to perform the functions of his or her position, including "serious health conditions" also eligible for workers' compensation;

2) Family Medical Leave ("FML") (see Section 4) - for the care of an employee's spouse, child, or parent (not parent-in-law) who has a "serious health condition";

3) Newborn Leave ("NL") (see Section 5) - for the care of a healthy newborn child;

4) Adoption Leave ("AL") (see Section 5) - for the care of a newly adopted or newly placed foster care child;

5) Military Family Leave ("MFL") (see Section 6) - for spouse, child, parent or next of kin of a covered servicemember to care for that servicemember; and

6) Qualifying Exigency Military Family Leave ("QEL") (see Section 7) - to take care of certain qualifying exigencies arising when a spouse, parent, or child has been called to, or is on, active duty in the National Guard or Reserves.

2.3 Eligible employees may receive up to a total of 12 weeks of FMLA leave on a rolling 12 month period starting with the first day that an employee commences any approved FMLA leave. However, Military Family Leave qualifies eligible employees to receive up to a combined total (with any other FMLA leave) of 26 weeks in a single rolling 12 month period.

NOTIFICATION/CERTIFICATION

3.1 When the need for FMLA leave is foreseeable, an employee should notify his/her supervisor and Human Resources at least 30 days in advance of the start date of the intended leave, or as soon as it is foreseeable. When the approximate timing of the need for leave is not foreseeable, an employee must provide notice to his/her supervisor and Human Resources as soon as practicable under the facts and circumstances of the particular case. Absent unusual circumstances, an employee will be expected to comply with his/her site/department's normal procedures for requesting leave and calling in absences. Failure to follow such procedures may result in a delay or denial of FMLA protection.

3.2 FMLA leaves can only be approved by the Vice President Ethics and Employee Resources, or designee(s), at the headquarters office, or the Facility Manager of Human Resources, or designee(s), at the sites. Once approved, FMLA leave is applied retroactively to the first day of absence.

3.3 The applicable fully completed Certification of Health Care Provider form or Certification of Serious Injury or Illness of Covered Servicemember ("Certifications"), signed by a health care provider, is required for all types of FMLA leave other than Qualifying Exigency Military Family Leave, which has its own separate form and requirements. Copies of the Certifications are attached in Attachments 2-5.

3.4 It is the employee's responsibility to see that the applicable Certification is completed, and returned to the Authority as soon as possible after the leave is requested, but no later than 15 calendar days from the date that the employee receives the Certification form from Human Resources.

3.5 If the Certification is incomplete or insufficient, the Authority will notify the employee and provide him/her up to seven calendar days to remedy any deficiencies. After this opportunity to remedy deficiencies has passed, a health care provider, human resources professional, leave administrator, or management official may contact the health care provider for purposes of limited clarification or authentication of the Certification. Under no circumstances may the employee's direct supervisor contact the employee's health care provider. In addition, in those situations where NYPA seeks to speak to the health care provider directly to obtain or discuss medical information related to the Certification, the employee may need to provide his/her doctor a HIPAA authorization allowing NYPA to do so.

3.6 The employee's request for FMLA leave may be denied in the event that an employee fails to: a) provide a Certification, b) timely remedy deficiencies in a Certification, or c) to provide a HIPAA authorization when requested as necessary for his/her health care provider to provide medical information directly to the Authority.

3.7 Employees attempting to obtain, or obtaining, FMLA leave by fraudulent means, shall be denied the restoration of their job or any other job at the Authority and utilization of paid time for time out of work.

3.8 Recertification of the need for FMLA leave may be required at various intervals, but generally not more than every 30 days, unless the Certification indicates that the minimum duration of the condition is more than 30 days, there is a change in circumstances or return to work date, an extension of leave is requested, or other circumstances cast doubt on the continuing validity of the leave.

