

FMLA  
DPW  
SEIU

## MEMORANDUM OF AGREEMENT

This Memorandum of Agreement is entered into by and between the Town of Weymouth ("Town") and the SEIU, Local 888, Town Clerical and Custodians, and AFSCME, Council 93, DPW Employees (The "Unions") as the full and final settlement of MUP-18-6442 and MUP-18-6452.

Whereas, the Unions filed a charge of prohibited practice with the Massachusetts Department of Labor Relations (DLR);

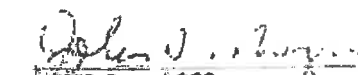

Whereas, the parties have met and, in accordance with Massachusetts General Laws Chapter 150E, have negotiated the terms of a settlement of MUP-18-6442 and MUP-18-6452 prior to hearing.

Now, therefore, in consideration of mutual covenants, the parties agree as follows:

1. The Town formally rescinds Memorandum from Ted Langill, Dated November 17, 2017 regarding Town's Family Medical Leave Act Policy as to the Unions listed above only.
2. Upon execution of this agreement The Unions will withdraw with prejudice the above Charge of Prohibited Practices against the Town.
3. After negotiation was conducted with the Unions in accordance with the Law. The Town will implement the attached "Guidelines for use of Paid Sick Time During Family and Medical Leave Act Approved Absences", Certification of Health Care Provider for Employee's Serious Health Condition (Family and Medical Leave Act), Town of Weymouth, Human Resources Policy- FMLA- Issued 10/01/2008. (Attached hereto)

Wherefore, the parties have caused this Memorandum of Agreement to be executed this \_\_ day of February, 2019.

  
Town of Weymouth

  
SEIU, Local 888,  
  
AFSCME, Council 93

**Human Resources**

75 Middle Street  
Weymouth, MA 02189

(781) 340-5010  
(781) 682-3561 FAX

**Town of Weymouth  
Massachusetts**



**Robert L. Hedlund  
Mayor**

75 Middle Street  
Weymouth, MA 02189

(781) 340-5012

**DRAFT  
TOWN OF WEYMOUTH  
GUIDELINES FOR USE OF PAID SICK TIME  
DURING FAMILY AND MEDICAL LEAVE ACT APPROVED ABSENCE**

**Policy**

The Town of Weymouth has established a Human Resources Policy, regarding the FMLA (Family Medical Leave Act of 1993), Policy number VI-F, issued on October 1, 2008.

The Use of Paid and Unpaid Leave section within the policy states the following:

Sick leave is payable during FMLA leave upon request by the employee, subject to the discretion of the Department Head, in consultation with Human Resources; and will run concurrently with the FMLA time. Sick leave will be administered in accordance with the Town's Human Resources policies, and various collective bargaining agreements.

Personal time and vacation time may be used concurrently with the FMLA leave at the employee's request after sick time is exhausted, subject to the discretion of the Department Head, in consultation with Human Resources. Vacation and personal time will be administered in accordance with the Town's Human Resources policies and the various collective bargaining agreements.

An employee who is taking leave for the adoption or foster care of a child must use all paid vacation, personal and family leave prior to being eligible for unpaid leave.

Disability leave for the birth of the child and for an employee's serious health condition including workers' compensation leave (to the extent that it qualifies), may be designated as FMLA leave and will run concurrently with FMLA.

**Guidelines**

The guidelines have been developed to create a level of uniformity and consistency for department heads in the review and application of FMLA requests and secondly, to provide employees with examples of when they may request paid sick leave on the FMLA leave of absence request form (attached). The examples provided are not intended to be an exhaustive list. Department heads will almost certainly approve these examples below. All approvals remain, however, at the discretion of the Department Head after consulting with Human Resources, and in conformity with other departments.

