Emergency Sick Leave

We are sorry to hear about your sudden illness and hope that you recover quickly. Please provide a doctor's note (if you have not already) to the HR office as soon as possible. The note should clearly state how long you are to be away from work. This note can be brought in person, sent via mail, fax or email (hr@gcdcwws.com) as soon as possible. The secure HR fax number is: 810-732-1934.

The short term disability plan has a 7 calendar day elimination period. As this has been deemed Emergency Leave, you have the choice of covering your first five work days with personal, vacation or unpaid time. If you have not already given your supervisor a request for leave, complete the attached Request for Leave form with your choice for covering this time. If you are choosing unpaid time, complete the emergency leave section. Return it to our office as soon as possible.

The Division has recognized Sick Leave as an FMLA event. FMLA runs concurrent with Sick and Disability Leave. Under the Family & Medical Leave Act, employees are entitled to 12-weeks of leave either paid or unpaid for a qualifying reason. Enclosed is the application for FMLA and official notices. Please complete the FMLA application and return it to the HR office.

Also enclosed is the application for Short Term Disability. Complete the Employee portion and send it directly to the carrier. With the advent of privacy laws, the Division will no longer accept the medical data that is required on the forms.

The doctor's statement is extremely important, so have your doctor fax it directly to our carrier as soon as possible. It is important that you communicate with your doctor's office to assure that this had been completed.

If the doctor authorizes an extension of your sick leave, you must provide an original updated doctor's note to the HR office. The note must be provided prior to the end of the approved sick leave date. The HR office will fax this note to the carrier however office notes from your visit must be sent to the carrier in a timely manner. The carrier often encloses medical paperwork in their mailing or email communication to you so please read everything carefully.

Emergency Sick Leave

You are required to provide a three working day return to work notice. You must produce a note from your doctor stating that you are released to work with no restrictions including a clear return to work date. It is strongly recommended that you notify your doctor that a three working day notice is a requirement of the Division. You will be required to visit the Division's doctor/clinic to obtain an occupational release for duty. This visit may require a physical agility test. Be prepared by dressing in comfortable clothes that allow you to move freely and wear sneaker/tennis shoes for mobility. This appointment can take time as emergencies are treated first. While you have an appointment time, the length of the visit is out of our control.

The day that you notify the HR office in writing that you can return to work shall be considered day one of the three working day notice. Every effort will be made to get a timely appointment. If you contact us prior to what you anticipate to be your final doctor's appointment, we will try to schedule a clinic appointment that same day or the next day. REMINDER: YOU MUST PROVIDE A NOTE FROM YOUR DOCTOR STATING THAT YOU ARE RELEASED TO WORK WITH NO RESTRICTIONS INCLUDING A CLEAR RETURN TO WORK DATE PRIOR TO YOUR CLINIC APPOINTMENT.

In Summary:

- Doctor's note, Request for Leave (if needed) and FMLA Application to HR Office
- Short Term Employee application to Carrier
- Short Term Physician's Statement to Doctor with instructions to fax to carrier
- If extension necessary: doctor's note to HR and office notes to carrier
- Read everything from carrier carefully
- Return to work without restrictions note to HR (3 working days prior to return)
- Return to work physical (may require physical agility wear comfortable clothes)

If you have any questions, Christine Simms or I can be reached at (810) 732-7870.

Anne Figueroa

Anne Figueroa, PHR, IPMA-CP
Human Resource Manager

GENESEE COUNTY
WWS
DRAIN COMMISSIONER

Emergency
Sick Leave Request for Leave
Covering the First Five Work Days

Name: _____ Department _____

Time Off: Date(s): _____, _____, _____, _____, _____

Charge To:

Personal Time: _____ Hours

Annual Leave (Vacation): _____ Hours

APPROVED FMLA _____ Hours

Unpaid Emergency Leave _____ Hours

_____ _____
Employee's Signature Date of Request

_____ _____
Supervisor's Signature Date Approved

This is a qualified approval contingent on employee having earned enough of the requested time

---

_____ _____
Received in the HR Office Date

Sun Life Assurance Company of Canada

Short Term Disability Instructions

Failure to provide complete and accurate information could result in the need for additional claims investigation, which could delay the initial benefit payment.

