LAKE COUNTY GOVERNMENT EMPLOYEE

APPLICATION FOR FAMILY MEDICAL LEAVE

Please fill in all applicable sections. Failure to provide the requested information may result in denial or delay in your ability to receive approval.

Name: ________________________________ **Department:** _____________________

Current Job Title: _____________________ **Supervisor's Name:** ___________________

Department Head (if different from Supervisor): ________________________________

Current Home Address (Street, City, and Zip): _________________________________

Start Date of Anticipated Leave: _______________

Expected Date of Return: _____________________

Reason for Leave (Choose one):

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

☐ A serious health condition that makes you unable to perform the essential functions of your job: or

☐ A serious health condition affecting your ☐ Spouse, ☐ Child, ☐ Parent, for which you are needed to provide care.

☐ Because of any qualifying exigency arising out of the fact that your spouse, son, daughter, or parent is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation.

☐ A leave to care for a service member spouse, son, daughter, parent, or next of kin. This leave may provide an employee up to 26 weeks of leave during a 12-month period. This leave shall only be available during a single 12-month period.

*A full description of an employee's rights for leave under the Family & Medical Leave Act of 1993 can be found in the Employee Handbook or in the FMLA handout (available from the Human Resource office)

Have you received an approved FMLA leave in the past 12 months? ☐ Yes ☐ No

If Yes, what was the date that you returned to work from that leave? ______________

I hereby authorize the Lake County Human Resources Consultant to contact my physician if necessary, to verify the need for my requested leave or for any other applicable information concerning my requested Family and Medical Leave.

I understand that a failure to return to work at the end of my leave period may be treated as a resignation unless an extension has been agreed upon and approved in writing by Lake County Government.

During an approved leave, I must use all sick/personal days, short term disability (if qualified), or compensatory time. I may use vacation days, if I choose, but I will not be required to do so.

Final approval or denial of leave will be made in writing. A copy will be provided to your Supervisor but will NOT include any specific information regarding the medical reason for the leave request.

Signature:____ Date:__________________

ACKNOWLEDGEMENT OF INSURANE RESPONSIBILITIES

WHILE ON PAID OR UNPAID LEAVE OF ABSENCE

I, ______________________________, hereby acknowledge that when I am on Family Medical Leave (either paid or unpaid, including short term disability) I am responsible for making payments to continue my insurance coverage. I understand the following to be the requirements:

1. Insurance payments must be received by the Insurance Office (Human Resource), Lake County,2293 North Main St. Crown Point, IN 46307, on or before the 15th of each month in order to keep your insurance in force.

   In the event that I am eligible for short-term disability payments, I authorize the aforementioned amount to be deducted from those payments in lieu of paying the employee contribution.
2. I am presently on the following type of coverage: (Circle Type)

   A. Single- $40.00/mo.

   B. Family- $75.00/mo.

3. I herby acknowledge that the current monthly amount which I must pay for this insurance is__________________ per month.

4. When I return to work as a full-time employee, I will notify the Lake County Human Resource Office (Insurance/Benefits) in writing so that they can activate the payroll deduction for my insurance.

Dated:_________ day of_________________________, 20_____

____

Employee's Name (Print)

____

Employee's Signature

CERTIFICATION RELATING TO CARE FOR AN EMPLOYEE'S SERIOUSLY ILL FAMILY MEMBER

(If this section does not apply, please skip)

Name of Family Member: ____

Relation to Employee: ____

	Yes	NO
1. Is inpatient hospitalization of family member required?	___	___
2. Does the family member require the care of health provider that? will last three or more days (excluding the flu, common cold, etc.)?	___	___
3. Does (or will) the patient require assistance for medical, hygiene, nutritional needs, safety or transportation, safety or transportation?	___	___
4. Would the care of the patient require the employee's presence/ assistance? (This may include psychological comfort.)	___	___

5. Estimate the period of time care that is needed or the employee's presence would be beneficial:

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6. Will the Leave be taken for a period of time or intermittently (Please explain)?

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____

Employee's Signature: ______________________________________

Date: ____________________

CHECKLIST FOR FAMILY & MEDICAL LEAVE REQUEST

- ☐ Completed Application **(Required)**
- ☐ Acknowledgement of Insurance Responsibilities while on Paid or Unpaid Leave of Absence **(Required)**
- ☐ Certification Relating to Care for An Employee's Seriously ILL Family Member (If Applicable)
- ☐ Certification of Health Care Provider **(Required)**

Once completed, return this application directly to the Insurance Office (Human Resource Dept.) for further processing.

You will be notified in writing as to whether or not your leave request has been approved.

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

U.S. Department of Labor
Wage and Hour Division

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.

OMB Control Number: 1235-0003
Expires: 8/31/2021

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, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination 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:

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____ ____________________
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. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e). 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):

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CONTINUED ON NEXT PAGE

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

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

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

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

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

   ____

   ____

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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:

   ____

   ____

   ____

   ____

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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: ________________________

   ____

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   ____

   ____

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.