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Examples of payable sick leave may include, but are not limited to, the following:

- a) A serious health condition of an employee that makes the individual unable to perform the function of the position. See below for more information about what constitutes a "serious health condition."
- b) To care for a spouse, child, or parent with a serious health condition.
- c) The birth of a child and to bond with the newborn child within one year of birth.
- d) The placement of a child for adoption or foster care and to care for the newly placed child.
- e) Qualifying worker's compensation claims will be designated as payable sick leave for any hours paid out through payroll.
- f) To care for a family member, such as spouse, son, daughter, parent or next of kin, who is a covered service member, with a serious illness or injury. This is known as covered service member leave. (This leave may extend for up to 26 weeks in a twelve month period for care).

This example, depending upon the exigency requested, could be deemed payable or non-payable sick leave:

- a) An employee whose spouse, son, daughter or parent either has been notified of an impending call or order to active military duty or who is already on covered active duty may take up to 12 weeks of leave for reasons related to, or affected by, the family members' call-up or service which may include; short-term deployment, military events and activities, child care and school activities, financial and legal arrangements, counseling, rest and recuperation, post-deployment activities or other activities that arise out of active duty.

The FMLA defines "serious health condition" as an "illness, injury, impairment, or physical or mental condition that involves" either "inpatient care in a hospital, hospice, or residential medical care facility" or "continuing treatment by a health care provider." 29 U.S.C. § 2611(11). Implementing regulations define "inpatient care" as "an overnight stay in a hospital, hospice, or residential medical care facility, including any period of incapacity... or any subsequent treatment in connection with such inpatient care." 29 C.F.R. § 825.114. The regulations also specify that "continuing treatment" includes "incapacity and treatment," "chronic conditions," "permanent or long-term conditions," and "conditions requiring multiple treatments." 29 C.F.R. § 825.115. For all conditions, "incapacity" means "inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery therefrom," and "treatment" includes "examinations to determine if a serious health condition exists and evaluations of the condition." 29 C.F.R. § 825.113(b), (c). An employee is incapacitated if he or she is "unable to work at all or is unable to perform any one of the essential functions of the employee's position," including when the employee "must be absent from work to receive medical treatment." 29 C.F.R. §§ 825.113(b), .123(a).

For additional information about other terms used within these guidelines, please see the Town's FMLA policy.



Human Resources Policy	Issued: 10/01/2008	Policy No.: VI-F
TOWN OF WEYMOUTH	Supersedes: 07/01/2001	Date Issued: 10/01/2008
Issued By: Human Resources	Approved By: Office of the Mayor	Page 1 of 9
Subject: FMLA (Family Medical Leave Act of 1993)		

## **POLICY**

It is the policy of the Town of Weymouth (the Town) to grant up to 12 weeks of family and medical leave during any 12-month period to eligible employees in accordance with the Family and Medical Leave Act of 1993 (FMLA); and up to 26 weeks of leave in any 12-month period in compliance with the expansion of FMLA under the Support for Injured Service members Act of 2007. The leave may be paid, unpaid or a combination of paid an unpaid leave, depending on the circumstances of the leave and as specified in this policy.

## **ELIGIBILITY**

To qualify for family or medical leave under this policy, the following conditions must be met:

1. An employee must have worked for the Town for 12 months or 52 weeks. The 12 months or 52 weeks need not be consecutive. For eligibility purposes, an employee will be considered to have been employed for an entire week even if he/she was on the payroll for only part of the week or is on leave during the week.
2. An employee must have worked at least 1,200 hours during the 12 month period immediately before the date when the leave is requested to begin.

## **TWO TYPES OF LEAVES COVERED BY THIS POLICY**

### **A. The following Type of Leaves is Covered Under This Policy**

1. The birth of a child and in order to care for that child
2. The placement of a child for adoption or foster care and to care for the newly placed child
3. To care for a spouse, child or parent with a serious health condition
4. The serious health condition (described below) of the employee

### **Definitions:**

- **Child:** a biological, adopted or foster child, a stepchild, a legal ward, or a child (a) under 18 years of age; or (b) 18 years of age or older and incapable

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of self-care because of a mental or physical disability, or of a person standing in loco parentis

- **Parent:** biological parent of an employee or an individual who stood in loco parentis to an employee
- **Spouse:** a husband or wife of the employee

An employee may take a leave because of a serious health condition that makes him/her unable to perform the functions of his/her position. A serious health condition is defined as a condition that requires inpatient care at a hospital, hospice or residential medical care facility, including any period of incapacity or subsequent treatment in connection with inpatient care or a condition that requires continuing care by a licensed health care provider

This policy covers illnesses of a serious and long-term nature, resulting in recurring or lengthy absences. Generally, a chronic or long-term health condition, which, if left untreated, would result in a period of incapacity of more than three days, would be considered a serious health condition.