- Send in ALL signed statements, which we require to properly review the claim.
  - Employee Statement
  - Attending Physician Statement
  - Authorization Statements

- An STD claim should be submitted for a disability absence that may extend beyond the required elimination period. The Division has a 7 calendar day elimination period.

- Employer is required to include the following (as applicable):
  - Employer Statement
  - W2
  - Worker Compensation Report
  - Job Description
  - Return-to-Work slip
  - Payroll Ledger

- Physician must completely fill out and sign the Physician Statement.

  - Have all the physicians keep a copy of your signed authorization for their files.

To file a Disability Claim:

- **Online** go to www.sunlife.com/us - Click on "Submit a Disability Claim"

- **Fax to: 781-304-5599**

Check on a status

- **Online go to www.sunlife.com/us**

- **Call 800-247-6875- Click on "Track my Disability Claim"**

Sun Life Assurance Company of Canada

Short Term Disability/Sick Leave Employee's Statement

Sun Life Financial®

1 General Information

Provide your full address and Social Security number.

Please print clearly

Your name (first, middle initial, last) ☐ M ☐ F	Social Security number	Date of birth
Your street address	City	State / Zip Code
Your occupation	Telephone Number	
Employer Name Genesee County Water and Waste	Group Policy Number 221924	

2 Information About the Condition Causing Your Disability

Reminder: Return completed claim form and all required documentation to:

Sun Life Assurance Company of Canada
Group STD Claims
P.O. Box 81915
Wellesley Hills, MA 02481

Tel: 1-800-247-6875
Fax: (781) 304-5599

Type (check one): ☐ Pregnancy ☐ Motor vehicle accident ☐ Work-related injury/sickness ☐ Sickness ☐ Other accident

Describe in detail how, when and where the accident occurred –OR – Describe the nature of your illness/condition and its first symptoms. If work-related, describe cause of injury/illness.		
Date you were first treated by a physician	Last day worked prior to disability	Did you work a full day? ☐ Yes ☐ No
Name of your first treating physician	Physician phone number	
Name of hospital	Hospital phone number	Date(s) of confinement
Date first unable to work	Date you expect to return to work	Do you expect to return full- or part-time? ☐ Full-Time ☐ Part-Time

If work-related, have you filed/do you intend to file, a Workers' Compensation claim?.... ☐ Yes ☐ No

3 Information About Other Income

Check all that apply and provide details for each source of income.

Are you currently receiving, or entitled to receive, benefits from any of the following sources?

	Source of income	Amount of each payment	Weekly or monthly?	Period/date(s) covered by payment
☐	Vacation pay	$	☐ Wkly ☐ Mthly	
☐	Sick pay	$	☐ Wkly ☐ Mthly	
☐	State Disability	$	☐ Wkly ☐ Mthly	
☐	Other:	$	☐ Wkly ☐ Mthly	

4 Signature

Reminder: Please be sure to sign and return any Authorization statements included in this packet.

I certify that the above statements are true and complete. I have read and understand the Fraud Warning included in this packet.

Employee's signature X	Date signed

Sun Life Assurance Company of Canada

Sun Life Financial®

Authorization for Release and Disclosure of Health Related Information

This Authorization complies with the HIPAA Privacy Rule. It is important for you to read, sign and submit all Authorizations in this packet. Failure to submit all Authorizations could result in a delay during the claims process.

