

**Family and Medical Leave Act of 1993  
Hill AFB Guidelines and Procedures**

1. The following are Hill AFB Guidelines and Procedures for the Family and Medical Leave Act of 1993 (FMLA), which must be utilized in conjunction with the Code of Federal Regulations (CFR), 5 CFR, Part 630, Subpart L, Family and Medical Leave (available at <http://www.gpoaccess.gov/cfr/index.html>). It entitles most federal employees a total of up to 12 administrative workweeks of leave without pay (LWOP) during any 12-month period for certain family and medical needs.

2. Most federal employees under appropriated funds, as defined in United States Code (USC) at 5 USC 6381(1), who have completed at least 12 months of qualified service, are covered. Employees on intermittent appointment or temporary appointment of one year or less are excluded.

3. Covered employees with an approved request are entitled to:

a. The amount necessary up to a total of 12 administrative workweeks of LWOP during any 12-month period, beginning on the date the leave begins, for one or more of the following qualifying events:

(1) Birth of a son or daughter of the employee and in order to care for such son or daughter.

(2) Placement of son or daughter with the employee for adoption or foster care.

(3) To care for the employee's spouse, son, daughter, or parent, due to their serious health condition as defined in 5 CFR 630.1202 (serious health conditions are also described on page 4 of Form WH-380-E – see paragraph 4b below).

(4) Because of a serious health condition, as defined in 5 CFR 630.1202 (serious health conditions are also described on page 4 of Form WH-380-E, see paragraph 4b below), which makes the employee unable to perform one or more of the “essential functions” of his or her position (determined by the supervisor, see also the position description/core document).

(5) **Added January 2009 – Military Family Leave Entitlements** – Eligible employees with a spouse, son, daughter, or parent on active duty or called to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12 week entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative child care, addressing certain financial or legal arrangements, attending certain counseling sessions, and attending post-deployment and reintegration briefings.

(6) **Added January 2009 – Military Family Leave Entitlements** - FMLA now also includes special leave entitlements that permit eligible employees to take up to 26 weeks of leave to care for a covered service member (who has a serious injury or illness incurred in the line of duty and is undergoing medical treatment, recuperation, or therapy), during a single 12 month period.

b. Protection of employment benefits, as described in 5 CFR 630.1208 and 1209. If elected, Federal Employees Health Benefits continue for up to 365 days in a nonpay status. Utilizing the **Benefits Summary for Civilian Employees on LWOP** (attachment 1 or the most current version at [http://ask.afpc.randolph.af.mil/docs/best/docs/5684\\_LWOPBenefitsSummary.pdf](http://ask.afpc.randolph.af.mil/docs/best/docs/5684_LWOPBenefitsSummary.pdf)), the employee may elect termination of health benefits or retention of health benefits with a designation of how the employee's share of the premiums will be paid.

c. Accrued or advanced annual or sick leave may be substituted for unpaid leave under FMLA consistent with current law and regulations governing the use of annual or sick leave and when requested in advance. Leave donated to the employee under the Voluntary Leave Donation Program may also be substituted under FMLA or used separately. Substitution of paid leave for unpaid leave under FMLA cannot be done retroactively.

#### 4. Employee Responsibilities:

a. Invoke entitlement by requesting leave under FMLA in accordance with **Employees Rights and Responsibilities** (attachment 2). This can be done by utilizing block 5 of **OPM Form 71, Request for Approved Absence** (attachment 3), in addition to completing blocks 1 through 7b. Include what type of leave (LWOP and/or substituted paid leave) is desired. Paid leave may not be substituted retroactively. See paragraph 6 below if use will be intermittent. Provide the completed OPM Form 71 to the immediate supervisor as follows:

(1) If foreseeable, at least 30 days prior to start date, provide the applicable medical certification or evidence described below in paragraph b or c within 15 days of the date the entitlement is invoked.