If a husband and wife both work for the Town and each wishes to take leave for the birth of a child, adoption or placement of a child in foster care, or to care for a child or parent (but not a parent in-law) with a serious health condition, the husband and wife may only take a combined total of 12 weeks of leave.

#### **B. The following Type of Leave is Covered by This Policy**

##### **1. A covered family member's active duty or call to active duty in the Armed Forces.**

An employee whose spouse, son, daughter or parent either has been notified of an impending call or order to active military duty or who is already on active duty may take up to 12 weeks of leave for reasons related to, or affected by, the family member's call-up or service. Reasons related to the call-up or service includes helping the family member prepare for the departure or caring for children of the service member. The leave may begin as soon as the individual receives the call-up notice. This type of leave would be counted toward the employee's 12-week maximum of FMLA leave in a 12-month period.

##### **2. To care for an injured or ill service member**

This leave may extend to up to 26 weeks in a 12-month period for an employee whose spouse, son, daughter, parent or next-of-kin is injured or recovering from an injury suffered while on active military duty and who is unable to perform the duties of the service member's office, grade, rank or rating. An employee is also eligible for this type of leave when the family service member is receiving medical treatment, recuperation or therapy, even if the service member is on a temporary disability retired list.

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Employees requesting this type of FMLA leave must provide certification of the family member or next-of-kin's injury, recovery or need for care. This certification is not tied to a serious health condition as for other types of FMLA leave. This is the only type of FMLA leave that may extend an employee's leave entitlement beyond 12 weeks to 26 weeks. Other types of FMLA leave are included with this type of leave totaling the 26 weeks.

An eligible employee can take up to 12 weeks (or up to 26 weeks of leave to care for an injured or ill service member) under this policy during any 12-month period. The Town will measure the 12-month period as a rolling 12-month period measured backward from the date an employee uses any leave under this policy. Each time an employee takes leave, the company will compute the amount of leave the employee has taken under this policy in the last 12 months and subtract it from the 12 weeks (or 26 weeks for the care of an injured or ill service member) of available leave, with the balance remaining being the amount the employee is entitled to take at that time.

If a husband and wife both work for the Town and each wishes to take leave to care for a covered injured or ill service member, the husband and wife may only take a combined total of 26 weeks of leave.

**Definitions:**

- **Next-of-kin:** the closest blood relative of the injured or recovering service member
- **Son or daughter:** "Son or daughter" (for this type of FMLA leave) is defined the same as for "child" for other types of FMLA leaves, except that the person does not have to be a minor

**INTERMITTENT LEAVE OR REDUCED WORK SCHEDULE**

The employee may take FMLA leave in 12 consecutive weeks, may use the leave intermittently (take a day periodically when needed over the year) or, under certain circumstances, may use the leave to reduce the work week or work day, resulting in a reduced hour schedule. In all cases, the leave may not exceed a total of 12 work weeks (or 26 work weeks to care for an injured or ill service member over a 12-month period).

The Town may temporarily transfer an employee to an available alternative position with equivalent pay and benefits if the alternative position would better accommodate the intermittent or reduced schedule in instances of when leave for the employee or employee's family member is foreseeable; and for planned medical treatment including recovery from a serious health condition, or to care for a child after birth, or placement for adoption or foster care.

For the birth, adoption or foster care of a child, the Town and the employee must mutually agree to the schedule before the employee may take the leave intermittently or

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work a reduced hour schedule. Leave for birth, adoption or foster care of a child must be taken within one year of the birth or placement of the child.