Return to:
Sun Life Assurance Company of Canada
Group STD Claims
P.O. Box 81915
Wellesley Hills, MA 02481
Fax: (781) 304-5599

I HEREBY AUTHORIZE any physician, health care provider, health plan, medical professional, hospital, clinic, laboratory, pharmacy or other medical or healthcare facility that has provided payment, treatment or services to me or on my behalf, to disclose my entire medical record and any other protected health information concerning me to the Claims Department of Sun Life Assurance Company of Canada ("the Company") its subsidiaries, affiliates, third party administrators and reinsurers.

I understand that such information may include records relating to my physical or mental condition such as diagnostic tests, physical examination notes and treatment histories, which may include information regarding the diagnosis and treatment of human immunodeficiency virus (HIV) infection, sexually transmitted diseases, mental illness and the use of alcohol, drugs and tobacco, but shall not include psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization, and I instruct any physician, health `care professional, hospital, clinic, medical facility or other health care provider to release and disclose my entire medical record without restriction.

I understand that the Company will use the information it obtains to (a) administer claims; (b) determine or fulfill responsibility for coverage and provision of benefits; (c) administer coverage; and/or (d) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company.

I understand that the Company will not disclose information it obtains about me except as authorized by this Authorization; as may be required or permitted by law; or as I may further authorize. I understand that if information is redisclosed as permitted by this Authorization, it may no longer be protected by applicable federal privacy law.

I understand that: (a) this Authorization shall be valid for 24 months from the date I sign it; (b) I may revoke it at any time by providing written notice to Sun Life Financial, Group Short Term Disability Claims, SC 3212, One Sun Life Executive Park, Wellesley Hills, Massachusetts, 02481, subject to the rights of any person who acted in reliance on it prior to receiving notice of its revocation; and (c) my authorized representative and I are entitled to receive a copy of the Authorization upon request.

A copy of this Authorization shall be as valid as the original.

Print Name of Employee or Personal Representative of Employee	Group Policy Number 221924
If Representative, description of your authority or relationship to employee	
Signature of Employee or Personal Representative X	Date

Sun Life Assurance Company of Canada

Authorization for Release and Disclosure of Psychotherapy Notes

This Authorization complies with the HIPAA Privacy Rule. It is important for you to read, sign and submit all Authorizations in this packet. Failure to submit all Authorizations could result in a delay during the claims process.

Return to:
Sun Life Assurance Company of Canada
Group STD Claims
P.O. Box 81915
Wellesley Hills, MA 02481
Fax: (781) 304-5599

I HEREBY AUTHORIZE any: physician, health care provider, health plan, medical professional, hospital, clinic, or other medical or health care facility that has provided payment, treatment or services to me or on my behalf; to disclose any psychotherapy notes relating to me to the Claims Department of Sun Life Assurance Company of Canada ("the Company") its subsidiaries, affiliates, third party administrators and reinsurers.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization, and I instruct any physician, health care professional, hospital, clinic, medical facility or other health care provider to release and disclose all psychotherapy notes relating to me without restriction.

I understand that the Company will use the information it obtains to: (a) administer claims; (b) determine or fulfill responsibility for coverage and provision of benefits; (c) administer coverage; and/or (d) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company.

I understand that the Company will not disclose information it obtains about me except as authorized by this Authorization; as may be required or permitted by law; or as I may further authorize. I understand that if information is redisclosed as permitted by this Authorization, it may no longer be protected by applicable federal privacy law.

I understand that: (a) this Authorization shall be valid for 24 months from the date I sign it; (b) I may revoke it at any time by providing written notice to Sun Life Financial Group Short Term Disability Claims Department, SC3212, One Sun Life Executive Park, Wellesley Hills, Massachusetts, 02481, subject to the rights of any person who acted in reliance on it prior to receiving notice of its revocation; and (c) my authorized representative and I are entitled to receive a copy of the Authorization upon request.

A copy of this Authorization shall be as valid as the original.