(2) If events beyond the control of the employee prevent the employee from making the request 30 days in advance, make the request as soon as practicable for the circumstances involved prior to the absence. In emergency situations, notice from an employee's personal representative (spouse, domestic partner, family member, or other responsible party) as designated in writing by the employee will suffice until the employee is able to contact the supervisor and within 15 days of the emergency notice provide the leave form and medical certification. If despite the employee's diligent, good faith efforts, the medical certification cannot be provided within 15 days of contact, it must be provided no later than 30 days.

b. For the purpose of 3a (3) and (4) the employee must also provide acceptable medical certification on **Form WH-380-E, Certification of Health Care Provider for Employee's Serious Health Condition** (attachment 4) or **Form WH-380-F, Certification of Health Care Provider for Family Member's Serious Health Condition** (attachment 5) to satisfy the mandatory requirement to furnish medical certification (IAW 5 CFR 630.1207) completed by a qualified health care provider, as defined in 5 CFR 630.1202. Also, under 3a (4) it is necessary to provide the health care provider with information on the "essential functions" of the employee's position (determined and provided by the supervisor, see

also the position description). Report status and intent to return to duty periodically. Failure to provide medical certification may result in unauthorized absence without leave (AWOL) charges and may form the basis for disciplinary action.

c. For the purpose of 3a (1) and (2) the employee must provide evidence that is administratively acceptable.

d. For the purpose of 3a (5) and (6) the employee may provide certification of military exigency on **Form WH-384, Certification of Qualifying Exigency for Military Family Leave** (attachment 6) or **Form WH-385, Certification for Serious Injury or Illness of Covered Servicemember for Military Family Leave** (attachment 7).

d. An employee may not retroactively invoke his or her entitlement to FMLA leave. However, if an employee and their personal representative are physically or mentally incapable of invoking the employee's entitlement to FMLA leave during the entire period of absence from work for a qualifying event, the employee may retroactively invoke his or her entitlement within two workdays after returning to work. Medical certification must then be provided within 15 days of invoking the entitlement. In addition to the medical certification, the employee will provide acceptable documentation explaining the inability of the representative to contact the agency and invoke the employee's entitlement to FMLA during the entire period of absence within 15 days of invoking the entitlement.

e. If an extension of the original leave period is requested, or the circumstances described in the original medical certification change significantly, or receipt of information casts doubt upon validity of the original medical certification, the employee may be required to provide updated medical certification on Form WH-380-E or WH-380-F (as appropriate).

f. To remain entitled to FMLA under 3a(3) and (4), an employee or the employee's family member must comply with any requirement from the agency to submit to examination (though not treatment) to obtain a second or third medical certification at the agency's expense from a health care provider designated by the agency.

#### 5. Supervisory responsibilities:

a. Confirm that the employee is invoking his or her entitlement to FMLA and determine eligibility for FMLA within five business days. If request is provided verbally, provide an OPM Form 71 and request that the employee complete it as described above in paragraph 4a.

(1) If the purpose is under 3a (4), provide a copy of the position description to the employee and indicate which duties are the "essential function" or fundamental job duties of the position (see 29 CFR 1630.2(n)).

(2) Within five business days, annotate the OPM Form 71 appropriately as follows: **provisionally approved**, "pending receipt of acceptable evidence or medical certification of a qualifying event within 15 days" or "pending determination regarding the documentation received;" **approved**, based on the receipt of acceptable evidence or medical certification for a qualifying event; **disapproved**, "evidence or medical certification is not based on qualifying event" and when determined after the fact,

"your absence has been charged as AWOL," unless other leave has been authorized. See also paragraph 6 below regarding intermittent use.

b. Regarding the medical certification, if the validity is in doubt, reasonableness of the amount of leave or treatment is in doubt, it is incomplete, or it is not received, the supervisor will contact their Employee Management Relations (EMR) Specialist in Civilian Personnel for further direction (see also 5 CFR 630. 1207 (d)). The supervisor will also contact their specialist if an alternate position is considered, due to the impact of the medical condition on the employee's ability to perform the essential functions of their job.

c. Provide a copy of the annotated OPM Form 71 to the EMR Specialist by mail to OO-ALC/DPCE or fax to 777-8479.

d. Up to 30 consecutive days of LWOP are documented in the timekeeping system. Initiate a Request for Personnel Action (RPA) for LWOP of 30 consecutive days or more and another for the return to duty as appropriate.