If the employee is taking leave for a serious health condition or because of the serious health condition of a family member, the employee should try to reach agreement with the Town before taking intermittent leave or working a reduced hour schedule. If this is not possible, then the employee must prove that the use of the leave is medically necessary.

#### **USE OF PAID AND UNPAID LEAVE**

Sick leave is payable during FMLA leave upon request by the employee, subject to the discretion of the Department Head, in consultation with Human Resources; and will run concurrently with the FMLA time. Sick leave will be administered in accordance with the Town's Human Resources policies, and various collective bargaining agreements.

Personal time and vacation time may be used concurrently with the FMLA leave at the employee's request after sick time is exhausted, subject to the discretion of the Department Head, in consultation with Human Resources. Vacation and personal time will be administered in accordance with the Town's Human Resources policies and the various collective bargaining agreements.

An employee who is taking leave for the adoption or foster care of a child must use all paid vacation, personal and family leave prior to being eligible for unpaid leave.

Disability leave for the birth of the child and for an employee's serious health condition including workers' compensation leave (to the extent that it qualifies), may be designated as FMLA leave and will run concurrently with FMLA.

#### **EMPLOYEE STATUS AND BENEFITS DURING A LEAVE**

During the FMLA leave period, the Town will continue all health and life insurance coverage at the same level and under the same conditions as if the employee had continued to work. During paid leave, the Town will continue to make payroll deductions to collect the employee's share of the premiums. During unpaid leave, the employee must continue to make these payments either in person or by mail. The employee must make arrangements with the Human Resources Department to collect his/her share of the premiums.

Benefits based on an accrual basis (i.e. vacation, sick time and/or personal time) will continue to accrue during a leave under this policy.

#### **EMPLOYEE STATUS AFTER LEAVE**

Upon return from a leave under this policy, the employee is entitled to be restored to the position held when the leave commenced; or to be restored to an equivalent position with

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the equivalent benefits, pay, and other terms and conditions of employment. Restoration to the same position, pay and benefits upon return from leave is subject to benefit reductions, adverse actions or layoffs as if employed during the FMLA leave period.

A key employee may be denied FMLA should such denial be necessary to prevent substantial grievous economic injury to the Town.

Key employee is defined as an employee whose salary is among the top 10% of Town employees.

#### **PROCEDURES FOR REQUESTING A LEAVE FOR:**

A). The birth of a child or in order to care for that child; 2) the placement of a child for adoption or foster care and to care for the newly placed child; 3) to care for a spouse, child or parent with a serious health condition; or 4) the serious health condition of the employee

- Employees requesting this type of leave must provide the Town a 30 days notice when FMLA leave is foreseeable. When the leave is not foreseeable, the employee must give notice within two working days of learning of the need for the leave. If the leave is unforeseeable due to a medical emergency, the employee must give notice as soon as practical by telephone or any electronic means. If the employee is unable to give such notice, then the employee's spouse, family member or other responsible party may give the notice. An employee who is to undergo planned medical treatment is required to make a reasonable effort to schedule the treatment in order to minimize disruptions to the Town's operations.
- The employee must complete a FMLA leave Request Form, including the reasons associated with the leave request, with a signed approval by his or her department head.
- The employee is responsible for the completion of the Town of Weymouth Certification of Health Condition Form. Upon completion by the Health Care Provider, the employee must forward this certification form and the FMLA request form (approved and signed by his/her Department Head) directly to Human Resources. Both forms are attached to this policy for your convenience.
- The Town may ask for certification of the serious health condition. The employee must respond to such a request within 15 days of the request or provide a reasonable explanation for the delay. Failure to provide certification may result in a denial of continuation of the leave. Medical certification may be provided by using the Medical Certification Form. Request for a medical certificate must be made in writing as part of the employer response to the employee's request for leave.

