CHART OF FMLA NOTICE OBLIGATIONS
(Effective January 16, 2009) **Form FML 1**

TYPE OF DOCUMENT	PROVIDED BY	TO WHOM	METHOD OF PROVIDING NOTICE	TIMEFRAME
FMLA General Notice	Employer	• Written notice to Employees • Workplace poster must be viewable by Employees and Applicants	• Written (electronic distribution OK) • Workplace poster	Upon hire and workplace poster
1. Request for FMLA Leave (Copy of Request goes to Payroll)	Employee	Employer	Oral or Written	***(Foreseeable)*** 30 Days advance notice ***(Unforeseeable)*** As soon as practicable
2. Group Coverage Election Form (Employee Provides copy of Form to Payroll)	Employer	Employee	Written	• *At time Employee gives notice to Employer of need for FMLA leave* • *As soon as practicable if Employee's circumstances change*
3. FMLA Eligibility and Rights and Responsibilities	Employer	Employee	*Part A: Notice of Eligibility:* Oral or written *Part B: Notice of Rights and Responsibilities:* Written notice (electronic distribution OK; Must be mailed to Employee if leave already began)	Both Parts A and B must be provided to the Employee within 5 business days following receipt of his/her notice of need for FMLA leave.

TYPE OF DOCUMENT	PROVIDED BY	TO WHOM	METHOD OF PROVIDING NOTICE	*TIMEFRAME*
4. FMLA Designation Notice **(Copy of Notice goes to Payroll)**	Employer	Employee	Written	Written Within 5 business days once sufficient information received to make FMLA determination
5. Medical Certification Form for Employee's Serious Health Condition	Employer completes Section I and gives to Employee	Employee completes Section II and gives to attending health care provider, who completes Section III and returns to Employee	Written	*Foreseeable*: Employer gives form to Employee at time he/she notifies Employer of need for leave; or within 5 business days thereafter. *Unforeseeable*: 5 business days following commencement of leave
~~**6. Medical Certification Form for Family Member's Serious Health Condition**~~	~~Same as above~~	~~Same as above~~	~~Same as above~~	~~Same as above~~
~~**7. Medical Certification of Qualifying Exigency for Military Family Leave**~~	~~Employer completes Section I and gives to Employee~~	~~Employee completes Section II and returns completed form to Employer~~	~~Written~~	~~Completed form must be provided to Employer within 15 calendar days~~

TYPE OF DOCUMENT	PROVIDED BY	TO WHOM	METHOD OF PROVIDING NOTICE	TIMEFRAME
~~**8. Medical Certification for Serious Injury or Illness of Current Service member for Military Family Leave (FMLA)**~~	~~Employer~~	~~Employee or Covered service member for whom Employee is requesting leave completes Section I, and gives form to attending health care provider, who completes Section II of the form and returns to Employee or Patient~~	~~Written~~	~~Completed form must be provided to Employer within 15 calendar days~~
9. Intent to Return to Work (Optional)	Employee	Employer	Oral or written	• At time Employee gives notice to Employer of need for FMLA leave • As soon as practicable if Employee's circumstances change
10. Fitness for Duty Certification **(Copy of Certification goes to Payroll)**	Employee	Employer	Written	Once every 30 days if required by Employer
11. Fact Sheet – USERRA and FMLA Questions and Answers	Employer	USERRA/Service member Employees	Written	Upon request and when called to military duty

General Notice
to
Employees of Rights Under FMLA *(WH Publication 1420)*
EMPLOYEE RIGHTS AND RESPONSIBILITIES
UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees with a spouse, son, daughter, or parent on active duty or called to active duty status with the Armed Forces 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 service member during a single 12-month period. A covered service member 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 service member medically unfit to perform his or her duties for which the service member 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.

MADISON COUNTY
REQUEST FOR FAMILY & MEDICAL LEAVE **Form FML 2**

This form is to be completed by any employee requesting Family & Medical Leave.

Employee's Name _____ Date _____

Reason(s) for leave requested:

☐ Birth of child or Adoption of child

☐ Serious health condition – employee

☐ Because you are needed to care for your ☐ spouse; ☐ child; ☐ parent due to his/her serious health condition.

☐ Because of a qualifying exigency arising out of the fact that your ☐ spouse; ☐ son or daughter; ☐ parent is on active duty or call to active duty status in support or a contingency operation as a member of the National Guard or Reserves.

