

**Carleton College
Family and/or Medical Leave (FMLA)**

Part I - To Be Completed By Employee (Please Print)

All forms are to be returned to Karyn Jeffrey, Human Resources at Carleton College
Fax: 507-222-7788 or mail to: One North College Street Northfield, MN 55057 (Phone: 507-222-4174)

Employee Name: _____ Mail Stop: _____

Position: _____ Department: _____

Reason for Leave is due to:

____ Birth of a child, or placement of child for adoption or foster care; or

____ Serious health condition that makes you unable to perform the essential functions of your job; or

____ Serious health condition affecting your ____ spouse, ____ child, ____ parent, for which you are needed to provide care.

Date leave is expected to begin _____ Date you expect to return to work _____

If leave will be part time or intermittent please specify expected dates and hours:

Paid Leave options: (*All College paid leave is calculated based on the non-exempt budgeted weekly hours or exempt budgeted FTE.)

For all regular employees (non-union) who work at least 20 hours per week and have worked for at least 12 months.

_____ up to 5 days paid leave by the College may be granted for approved FMLA leaves or

_____ Carleton Paid Parental Leave:

_____ up to 12 weeks paid leave for a Primary Caregiver or

_____ up to 3 weeks of College paid leave for a Secondary caregiver

For leave time extending beyond the College paid leave time described above, accrued sick, vacation and floating holiday hours will be used. For an employee's illness sick time will be paid out according to amount of time indicated by the employee's physician. Accrued sick leave for family members is unlimited for a child, and 2 days per 12 month rolling year for a spouse, domestic partner, parent or adult child.

Please list absent accruals to be used: _____ sick hours _____ vacation hours _____ floating holiday hours

Any unpaid leave time is to be approved by the employee's supervisor. Unpaid hours _____

You have a right under FMLA for up to 12 weeks of paid or unpaid leave in a 12-month rolling period, (rolling backwards), for the reasons listed above.

If your total leave, as currently agreed upon, is six months or less, you are eligible to receive the College contributions to the College-provided benefits in which you are enrolled. If your leave should, with supervisory approval, extend beyond six months, you will need to pay the entire premiums on any insured benefit plans in which you participate, if you wish to remain in the group plan, for up to 18 months.

If your leave is for a serious health condition of yourself, a spouse, a child or a parent, a DOL's Certification of Health Care Provider will need to be completed in order for the leave to qualify as a FMLA leave. A Fitness for Duty form will also need to be completed for you, if the leave is for a serious health condition. Both forms are attached for your use if applicable.

Your signature below indicates that you understand your FMLA entitlement and agree to the provisions of this leave.

Employee Signature

Date

**Certification of Health Care Provider
(Family and Medical Leave Act of 1993)**

Part II - Certification of Health Care Provider

All forms are to be returned to Karyn Jeffrey, Human Resources at Carleton College
Fax: 507-222-7788 or mail to: One North College Street Northfield, MN 55057 (Phone: 507-222-4174)

U.S. Department of Labor

Employment Standards Administration
Wage and Hour Division

(When completed, this form goes to the employee, Not to the Department of Labor.)

OMB No. 1215-0181
Expires: 07/31/07

1. Employee's Name

2. Patient's Name (If different from employee)

3. Page 4 describes what is meant by a **“serious health condition”** under the Family and Medical Leave Act. Does the patient's condition¹ qualify under any of the categories described? If so, please check the applicable category.

(1)_____ (2)_____ (3)_____ (4)_____ (5)_____ (6)_____ , or None of the above _____

4. Describe the **medical facts** which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories:

5. a. State the approximate **date** the condition commenced, and the probable duration of the condition (and also the probable duration of the patient's present **incapacity**² if different):

b. Will it be necessary for the employee to take work only **intermittently or to work on a less than full schedule** as a result of the condition (including for treatment described in Item 6 below)?

If yes, give the probable duration:

c. If the condition is a **chronic condition** (condition #4) or **pregnancy**, state whether the patient is presently incapacitated² and the likely duration and frequency of **episodes of incapacity**²:

¹ Here and elsewhere on this form, the information sought relates **only** to the condition for which the employee is taking FMLA leave.

² “Incapacity,” for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore or recovery therefrom.

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6. a. If additional **treatments** will be required for the condition, provide an estimate of the probable number of such treatments.

If the patient will be absent from work or other daily activities because of **treatment** on an **intermittent** or **part-time** basis, also provide an estimate of the probable number of and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any:

- b. If any of these treatments will be provided by **another provider of health services** (*e.g.*, physical therapist), please state the nature of the treatments.
- c. **If a regimen of continuing treatment** by the patient is required under your supervision, provide a general description of such regimen (*e.g.*, prescription drugs, physical therapy requiring special equipment):

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7. a. If medical leave is required for the employee's **absence from work** because of the **employee's own condition** (including absences due to pregnancy or a chronic condition), is the employee **unable to perform work** of any kind?