Print Name of Employee or Personal Representative of Employee	Group Policy Number 221924
If Representative, description of your authority or relationship to employee	
Signature of Employee or Personal Representative X	Date

Sun Life Assurance Company of Canada

Attending Physician's Statement

Sun Life Financial®

1 Information About the Patient

Return to:

Sun Life STD Claims
P.O. Box 81915
Wellesley Hills, MA 02481
Fax: (781) 304-5599

The patient is responsible for any costs associated with the completion of this form.

Name of Patient (first, middle initial, last) ☐ M ☐ F	Social Security number	Date of birth (m/d/y)
Name of Employer	**Group Policy number**	**Employee phone no.**
Genesee County Water and Waste	221924	

2 Diagnosis and History

Provide general information about diagnosis and history in this section. Then, please elaborate in section(s) 3 – 6 as appropriate.

Diagnosis including any complications and ICD-9 Codes(s)	
Objective findings (i.e. x-rays, EKGs, MRIs, laboratory data and any other clinical findings)	
Subjective Symptoms	
Date symptoms first appeared or date of accident	Date Disability Commenced
Has patient ever had same or similar condition? ..... ☐ Yes ☐ No If Yes, when:	
Is condition due to injury/sickness arising out of patient's employment? ..... ☐ Yes ☐ No ☐ Unknown	
Names and telephone numbers of Other Treating Physicians (if applicable)	
If pregnancy, please provide the following information: • Expected delivery date: _____ • Actual delivery date: _____ • C-Section? ☐ Yes ☐ No	
Describe any complications that would extend this disability longer than a normal pregnancy	

3 Treatment

Include in description any surgery, therapeutic modalities, psychological intervention and medications prescribed.

Date of first visit	Date of last visit	Date of last examination
Frequency of treatment ..... ☐ Weekly ☐ Monthly ☐ Other (please specify: _____)		
Description of Treatment		

4 Progress

Has patient: ..... ☐ Recovered ☐ Unchanged ☐ Improved ☐ Retrogressed

Is patient:..... ☐ Ambulatory ☐ Bed confined ☐ House confined ☐ Hospital confined

If unchanged or retrogressed, please explain:		
Has patient been hospital confined? ..... ☐ Yes ☐ No	From:	To:
If yes, provide name and address of hospital		

Continued on next page

5 Restrictions and Limitations

Restrictions and Limitations should be associated with the Objective and Subjective findings/symptoms noted in section 2.

Restrictions (what the patient should not do)
Limitations (what the patient cannot do)

Is the patient capable of working within these restrictions/limitations? ..... ☐ Yes ☐ No
Can the patient work an eight-hour day with these restrictions/limitations? ..... ☐ Yes ☐ No
If no, how many hours could he/she work? ..... _____ hours
Is patient capable of working in another occupation?..... ☐ Yes - Full-time ☐ Yes - Part-time ☐ No

Indicate class of physical impairment.

* As defined in federal dictionary of occupation titles

Physical Impairment

☐ Class 1 – No limitation of functional capacity; capable of heavy work* No restrictions (0-10%)
☐ Class 2 – Medium manual activity* (15-30%)
☐ Class 3 – Slight limitation; capable of light work* (35-55%)
☐ Class 4 – Moderate limitation; capable of clerical/administrative (sedentary*) activity (60-70%)
☐ Class 5 – Severe limitation; incapable of minimum (sedentary*) activity (75-100%)

Indicate class of mental impairment.

Mental Impairment (if applicable)

☐ Class 1 – No limitation
☐ Class 2 – Slight limitation
☐ Class 3 – Moderate limitation
☐ Class 4 – Marked limitation
☐ Class 5 – Severe limitation

What is the patient's current DSM-IV-R diagnosis?