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- Certification of the serious health condition must include the date when the condition began, its expected duration and a brief statement of treatment. For a medical leave for the employee's own medical condition, the certification must also include a statement that the employee is unable to perform work of any kind or a statement that the employee is unable to perform the essential functions of his/her position. For a family member who is seriously ill, the certification must include a statement that the patient, the family member, requires assistance and that the employee's presence would be beneficial or desirable.
- If the employee plans to take intermittent leave or work a reduced schedule, the certification must also include dates and the duration of treatment as well as a statement of medical necessity for taking intermittent leave or working a reduced schedule.
- The Town, at its own expense, may require the employee to obtain the opinion of a second health care provider. The second health care provider will be designated or approved by the Town, and is not employed on a regular basis by the Town. If the two opinions differ, the Town may again require, at its expense, that the employee obtain the opinion of a third health care provider who is designated or approved jointly by the Town and the employee.
- There is a presumption of sick leave during the initial eight weeks for the birth of one child only. Use of sick leave beyond this period must be based upon medical evidence, submitted by the employee's physician.
- The Human Resources Department will provide individual notice of rights and obligations to each employee requesting leave within two business days or as soon as practicable. For employees on intermittent or recurring leave for the same incident, this notice will be provided every three months.
- Employees must provide medical verification within five business days from commencement of medical leave by the health care provider of the employee, or the employee's family or household member. All FMLA leave must be approved two weeks in advance for the birth, adoption, or foster care placement of a child.

**B). A covered family member's active duty or call to active duty in the Armed Forces or; 2) to care for an injured or ill service member**

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An employee requesting this type of FMLA leave must provide verbal notice with an explanation of the reason for the needed leave to his/her immediate supervisor who will advise the Human Resources Department. The Leave may commence as soon as the individual receives the call-up notice. If the leave is foreseeable, the immediate supervisor may require the employee to provide a written request for leave and reasons with a copy to the Human Resources Department.

**Documentation of the Covered Family Member's Active Duty or Call to Active Duty in the Armed Forces**

Employees requesting this type of service member FMLA leave must provide proof of the qualifying family member's call-up or active military service. This documentation may be a copy of the military orders or other official Armed Forces communication.

**Documentation of the Need for Service member FMLA Leave to Care for an Injured or Ill Service member**

Employees requesting this type of Service member FMLA leave must provide documentation of the family member's or next-of-kin's injury, recovery or need for care. This documentation may be a copy of the military medical information, orders for treatment, or other official Armed Forces communication pertaining to the service member's injury or illness incurred on active military duty that renders the member medically unfit to perform his/her military duties.

**PLEASE NOTE:** The leave is not approved until it has been approved by the Department Head and the Director of Human Resources. The Human Resource Department will provide written verification of FMLA approval to the employee indicating rights and obligations within two business days or as soon as practicable.

The employee's privacy will be protected. Only those individuals who need to know, such as the employee's direct supervisor or department head will be made aware of the employee's FMLA leave and the reason.

**IF THE EMPLOYEE DOES NOT RETURN TO WORK**

If the employee fails to return from the Family Medical Leave of Absence on the authorized return date, or if the request for an extension of the leave is denied and the employee fails to return on the authorized return date, the employee will be considered as having voluntarily resigned and terminated from his/her position. The Human Resources Department will contact the employee to determine the reason for the employee's failure to return to work.

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An employee is liable to the Town of Weymouth for health and life insurance premiums during the leave period, or retroactive termination of benefits to the beginning of the leave period unless the employee returns to work for at least 30 days after the leave ends.

**GENERAL**

The Town reserves the right to amend this policy at any time without prior notice. All exceptions to this policy must be approved in advance by the Director of Human Resources and the Mayor.

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**FMLA LEAVE OF ABSENCE REQUEST FORM**

Employees requesting a Family Medical Leave of Absence should complete this form and submit it to their Department Head for approval and signature. Upon Department Head approval, this form must be forwarded to Human Resources with a signed Certification of Physician or Practitioner form.