- b. If able to perform some work, is the employee **unable to perform any one or more of the essential functions of the employee's job** (the employee or the employer should supply you with information about the essential job functions)? If yes, please list the essential functions the employee is unable to perform:

- c. If neither a. nor b. applies, is it necessary for the employee to be **absent from work for treatment**?

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8. a. If leave is required to **care for a family member** of the employee with a serious health condition, **does the patient require assistance** for basic medical or personal needs or safety, or for transportation?
- b. If no, would the employee's presence to provide **psychological comfort** be beneficial to the patient or assist in the patient's recovery?
- c. If the patient will need care only **intermittently** or on a part-time basis, please indicate the probable **duration** of this need:

Signature of Health Care Provider

Type of Practice

Address

Telephone Number

Date

To be completed by the employee needing family leave to care for a family member:

State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule:

Employee Signature

Date

A “**Serious Health Condition**” means an illness, injury impairment, or physical or mental condition that involves one of the following:

1. Hospital Care
Inpatient care (*i.e.*, an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity² or subsequent treatment in connection with or consequent to such inpatient care.
2. Absence Plus Treatment
 - (a) A period of incapacity² of **more than three consecutive calendar days** (including any subsequent treatment or period of incapacity² relating to the same condition), that also involves:
 - (1) **Treatment³ two or more times** by a health care provider, by a nurse or physician’s assistant under direct supervision of a health care provider, or by a provider of health care services (*e.g.*, physical therapist) under orders of, or on referral by, a health care provider; or
 - (2) **Treatment** by a health care provider on **at least one occasion** which results in a **regimen of continuing treatment⁴** under the supervision of the health care provider.
3. Pregnancy
Any period of incapacity due to **pregnancy**, or for **prenatal care**.
4. Chronic Conditions Requiring Treatments
A **chronic condition** which:
 - (1) Requires **periodic visits** for treatment by a health care provider, or by a nurse or physician’s assistant under direct supervision of a health care provider;
 - (2) Continues over an **extended period of time** (including recurring episodes of a single underlying condition); and
 - (3) May cause **episodic** rather than a continuing period of incapacity² (*e.g.*, asthma, diabetes, epilepsy, etc.).
5. Permanent/Long-Term Conditions Requiring Supervision
A period of **Incapacity²** which is **permanent or long-term** due to a condition for which treatment may not be effective. The employee or family member must be **under the continuing supervision of, but need not be receiving active treatment by, a health care provider**. Examples include Alzheimer’s a severe stroke, or the terminal stages of a disease.
6. Multiple Treatment (Non-Chronic Conditions)
Any period of absence to receive **multiple treatments** (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for **restorative surgery** after an accident or other injury, **or** for a condition that **would likely result in a period of Incapacity² of more than three consecutive calendar days in the absence of medical intervention or treatment**, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), and kidney disease (dialysis).

This optional form may be used by employees to satisfy a mandatory requirement to furnish a medical certification (when requested) from a health care provider, including second or third opinions and recertification (29 CFR 825.306).

Note: Persons are not required to respond to this collection of information unless it displays a current valid OMB control number.

³ Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

⁴ A regimen of continuing treatment includes, for example, a course of prescription medication (*e.g.*, an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

Public Burden Statement

We estimate that it will take an average of 20 minutes 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 of information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, Department of Labor, Room S-3502, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE; IT GOES TO THE EMPLOYEE.

Family and/or Medical Leave (FMLA)

Part III - Fitness-for-Duty Certification of Health Care Provider

Form to be returned to: Karyn Jeffrey, Carleton College Human Resources (Phone: 507-222-4174)
Fax: 507-222-7788 or mail to: One North College Street Northfield, MN 55057

1. Employee Name: _____ Title: _____

2. Is the above named employee, who has been on medical leave from work because of the employee's own serious health condition¹, able to return to work?

_____ yes _____ no

If yes, what date is the employee able to return to work? _____

3. If the employee is able to return to work, is the employee unable to perform any one or more of the essential functions of the employee's job (the employee or the employer should supply you with information about the essential job functions)?

_____ yes _____ no

If yes, please list the essential function the employee is unable to perform and/or any limitations related to the essential functions. Please also specify the duration of any limitations:

Please list any additional limitations that apply to the employee's return to work and the duration of those limitations.

Signature of Health Care Provider

Type of Practice

Printed name of Health Care Provider

Telephone number

Date Signed

¹ Here and elsewhere on the form, the information sought relates only to the condition for which the employee is taking medical leave.