Axis I _____ Axis IV _____
Axis II _____ Axis V _____
Axis III _____

Do you believe this patient is competent to endorse checks/direct the use of proceeds? ... ☐ Yes ☐ No

6 Return-to-Work

1. When will patient recover sufficiently to perform duties? (Specify date or check recovery period)
   - Patient's occupation part-time:
     Date: _____ **-or-** ☐ < 3 wks ☐ 3-4 wks ☐ 5-6 wks ☐ 7-8 wks ☐ 2 months or more ☐ Never
   - Patient's occupation full-time:
     Date: _____ **-or-** ☐ < 3 wks ☐ 3-4 wks ☐ 5-6 wks ☐ 7-8 wks ☐ 2 months or more ☐ Never
2. After reviewing the material and substantial duties of the patient's occupation, would you recommend vocational counseling and/or rehabilitation or job modification? ..... ☐ Yes ☐ No

7 Certification and Signature

Remember to provide your full address and Tax ID number.

A stamp or signature of a person other than the examining physician is not acceptable.

I certify that the above statements are true and complete. I have read and understand the Fraud Warning included in this packet.

Name of Attending Physician	Degree/Specialty		
Street address	City	State	Zip Code
Tax ID number	Telephone number	Fax number	
Attending Physician Signature X		Date	

Sun Life Assurance Company of Canada

Sun Life Financial®

Fraud Warnings

State law requires that we notify you of the following:

Fraud Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Fraud Warning - California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Fraud Warning - Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Fraud Warning - Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Fraud Warning - Louisiana and Massachusetts: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Fraud Warning - Maryland: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime as determined by a court of competent jurisdiction.

Fraud Warning - New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Fraud Warning - Oregon, Virginia and Washington: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Fraud Warning - Vermont: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and subjects such person to criminal and civil penalties.

Sun Life Assurance Company of Canada
Wellesley Hills, MA 02481
1-800-247-6875

Sun Life Financial®

PRIVACY INFORMATION NOTICE

This notice explains why Sun Life Assurance Company of Canada ("the Company") collects personal information about you, how we use that information, and under what circumstances we disclose it to others.

COLLECTION OF INFORMATION

We need to obtain information about you to determine whether we can provide the insurance benefits you have requested. As part of the claims process, we may ask you to undergo a physical examination, submit a statement from your physician, or provide copies of medical tests or other information relating to your health, finances and activities.

We also may collect information about you from other sources. By signing the Authorization For Release And Disclosure of Health Related Information and/or the Authorization For Release And Disclosure of Psychotherapy Notes, you authorize us to obtain medical information about you that we need to underwrite your application. Depending upon your particular circumstances, we may collect additional information about you from the following sources:

- Physicians, health care providers, medical professionals, hospitals, clinics or other medical or health care related facilities
- Other insurance companies you have applied to for insurance
- Public records, such as Social Security and tax records

DISCLOSURE OF PERSONAL INFORMATION

When you sign the Authorization For Release And Disclosure of Health Related Information and/or the Authorization For Release And Disclosure of Psychotherapy Notes, you authorize us to disclose information we have about you:

- To our reinsurers
- As required or permitted by law

In the course of the claims process, we may need to disclose information about you to others. The law permits us to disclose such information, without obtaining authorization from you, to:

- Companies that help us conduct our business or perform services on our behalf
- Your physician or treating medical professional
- Comply with federal, state or local laws, respond to a subpoena or comply with an inquiry by a government agency or regulator

ACCESS, CORRECTION AND AMENDMENT OF PERSONAL INFORMATION

Upon written request to the Company, you can:

- Obtain a copy of the personal recorded information we have about you in our files (a fee may be charged to cover the cost of providing a copy of such information)
- Request that we correct, amend or delete any recorded personal information about you in our possession
- File your own statement of facts if you believe that the recorded personal information we have about you is incorrect

To take any of these actions, please contact us at the following address for further instructions:

Sun Life Assurance Company of Canada
Group Short Term Disability Claims
P.O. Box 81915
Wellesley Hills, MA 02481

GENESEE COUNTY
WWS
DRAIN COMMISSIONER

APPLICATION FOR FMLA LEAVE

Employee's name: _____

Location: _____ Department_____

Eligible employees are entitled under the Family and Medical Leave Act (FMLA) to up to 12 weeks of unpaid, job-protected leave for certain family and medical reasons.