EMPLOYEE MEDICAL LEAVE ("EML") AND FAMILY MEDICAL LEAVE ("FML")

4.1 When an employee has been absent from work for three (3) consecutive or closely occurring intermittent business days due to a "serious health condition," or when it appears that an employee will not be returning to work for a lengthy or undetermined amount of time due to a "serious health condition," he/she may be eligible for an Employee Medical Leave ("EML") under the FMLA.

4.2 If more than three (3) business days (consecutive or intermittent) are needed to care for the "serious health condition" of a spouse, child, or parent (not parent-in-law), an employee may be eligible for Family Medical Leave ("FML") under the FMLA.

4.3 When the absences exceed this three day period for a "serious health condition," the employee should provide notification to Human Resources, at which point the FMLA process will be initiated for eligible employees.

4.4 EML and FML may be taken on a consecutive, intermittent or reduced work schedule basis as provided by the health care provider on the Certification.

4.5 FMLA leave on an intermittent basis is leave which is taken in separate blocks of full or half day increments, on a non-regular basis, because of a single qualifying reason. FMLA leave on a reduced schedule is leave which reduces the number of working hours in a basic work week or workday for a period of time. If an employee needs leave intermittently or on a reduced leave schedule for planned medical treatment, then the employee must make a reasonable effort to schedule the treatment so as not to disrupt unduly the Authority's operations.

4.6 Employees who qualify for EML and FML must first utilize all accrued sick time. Employees may then request and utilize any approved accrued vacation or accrued floating holidays (see Sections 10.6 and 10.8 below). Vacation time may only be used prior to sick time for salaried employees EML's for service credit purposes related to sick leave at half-pay (see Sick Leave Policy EP: 3.9). In all cases, qualifying time absent, whether paid or not, will be applied toward the maximum 12-week FMLA time period. Use of vacation time does not alter the status of the leave as FMLA leave, nor does it extend any Authority provided job security periods. (For EMLs related to Workers Compensation also see Sections 9.1-9.3).

4.7 Once accrued sick time is exhausted (and where vacation or floating holiday time is not being used, or has been exhausted), eligible salaried (non-bargaining unit) employees on EML will be placed on sick leave at half-pay (see Sick Leave Policy EP: 3.9), or on no-pay status if not eligible. In certain circumstances, salaried employees may also be eligible to receive donated vacation leave (see Attachments 6 and 7). Sick leave at half-pay is not available for any other type of FMLA Leave. If an employee on FML has no sick or vacation credits, or elects not to apply vacation credits, non-worked hours will be unpaid.

4.8 After three consecutive months of EML, and after all accrued sick leave and sick leave at half pay has been exhausted, a salaried employee may be eligible for benefit payments under the Long-Term Disability ("LTD") benefits. (See Sick Leave Policy EP: 3.9). Employees covered under a Collective Bargaining Agreement ("CBA") may be entitled to short and/or long term disability benefits. Such employees should contact their Human Resources Facility Manager and refer to their applicable Collective Bargaining Agreement and Benefit book for information on their benefits.

4.9 Employees returning to work from an EML must provide Human Resources with written medical documentation verifying their ability to return to work and fitness for duty. This should be provided at the earliest practicable time **before** returning to work. An employee will not be allowed back to work without sufficient written medical documentation.

NEWBORN ("NL")/ADOPTION ("AL") LEAVE

5.1 An employee may take a Newborn Leave ("NL") to care for a healthy newborn under the FMLA.

5.2 An employee may take an Adoption Leave ("AL") in connection with travel for and placement of a child for adoption or foster care within one year of initial placement in the home, or adoption, whichever comes first. Documentation from an agency or attorney verifying such placement of a child must be submitted to Human Resources within 15 business days or as soon as practicable.

5.3 Newborn and Adoption Leave may only be taken as consecutive leave and will be without pay unless the employee chooses, and receives approval, to use accrued vacation time. In all cases, time absent, whether paid or not, will be applied toward the maximum yearly 12-week FMLA period.

5.4 If both parents of a healthy newborn or a newly placed foster or adopted child work for the Authority, only one parent is entitled to these types of FMLA leave for each qualifying occurrence. However, both parents will be allowed leave for travel necessary for placement of a child for adoption or foster care.