☐ Because you are the ☐ spouse; ☐ son or daughter; ☐ parent; ☐ next of kin of a covered service member with a serious injury or illness.

Detailed explanation why leave is necessary:

_____

_____

Start date of leave _____ Anticipated return date _____

Is leave requested on an intermittent basis, i.e. hour by hour?

☐ Yes ☐ No

If intermittent leave is requested, please provide detailed schedule of expected leave dates and times:

_____

_____

I understand that if I do not return to work at the expiration of the requested leave, my employment may be terminated, except as provided for in the Madison County Employee Handbook.

Employee's Signature _____ Date _____

Supervisor/Department Head _____ Date _____

FAMILY MEDICAL LEAVE
GROUP COVERAGE ELECTION FORM **Form FML 3**

Name of Employee: _____ Date: _____

Be advised that the Family Medical Leave Act of 1993 ("FMLA") became effective August 5, 1993. In accordance with the FMLA, you may be eligible to continue with your current health benefits plan at your present coverage status, if you have been employed for a 12 month period and have worked at least 1,250 hours prior to requesting a FMLA leave.

Upon departmental approval of your requested FMLA leave, you may elect to continue with your current plans. Madison County will continue its contribution to the medical plan as if you were an active employee, but you must continue to pay your contribution. This contribution, if any, must be received by the Payroll Department by the pay issue date during your scheduled leave to ensure continuation of your health benefits coverage. (Once your FMLA leave is approved and scheduled, you may want to discuss pre-payment of your contributions on a pre-tax basis with the Payroll Department.)

If you have any questions regarding the contributions, contact the Payroll Department at 296-4026 or 4027 or if you need further information regarding the FMLA, ask your Department Head for assistance or refer to your Madison County Personnel Policy Handbook.

Please make your election below, then sign and return this form to the **Payroll Department** within five (5) days after your request has been approved.

I wish to continue my present:

- ☐ Medical coverage at the rate of _____per pay period
- ☐ Dental coverage at the rate of _____per pay period
- ☐ Vision coverage at the rate of _____per pay period
- ☐ Life Insurance at the rate of _____per pay period
- ☐ Unum Critical Illness/Accident coverage at the rate of _____per pay period
- ☐ Participation in the Flexible Spending Account at the rate of _____per pay period

Total Amount Due _____

_____ _____
Signature Date

_____ _____
Home Phone # Work Extension Person Code

Payroll

Rev 2/13

NOTICE OF ELIGIBILITY AND RIGHTS & RESPONSIBILITIES
(FAMILY AND MEDICAL LEAVE ACT)

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

In general, to be eligible an employee must have worked for an employer for at least 12 months, have worked at least 1,250 hours in the 12 months preceding the leave, and work at a site with at least 50 employees within 75 miles. While use of this form by employers is optional, a fully completed Form WH- 381 provides employees with the information required by 29 C.F.R.§825.300(b), which must be provided within five business days of the employee notifying the employer of the need for FMLA leave. Part B provides employees with information regarding their rights and responsibilities for taking FMLA leave, as required by 29 C.F.R.§ 825.300(b),(c).

Part A – NOTICE OF ELIGIBILITY

TO: _____
Employee

FROM: _____
Employer Representative

DATE: _____

On _____ , you informed us that you needed leave beginning on _____for:

□ The birth of a child, or placement of a child with you for adoption or foster care;

□ Your own serious health condition;

□ Because you are needed to care for your ___spouse; ___child; ___parent due to his/her serious health condition.

□ Because of a qualifying exigency arising out of the fact that your ___spouse; ___son or daughter;___ parent is on covered active duty status with the Armed Forces..

□ Because you are the ___ spouse; ___ son or ___ daughter; ___ parent; ___ next of kin of a covered service member with a serious injury or illness.

This Notice is to inform you that you:

□ Are eligible for FMLA leave (See Part B below for Rights and Responsibilities)

□ Are **not** eligible for FMLA leave, because (only one reason need be checked, although you may not
be eligible for other reasons):

- You have not met the FMLA's 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately _____months towards this requirement.
- You have not met the FMLA's 1,250-hours-worked requirement.
- You do not work and/or report to a site with 50 or more employees within 75-miles.