Submit this request form at least 30 days before the leave is to commence, when practicable. When submission of the request 30 days in advance is not practicable, submit the request as early as is practicable.

According to the Division's Family and Medical Leave (FMLA) policy, you are required to exhaust Vacation leave up to your annual allotment and Personal time above 24 hours before going on leave without pay for FMLA leave.

EMPLOYEE STATEMENT: I am requesting leave for the following reason:

☐ **For a serious health condition that makes me unable to perform my job**

(Medical certification must be provided 15 calendar days after date of application)

☐ **To care for a family member with a serious health condition**

(Medical certification must be provided 15 calendar days after date of application)

☐ **The birth of a child:** Expected Delivery Date_____

(Medical certification must be provided 15 calendar days after date of application)

☐ **The placement of a child for adoption or foster care** (documentation required)

☐ **To care for a spouse, son, daughter, parent, or next of kin to take up to 26 work weeks of leave to care for a member of the Armed Forces**

(Medical certification must be provided 15 calendar days after date of application)

DATE OF LEAVE REQUESTED:

☐ I request leave from _____to Expected Return Date_____

☐ I request intermittent leave according to the following schedule: _____

☐ I request reduced schedule leave according to the following schedule._____

The total number of days of leave that I request is: _____

Employee Signature _____Today's Date _____

Human Resource Signature _____ Date _____

Supervisor's Signature _____ Date _____

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, 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 whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status 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 servicemember is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness*; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness.*

***The FMLA definitions of "serious injury or illness" for current servicemembers and veterans are distinct from the FMLA definition of "serious health condition".**

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 12 months, have 1,250 hours of service in the previous 12 months*, and if at least 50 employees are employed by the employer within 75 miles.

***Special hours of service eligibility requirements apply to airline flight crew employees.**

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; and
- 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. Regulation 29 C.F.R. § 825.300(a) may require additional disclosures.

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 | Wage and Hour Division

WHD Publication 1420 · Revised February 2013

Division of Water and Waste FMLA Policy

Division of Water and Waste Policies and Work Rules Article 9.3 FMLA Leave
Bargaining Unit Agreement AFSCME Local 1918.15 Article 12 Section 10

Family and Medical Leave Act (FMLA)

A. Eligibility: Employees who have a minimum of one (1) year's seniority and have worked a minimum of twelve hundred and fifty (1250) hours during the preceding twelve (12) month period are eligible for a Family and Medical Leave Act (FMLA) leave in accordance with existing federal statutory provisions for the following reasons:

1. The birth of the Employee's child and in order to care for the child;
2. The placement of a child with the Employee for adoption or foster care;
3. To care for a spouse, child or parent who has a serious health condition; or
4. A serious health condition that renders the Employee incapable of performing the function of his or her job.
5. Leave Related to Military Service – connection with any qualifying exigency arising out of the fact that the employee's spouse, son, daughter or parent is on active duty or has been notified of an impending call or order to active military duty in the Armed Forces in support of a contingency operation. Employees may take up to 12 weeks of leave in a 12 month period for this type of leave.
6. To Care for an Injured or Ill Service Member – Leave is available to an eligible employee whose spouse, son, daughter, parent or next-of-kin is recovering from a serious injury or illness sustained while on active military duty and who is unable to perform the duties of the service member's office, grade, rank or rating. Unlike the other types of leave available under the FMLA, an employee may take up to 26 weeks in a 12 month period for this type of leave.

NOTE: If the employee and his or her spouse are both employed by the Division and both take FMLA leave, the spouses' combined leave cannot exceed 12 weeks during any 12-month period if the leave is taken for the birth of a child, for the placement of a child with the employee for adoption or foster care, or to care for the employee's parent with a serious health condition. However, spouses may each take up to 12 weeks of leave to care for a newborn child with a serious health condition even if both are employed by the Division.