5.5 In all cases, time absent, whether paid or not, will be applied toward the applicable 12-week FMLA time period.

MILITARY FAMILY LEAVE ("MFL")

6.1 Military Family Leave ("MFL") provides eligible employees unpaid leave to care for a covered family member who has incurred an injury or illness in the line of duty while on active duty in the Armed Forces, provided that such injury or illness may render the family member medically unfit to perform duties of the member's office, grade, rank or rating.

6.2 A covered family member is a spouse, son, daughter, parent or next of kin.

6.3 An employee who is a covered family member may take up to 26 weeks of leave during a single 12-month period to care for the covered servicemember. This 26-week period is the maximum amount of leave that may be taken in combination with any other FMLA-qualifying leaves in a single 12-month period beginning with the employee's first day out.

6.4 Such leaves may be on a consecutive basis, intermittent or a reduced schedule basis, as detailed by the health care provider on the Certification.

6.5 Employees must utilize accrued sick time first until sick leave accruals are exhausted. Employees may then request and utilize any accrued floating holidays (salaried only), vacation or other accrued paid time off (see Section 10.6 below) or be placed on no-pay status.

6.6 In all cases, time absent, whether paid or not, will be applied toward the applicable 26-week FMLA time period.

QUALIFYING EXIGENCY MILITARY FAMILY LEAVE ("QEL")

7.1 An employee who is a spouse, son, daughter, or parent of a covered servicemember called to, or on, active duty in the National Guard or military reserves in support of a federal contingency operation may take up to 12 workweeks of leave during any 12 month period for a "qualifying exigency."

7.2 Reasonable documentation of family relationship may be required.

7.3 A "qualifying exigency" may include attending certain military events and related activities, arranging for alternative childcare and school activities, addressing certain financial and legal arrangements, attending certain counseling sessions and attending post-deployment reintegration briefings.

7.4 Leaves for Qualifying Exigencies shall be unpaid, unless the employee requests and is given permission to use accrued vacation time, floating holidays (salaried only) or other accrued time off (excluding sick time).

7.5 In all cases, time absent, whether paid or not, will be applied toward the applicable 12-week FMLA time period.

JOB SECURITY FOR SALARIED EMPLOYEES WHILE ON FMLA OR EXTENDED MEDICAL LEAVE

8.1 When a salaried employee is absent from work on any qualified consecutive FMLA leave, other than Military Family Leave, their position will only be held open for a period of three months beginning on the first day of absence for the first FMLA leave within a 12-month period, even if the employee has accumulated sick and/or vacation leave that extends beyond that three month period.

8.2 If a department intends to fill a salaried position held by someone on FMLA leave (other than qualifying Military Family Leave) at any time after the expiration of the three month job security period, the employee's supervisor must notify site/headquarters Human Resources and the employee of this intent.

8.3 For all FMLA leaves other than Military Family Leave, any extended leave beyond the three months FMLA and job security period up to, but not exceeding, six months must be approved by the employee's Business Unit head or Regional Manager in conjunction with Human Resources prior to informing the employee of the approval of the extension. By approving the extension, the Authority will attempt to maintain the availability of a position, but not necessarily the same position, for the agreed upon leave period. In these circumstances, there is no guarantee that the employee's current position will remain open. The Authority will attempt to place the employee in a similar (or lesser) position for which they are qualified at the time of return. A position will not be created. At the conclusion of six months, the employee will be advised that his/her continued employment has been terminated.

8.4 When an employee is absent from work on a qualifying Military Family Leave, their position will be held open for a period of up to six months beginning on the first day of absence for the first FMLA leave within a 12-month period, even if the employee has accumulated sick and/or vacation leave that extends beyond that six month period. At the conclusion of six months, the employee will be advised that his/her employment has been terminated.