Name: \_\_\_\_\_ Dept. \_\_\_\_\_

Date of Hire: \_\_\_\_\_ Telephone #: \_\_\_\_\_

**Type of Leave:**

- ☐ Parental
- ☐ Expected Due Date: \_\_\_\_\_
  - ☐ Expected Placement Date: \_\_\_\_\_  
(for adoption, foster care, etc.)
- ☐ Medical
- ☐ Employee
  - ☐ Family/ Household Member

Estimated Leave Date From: \_\_\_\_\_ To: \_\_\_\_\_

I wish that my time be allocated as follows:

<u>Order</u>	<u>Type</u>	<u>Dates</u>	<u>Hours</u>
_____	Sick Time	_____	_____
_____	Vacation Time	_____	_____
_____	Unpaid Time	_____	_____

Please leave a balance of \_\_\_\_\_ hours of sick time.  
\_\_\_\_\_ hours of vacation time.

I wish to continue my employee contribution amounts for health and dental benefits by: (check one) \_\_\_\_\_ employee deductions \_\_\_\_\_ delivering a check made to the Town of Weymouth in accordance with the agreement I will make with Human Resources.

I understand upon expiration of my family medical leave (12 weeks), I will be subject to COBRA payments to continue my benefits.

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

Department Head Signature \_\_\_\_\_ Date \_\_\_\_\_

Human Resource Director \_\_\_\_\_ Date \_\_\_\_\_

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

**U.S. Department of Labor**  
Wage and Hour Division



OMB Control Number: 1215-0003

Revised: 2/28/2015

**SECTION I: For Completion by the EMPLOYER**

**INSTRUCTIONS to the EMPLOYER:** The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave 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. 29 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: \_\_\_\_\_

*(Signature)*  
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**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):  
\_\_\_\_\_  
\_\_\_\_\_  
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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**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:**

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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.





**FITNESS FOR DUTY TO RETURN FROM LEAVE CERTIFICATION**

An employee on Family and Medical Leave because of his/her own serious medical condition must present this release to his/her supervisor prior to or on the day he/she returns to work. An employee may not work without this release.

TO: Health Care Provider

Our employee, \_\_\_\_\_, began a period of medical care leave for his/her serious health condition on \_\_\_\_\_  
(date employee commenced leave)

As a condition of return to work, the employee must have a medical examination. This form must be completed by you, as his/her health care provider, before the employee is allowed to resume his/her job duties.

1. Employee Name: \_\_\_\_\_
2. Employee's Job Title: \_\_\_\_\_
3. Date of Medical Examination: \_\_\_\_\_
4. Date employee may return from leave \_\_\_\_\_
5. Please indicate with a check mark the status of the employee's release for duty.

\_\_\_\_\_ Full, unrestricted duty. (Skip question 6 and proceed to item 7.)  
 \_\_\_\_\_ Modified duty. (Complete question 6.)  
 \_\_\_\_\_ Not released for any type of duty. (Go to item 7.)

6. If you are releasing the employee to modified duty, you must complete the following:
  - a. Estimated date that employee will be able to return to full, unrestricted duty: \_\_\_\_\_
  - b. Date of your next medical evaluation of the employee: \_\_\_\_\_
  - c. Indicate the exact work restrictions which apply to the employee at this time on the chart on the back of this form.

KS  
 [Signature]

EMPLOYEE NAME: \_\_\_\_\_

(Complete this section if the employee is being released to modified duty.)

PHYSICAL EXAMINATIONS	FULL RESTRICTIONS	PARTIAL RESTRICTIONS	NO RESTRICTIONS
Sedentary-Lifting 0 to 10 pounds			
Light-Lifting 10 to 20 pounds			
Moderate-Lifting 20 to 50 pounds			
Heavy-Lifting 50 to 100 pounds			
Pulling/Pushing, Carrying			
Reaching or working above shoulder			
Walking (hrs)			
Standing (hrs)			
Sitting (hrs)			
Stooping (hrs)			
Kneeling (hrs)			
Repeated Bending (hrs)			
Climbing (hrs)			
Operating a motor vehicle			
Other:			
Exposure Limitation (Specify):			

7. I hereby certify that the foregoing facts are true and correct, and that this form is executed under penalty of perjury at \_\_\_\_\_, this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
(List City and State) (month) (year)

\_\_\_\_\_  
Signature of Health Care Provider

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Health Care Provider

\_\_\_\_\_  
Phone Number

RS  
JF  
K