B. Duration of Leave: Employees meeting the eligibility requirements will be granted up to a total of twelve (12) weeks/60 workdays/480 hours of paid or unpaid FMLA leave and paid personal and vacation time combined during any "12-month period." Employees will be required to exhaust accumulated personal and vacation time balances prior to beginning unpaid FMLA leave but will be permitted to retain an amount of accumulated vacation time equivalent to their current annual allotment and up to a maximum of 24 hours of accumulated personal leave. The amount of leave available to the employee will be determined on a "rolling" 12-month period, measured backward from the date the employee's leave is to begin. Any leave that qualifies as a FMLA leave, according to federal statute, may be counted against an employee's 12-week-leave, whether paid or unpaid provided the employer gives proper notice as outlined in federal guidelines.

FMLA leave may be taken intermittently or on a reduced leave schedule under certain circumstances. Leave taken because of a birth or placement of a child for adoption or foster care may be taken intermittently or on a reduced leave schedule only if mutually agreed upon by the Employee and the Employer. Leave taken to care for a sick child, spouse, or parent or for an Employee's own serious health condition or covered service member may be taken intermittently or on a reduced schedule when medically necessary, as evidenced by medical certification. Intermittent Leave will be counted first in one hour increments and then half (.5) hour increments.

C. Medical Certification of Leave: An application for FMLA leave based on a serious health condition of the Employee's spouse, child, or parent, must also be accompanied by a medical certification statement, completed by the applicable health care provider within 15 calendar days of application. If needed, the employee may request up to two (2) extensions of three (3) days per extension to submit such documentation. For employees requesting leave related to Military Service must provide proof of the qualifying family member's call-up or active military service. This documentation may include a copy of the military orders or other official communications. For Employees who are covered by the Employer's sick/accident insurance, the completed sick leave forms shall serve as the medical leave forms, which shall serve as the medical certification statement. For an Employee out on Workers Compensation lost time, the physicians' report shall serve as the medical certification statement. The completed medical certification statement must state the date on which the health condition commenced, the probable duration of the condition, and the appropriate medical facts regarding the condition. If the Employee is needed to care for a spouse, child, or parent, the medical certification statement must so state, along with an estimate of the amount of time the Employee will be needed. If the Employee has a serious health condition, the medical certification statement must document that the Employee cannot perform the functions of his/her job.

D. Group Health Benefits Coverage during Leave: During a period of FMLA leave, an Employee will be retained on their current group health plans (life, dental, optical, and hospital medical insurances) under the same conditions that applied before the leave commenced.

E. Restoration to Employment and Seniority Accumulation: An Employee returning from FMLA leave will be restored to his/her old position or to a position with equivalent pay, benefits, and other terms and conditions of employment. When an employee is on intermittent or reduced schedule leave caused by foreseeable medical treatment, the Employer may temporarily transfer an employee to an equivalent hourly pay and benefits that will be better accommodate the Employer's needs and the Employee's recurring periods of leave. The Employer will first attempt to place them at their facility but if no opening exits the Employer will place them at another facility within the Division. Upon discontinuation of intermittent or reduced schedule leave, the employee will then transfer back to the position/shift from which they were transferred. An Employee is not entitled to the accrual of any seniority or employment benefits (vacation time, personal days, or holidays) that would have accrued if not for the taking of unpaid FMLA leave, with the exception that an Employee who takes an unpaid FMLA leave will not lose seniority for the first thirty (30) calendar days of said unpaid FMLA leave. Any Employee who takes FMLA leave will not lose any seniority or employment benefits that accrued before the date of the leave began. Employees on such leave will also accumulate retirement credit if the employee submits both the Employer and employee contributions for the duration of time the employee is off. The Employee will need to make application with the Retirement office for the contribution amount and conditions of repayment.