8.5 Extensions of leave beyond the six month period will be considered on an individual basis. Such a request **must** be made in writing and can only be approved by the Human Resources Department Head. Such requests should be made as soon as practicable before the end of the six-month period and must include information from the health care provider about the employee's current medical status, expected return to work dates as well as any return to work conditions or limitations. Any remaining accrued sick leave will also be taken into consideration in reviewing the request for an extension of the leave. For extensions of Military Family Leave beyond the six month period, the military member's current medical status and the employee's expected return to work date must be provided.

WORKERS' COMPENSATION

9.1 If an employee is out on a Workers' Compensation leave for a health condition which also qualifies as an FMLA leave, it will be treated concurrently as an FMLA leave.

9.2 In such cases, employees have the option of applying unused accrued sick and/or vacation time to their first three months of absence from work. The employee must complete a "Use of Vacation/Sick Accruals" form (provided by their Human Resources representative) to make their election, which is irrevocable. If the employee chooses to apply sick/vacation time towards a Workers' Compensation/FMLA leave and the Workers' Compensation claim is found to be compensable, sick/vacation time will be credited back to the employee on a prorated basis in a proportionate manner based on the amount of the award and the amount of sick/vacation time used or other Collective Bargaining Agreement contractual language.

9.3 Bargaining Unit employees are directed to their Human Resources Facilities Manager and the applicable Collective Bargaining Agreement or Benefit book.

PAYROLL STATUS WHILE ON FMLA LEAVE

10.1 Depending on the particular type of leave and an employee's individual circumstances (including whether they are salaried or members of a bargaining unit), an employee may be eligible for income while on a FMLA leave through sick leave, sick leave at half-pay for salaried employees, vacation leave, short term disability for bargaining unit employees, and/or long term disability, or all or part of a FMLA leave may be unpaid.

10.2 Applicable benefits and associated payroll deductions (taxes, flexible benefit credits and deductions, NYS Retirement System contributions, PowerFlex, Employees' Savings Plan, loans, Liberty Mutual insurance, other insurance, etc.) will continue while an employee is out on any qualified FMLA leave and is still receiving compensation regardless of whether it is full- or half-pay (using sick or vacation accruals) or sick leave at half-pay, if applicable.

10.3 Deductions are prioritized by the Payroll Department. Any questions concerning the priority of deductions should be addressed to the Payroll Department and/or the applicable Human Resources representative.

10.4 For salaried employees, if an employee works on a part-time schedule prior to going out on FMLA leave, and is receiving compensation while on that leave, they will be paid based on the days they work on their part-time schedule.

10.5 For bargaining unit employees, holidays will be fully paid if during the calendar week in which such holiday occurs the employee has been on paid status at least two full days and all absences from work on the employee's remaining regularly scheduled work days during that week are approved in writing by the supervisor in accordance with the applicable Collective Bargaining Agreement. Employees on unpaid status prior to the

calendar week of the holiday will not be paid for the holiday.

10.6 An employee on an FMLA leave who wants to use their accrued vacation time to cover any part of that leave must make a request to their local Human Resources Department. Without notification, accrued vacation time will not be automatically applied.

10.7 Holidays will be fully paid only if an employee is on a full-pay status (using sick or vacation leave or floating holiday) on the business day prior to the holiday. Holidays will be paid at half-pay if the employee is on sick leave at half-pay on the business day prior to the holiday. Employees on unpaid status on the day prior to a holiday will not be paid for the holiday.

10.8 Floating holidays, if accrued but not used before FMLA leave commences, must be used before any unpaid leave begins. If an employee on half or full pay status will be on leave at the end of the calendar year, and has not yet used their floating holidays, they will automatically be applied toward the leave prior to year's end.