If you have any questions, contact the Manager of Personnel Services at 4177 or view the FMLA poster located in the area where employment posters are posted or the Madison County Personnel Policy Handbook
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PART B-RIGHTS AND RESPONSIBILITIES FOR TAKING FMLA LEAVE

As explained in Part A, you meet the eligibility requirements for taking FMLA leave and still have FMLA leave available in the applicable 12-month period. **However, in order for us to determine whether your absence qualifies as FMLA leave, you must return the following information to us by _____.** (If a certification is requested, employers must allow at least 15 calendar days from receipt of this notice; additional time may be required in some circumstances.) If sufficient information is not provided in a timely manner, your leave may be denied.

□ Sufficient certification to support your request for FMLA leave. A certification form that sets forth the information necessary to support your request ___**is**/ ___**is not** enclosed.
□ Sufficient documentation to establish the required relationship between you and your family member.
□ Other information needed:_____
□ No additional information requested

If your leave does qualify as FMLA leave you will have the following **responsibilities** while on FMLA leave (only checked blanks apply):

□ Contact Payroll at 4027 to make arrangements to continue to make your share of the premium payments on your health insurance to maintain health benefits while you are on leave. You have a minimum 30-day *(or, indicate longer period, if applicable)* grace period in which to make premium payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse, or, at our option, we may pay your share of the premiums during FMLA leave, and recover these payments from you upon your return to work.
□ You will be required to use your available paid _____**sick**, ____**vacation**, and/or _____**other leave** during your FMLA absence. This means that you will receive your paid leave and the leave will also be considered protected FMLA leave but not counted against your FMLA leave entitlement.
□ Due to your status within the company, you are considered a "key employee" as defined in the FMLA. As a "key employee," restoration to employment may be denied following FMLA leave on the grounds that such restoration will cause substantial and grievous economic

injury to us. We ____**have**/____ **have not** determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic harm to us.

 While on leave you will be required to furnish us with periodic reports of your status and intent to return to work every _____ . (*Indicate interval of periodic reports, as appropriate for the particular leave situation*).

If the circumstances of your leave change, and you are able to return to work earlier than the date indicated on the reverse side of this form, you will be required to notify us at least two workdays prior to the date you intend to report for work.

If your leave does qualify as FMLA leave you will have the following **rights** while on FMLA leave:

- You have a right under the FMLA for up to 12 weeks of unpaid leave in a 12-month period calculated as the 12-month period measured forward from the date of your first FMLA leave usage.

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- You have a right under the FMLA for up to 26 weeks of unpaid leave in a single 12-month period to care for a covered service member with a serious injury or illness. This single 12-month period commenced on _____.

- Your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work.
- You must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA-protected leave. (If your leave extends beyond the end of your FMLA entitlement, you do not have return rights under FMLA.)
- If you do not return to work following FMLA leave for a reason other than: 1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; 2) the continuation, recurrence, or onset of a covered service member's serious injury or illness which would entitle you to FMLA leave; or 3) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave.
- If we have not informed you above that you must use accrued paid leave while taking your unpaid FMLA leave entitlement, you have the right to have _____**sick**, _____**vacation**, and/or_____**other leave** run concurrently with your unpaid leave entitlement, provided you meet any applicable requirements of the leave policy. Applicable conditions related to the substitution of paid leave are referenced or set forth below. If you do not meet the requirements for taking paid leave, you remain entitled to take unpaid FMLA leave.

____For a copy of conditions applicable to sick/vacation/other leave usage please refer to_____ available at:_____ .

____Applicable conditions for use of paid Leave_____
_____

Once we obtain the information from you as specified above, we will inform you, within 5 business days, whether your leave will be designated as FMLA leave and count

towards your FMLA leave entitlement. If you have any questions, please do not hesitate to contact:_____ at _____.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT
It is mandatory for employers to provide employees with notice of their eligibility for FMLA protection and their rights and responsibilities. 29 U.S.C. § 2617; 29 C.F.R. § 825.300(b), (c). 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 10 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 THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION. *Form WH-382 November 2008* 13

DESIGNATION NOTICE FAMILY AND MEDICAL LEAVE ACT

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

Leave covered under the Family and Medical Leave Act (FMLA) must be designated as FMLA-protected and the employer must inform the employee of the amount of leave that will be counted against the employee's FMLA leave entitlement. In order to determine whether leave is covered under the FMLA, the employer may request that the leave be supported by a certification. If the certification is incomplete or insufficient, the employer must state in writing what additional information is necessary to make the certification complete and sufficient. While use of this form by employers is optional, a fully completed Form WH-382 provides an easy method of providing employees with the written information required by 29 C.F.R. §§ 825.300(c), 825.301, and 825.305(c).