10.9 Deductions and Credits:

1) FlexAbility Deductions

a) Where applicable, FlexAbility credits for Salaried employees, or payments for Waiving Coverage for IBEW employees and/or any other applicable benefit costs, will continue to be paid/deducted while an employee is out on FMLA leave and is still receiving pay from NYPA.

b) Once on a no pay status, in order for the benefit costs to remain a pre-tax deduction, where applicable, Human Resources and Payroll must receive enough advance notice (30 days) before a leave begins, to be able to arrange for the pre-tax deductions to be taken from the paycheck.

c) Otherwise, an employee must pay their applicable contributions to the Authority monthly during their leave on an after-tax basis. (Bargaining unit employees contact your HR Department for appropriate no pay status form)

d) The Authority's obligation to maintain the above coverages ceases if the contribution is more than 30 days late. The Authority must give 15 days' notice to the employee prior to the termination of benefits.

2) If a portion of a salaried employee's FMLA leave will be unpaid, flex credits will be used to determine the premium they must pay to the Authority. The cost will be based on the flex credits they were entitled to while being paid, minus the cost of deductions.

Bargaining Unit employees' payments will be based on their benefit elections and applicable contractual contribution.

3) All other deductions (i.e., PowerFlex accounts) will be doubled per pay-period when an employee returns to work until they are back on the appropriate annual deduction schedule or have made up the appropriate percentage amount.

4) Benefits Coverage Period:

a) Salaried employee's benefits will continue for 6 months (from first day of absence) as long as an employee pays the required employee contributions while they are out on leave.

b) A salaried employee's benefits will cease once the employee has been absent for six months from their first day of absence, even if their leave is approved to be extended beyond six months under the provisions of Section 8.5. If a salaried employee has 10 or more years of service with the Authority and is collecting long-term disability payments (see the Employee Benefits Handbook for Salaried Employees for LTD eligibility criteria), their health care coverage will be continued at a cost to them. The cost will be based on flex credits, minus the cost of the medical plan.

c) Bargaining unit employees should contact their Human Resources Facility Manager and refer to their applicable Collective Bargaining Agreement and Benefit book.

Vice President Human Resources

EMPLOYEE RIGHTS AND RESPONSIBILITIES
UNDER THE FAMILY AND MEDICAL LEAVE ACT

Attachment 1

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.

Attachment 2

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

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division

OMB Control Number: 1215-0181
Expires: 12/31/2011

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 due to a serious health condition to submit a medical certification issued by the employee's health care provider. 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 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: _____

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions: _____

_____

Check if job description is attached: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your 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 due to your own 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. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: _____
First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the 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. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

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

CONTINUED ON NEXT PAGE

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Probable duration of 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 so, dates of admission:

   _____

   Date(s) you treated the patient for condition:

   _____

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

   Was medication, other than over-the-counter medication, prescribed? ___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. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

   Is the employee unable to perform any of his/her job functions due to the condition: ____ No ____ Yes.

   If so, identify the job functions the employee is unable to perform:

   _____

4. Describe other relevant medical facts, if any, 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):

   _____

   _____

   _____

   _____

   _____

   _____

   _____

CONTINUED ON NEXT PAGE

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___No ___Yes.

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

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

   If so, are the treatments or the reduced number of hours of work medically necessary? ___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:

   _____

   Estimate the part-time or reduced work schedule the employee needs, if any:

   _____ hour(s) per day; _____ days per week from _____ through _____

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

   Is it medically necessary for the employee to be absent from work during the flare-ups? ____ No ____Yes. If so, 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):

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

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

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.**

Attachment 3

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

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division

OMB Control Number: 1215-0181
Expires: 12/31/2011

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):

_____

_____

_____

_____

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:

   _____

   _____

   _____

   _____

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.

Attachment 4

Certification for Serious Injury or Illness of Covered Servicemember - - for Military Family Leave (Family and Medical Leave Act)

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division

OMB Control Number: 1215-0181
Expires: 12/31/2011

Notice to the EMPLOYER **INSTRUCTIONS to the EMPLOYER:** The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a serious injury or illness of a covered servicemember to submit a certification providing sufficient facts to support the request for leave. 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. § 825.310. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees or 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.

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 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.

CONTINUED ON NEXT PAGE

Certification for Serious Injury or Illness of Covered Servicemember - - for Military Family Leave (Family and Medical Leave Act)

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division

U.S. Wage and Hour Division

SECTION I: 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, 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: HEALTH CARE PROVIDER INFORMATION

Health Care Provider's Name and Business Address:

_____

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 DOL FORM WH-380 or an employer-provided form 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:

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:

_____

_____

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, in accordance with 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 AV, NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE PATIENT.**

Attachment 5

Certification of Qualifying Exigency For Military Family Leave (Family and Medical Leave Act)

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division

OMB Control Number: 1215-0181
Expires: 12/31/2011

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 leave due to a qualifying exigency to submit a certification. Please complete Section I before giving this form to your employee. Your response is voluntary, and 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. § 825.309.

Employer name: _____

Contact Information: _____

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.

CONTINUED ON NEXT PAGE

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):

_____

_____

_____

_____

_____

_____

2. A complete 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:

   _____.

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:_____

   _____

   _____

   _____

   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.

CONTINUED ON NEXT PAGE

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: _____

_____

_____

_____

_____

_____

_____

_____

_____

PART D:

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

_____ _____

Signature of Employee 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 AV, NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE EMPLOYER.**

DONATION OF VACATION LEAVE

This attachment allows eligible salaried employees who are on medical leave to receive vacation leave that has been donated by other salaried employees.

Eligibility
An employee *absent for his/her own personal illness or injury* who has been out for at least 20 ***consecutive business*** days due to a ***serious health*** condition and who has exhausted ALL accumulated sick and vacation leave credits will be eligible to receive donated vacation leave. The 20-day waiting period has been established in order to limit eligibility to long-term serious ***health*** conditions rather than short-term sick leave.

An employee receiving any form of pay (i.e., workers' compensation, sick leave at half-pay, long-term disability) is not eligible to receive donated vacation leave.

Who May Donate
An employee who has accumulated vacation leave credits and who is on the active payroll may donate vacation leave.

Donated Vacation Information
An employee may donate vacation leave in increments of 1 day.

A donating employee must be left with a remaining vacation leave balance of 5 days, in the event he/she needs the time for unforeseen reasons.

If an employee returns to work and all of the donated vacation leave is not fully utilized by the recipient, ***up to 10 days of donated vacation may be kept by the employee. The remainder will be credited back proportionately to the donating employees based on the number of days donated by each employee compared to the total days donated.***

Procedures
When an eligible employee exhausts his or her accumulated sick and vacation leave credits, Payroll will notify the employee and his or her business group, unit/department head. The business group, unit/department head may, at his or her discretion, ask employees if they wish to donate vacation leave days. When determining whether an employee is eligible to receive donated vacation leave, the business group, unit/department head should consider factors such as the employee's attendance record. The business group, unit/department head, or his/her designee, should try to determine how much time is needed until the employee is eligible for long-term disability benefits.

When a department cannot provide an employee with a sufficient number of days at full pay until the employee is eligible for long-term disability benefits, the business group, unit/department head may request the Vice President of Ethics & Employee Resources at headquarters, or the Facility Manager of Human Resources at the sites, to solicit other departments to participate.

Donated vacation leave cannot exceed three months from commencement of the leave (the time at which the employee is eligible for long-term disability benefits).

An employee who wishes to donate vacation leave must complete a Vacation Donation Form (see Attachment 7) and submit the form to the employee's business group, unit/department head or designee, who in turn should forward the form to Payroll.

Payroll will credit the donated vacation leave days to the recipient employee's vacation leave balance (not calculated by rate of pay). Donated vacation leave will be paid to the employee at his or her regular rate of pay. Applicable payroll taxes and deductions will be withheld from such payments.

When an employee donates vacation leave, his or her vacation leave balance will be reduced by the number of days donated (not calculated by rate of pay).

VACATION DONATION FORM FOR SALARIED EMPLOYEES

TO: WPO Payroll

Donor's Name _____ **Date** _____

Department _____ **Location** _____ **Extension** _____

Number of Vacation Days to be Donated _____ **Donated To** _____

Signature _____ **Date** _____

Cc: Recipient