To: _____

Date: _____

Date Leave Starts:_____

We have reviewed your request for leave under the FMLA and any supporting documentation that you have provided. We received your most recent information on _____and decided:

☐ **Your FMLA leave request is approved. All leave taken for this reason will be designated as FMLA leave.**

The FMLA requires that you notify us as soon as practicable if dates of scheduled leave change or are extended, or were initially unknown. Based on the information you have provided to date, we are providing the following information about the amount of time that will be counted against your leave entitlement:

☐ Provided there is no deviation from your anticipated leave schedule, the following number of hours, days, or weeks will be counted against your leave entitlement: _____.

☐ Because the leave you will need will be unscheduled, it is not possible to provide the hours, days, or weeks that will be counted against your FMLA entitlement at this time. You have the right to request this information once in a 30-day period (if leave was taken in the 30-day period).

Please be advised (check if applicable):

☐ You have requested to use paid leave during your FMLA leave. Any paid leave taken for this reason will count against your FMLA leave entitlement.

☐ We are requiring you to substitute or use paid leave during your FMLA leave.

☐ You will be required to present a fitness-for-duty certificate to be restored to employment. If such certification is not timely received, your return to work may be delayed until certification is provided. A list of the essential functions of your position ____**is** ____i**s not** attached. If attached, the fitness-for-duty certification must address your ability to perform these functions.

_____

☐ Additional information is needed to determine if your FMLA leave request can be approved:

- o The certification you have provided is not complete and sufficient to determine whether the FMLA applies to your leave request. You must provide the following information no later than *[Provide at least seven calendar days]*, unless it is not practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied.*[Specify information needed to make the certification complete and sufficient]*
- ☐ We are exercising our right to have you obtain a second or third opinion medical certification at our expense, and we will provide further details at a later time.

_____

☐ Your FMLA Leave request is Not Approved.
☐ The FMLA does not apply to your leave request.
☐ You have exhausted your FMLA leave entitlement in the applicable 12-month period.

_____ _____

Department Head Signature **Date**

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT
It is mandatory for employers to inform employees in writing whether leave requested under the FMLA has been determined to be covered under the FMLA. 29 U.S.C. § 2617; 29 C.F.R. §§ 825.300(d), (e). 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 10 – 30 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 THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.

Payroll

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

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.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by the law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.29 C.F.R. § 1635.8(b)(1)(i).

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:

_____

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):
_____
_____
_____

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 flareups? ___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. 29U.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.** For **additional** information: 1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627 **WWW.WAGEHOUR.DOL.GOV** U.S. Department of Labor | Employment Standards Administration | Wage and Hour Division WHD Publication 1420 (Rev. XX-XXXX)

MADISON COUNTY
PERIODIC NOTICE OF INTENT TO RETURN TO WORK

To: _____

From: _____

Re: Intent to Return to Work

Date: _____

Anticipated Return to Work Date _____.

The remainder of this form is to be completed by the employee on FMLA leave and returned to the Elected Official/Department Head.

[ ] I intend to return to work on the Anticipated Return to Work Date.

[ ] I do not intend to return to work following my FMLA leave due to the following reason(s).

_____

_____

_____

_____

Employee's Signature: _____ Date: _____

MADISON COUNTY
FITNESS-FOR-DUTY CERTIFICATION

This form must be completed by the physician of an employee who has been or expects to be absent from work due to illness or disability for a period in excess of three (3) consecutive working days. It must be completed and filed with the Department Head/Elected Official immediately upon return to work or prior to the tenth (10^{th}) day of the absence, whichever is earlier.

1. Employee's Name _____ Date _____

2. First day unable to work _____

3. Is employee still under your care? _____

4. * Date the employee is expected to return to work _____

5. Is the employee to limit his/her duties? _____

   If so, How?

   _____

   _____

6. Physician's name, address, and telephone #

   _____

   _____

   _____

Signature of Physician _____ Date _____

*If the actual date of release is different from this date, an additional statement is required before the employee may return to work.

EMPLOYEE, PLEASE READ CAREFULLY BEFORE SIGNING

AUTHORIZATION: I hereby authorize Madison County to contact the physician who has examined or treated me to determine fitness for duty. I further authorize said physician to release such information to Madison County.

Signature of Employee _____ Date_____

If the employee is returning from Family & Medical Leave, a copy of this form is to be provided to Payroll.