e. The supervisor will monitor the amount of leave used under FMLA, maintain these records within the Employee's Supervisory Record, and ensure FMLA leave does not exceed 12 administrative workweeks during any 12 month period beginning on the date the leave begins. An employee is not entitled to 12 additional workweeks of FMLA leave until the previous 12 month period ends and an event occurs that entitles the employee to another period of FMLA leave (may include a continuation of a previous situation).

f. Supervisors safeguard medical certifications from unauthorized access, use, modification, destruction or disclosure. Ensure the records are secured whenever they are not in use or under the direct control of authorized persons. Medical documentation that includes information beyond current work restrictions should be forwarded to Occupational Medical Services (OMS). Maintain certification until no longer applicable.

g. If the employee requests an extension of the original leave period, or the circumstances described in the original medical certification change significantly, or receipt of information casts doubt upon validity of the medical certification, the employee may be required to provide an updated medical certification on Form WH-380-E or WH-380-F (as appropriate). When these situations arise, supervisors will contact their EMR Specialist for further direction.

**6. Intermittent Leave Usage.** Supervisors may authorize intermittent leave usage or a reduced work schedule under 3a(3) and (4) when medically necessary and under 3a(1), (2) and 3a(5) and (6) if mutually agreed.

a. If the use of FMLA leave is required on an intermittent basis, the employee must indicate this in the notice of leave and obtain approval from the supervisor. The employee must consult with the supervisor and make a reasonable effort to schedule leave and treatment so as not to unduly disrupt the operations of the agency. Applicable leave requesting procedures must be adhered to when seeking intermittent FMLA usage.

b. The employee may be temporarily placed in another position, for which qualified and at the same pay, to better accommodate recurring periods of leave if required by the immediate supervisor. If this is the case the supervisor should contact their ERS for additional guidance. The branch chief or equivalent will determine whether the alternative position meets the criteria set forth in 5 CFR 630.1204 (d) and will document this decision in the FMLA file maintained within the Employee Supervisory Records.

#### 7. Miscellaneous.

a. An employee who takes leave under FMLA for his or her own serious health condition will report to the Civilian Dispensary, Building 249, upon returning to work.

b. If the employee is not fully recovered when he or she returns to work, other leave may be requested and considered in accordance with applicable policies and procedures. If the employee will be unable to return to work, the supervisor will contact their EMR Specialist for further direction.

c. Disciplinary action may be taken against an employee who provides false certification of the need for leave.

d. Employees may file a grievance under the agency's grievance procedures or negotiated grievance procedures if he or she believes that the agency has not fully complied with the rights or requirements of the FMLA.

#### 7 Attachments

1. Benefits Summary for Civilian Employees on LWOP
2. Employee Rights and Responsibilities
3. **OPM Form 71**, Request for Approved Absence
4. **Form WH-380-E**, Certification of Health Care Provider for Employee's Serious Health Condition
5. **Form WH-380-F**, Form WH380-F, Certification of Health Care Provider for Family Member's Serious Health Condition
6. **Form WH-384**, Certification of Qualifying Exigency for Military Family Leave
7. **Form WH-385**, Certification for Serious Injury or Illness of Covered Service member for Military Family Leave

## Request for Leave or Approved Absence

1. Name (Last, first, middle)	2. Employee or Social Security Number
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3. Organization

4. Type of Leave/Absence						5. Family and Medical Leave
Check appropriate box(es) and enter date and time below						If annual leave, sick leave, or leave without pay will be used under the Family and Medical Leave Act of 1993 (FMLA), please provide the following information:
Date		Time		Total Hours		
From	To	From	To			
<input type="checkbox"/> Accrued annual leave						<input type="checkbox"/> I hereby invoke my entitlement to family and medical leave for: <input type="checkbox"/> Birth/Adoption/Foster care  <input type="checkbox"/> Serious health condition of spouse, son, daughter, or parent  <input type="checkbox"/> Serious health condition of self  <i>Contact your supervisor and/or your personnel office to obtain additional information about your entitlements and responsibilities under the FMLA. Medical certification of a serious health condition may be required by your agency.</i>
<input type="checkbox"/> Restored annual leave						
<input type="checkbox"/> Advance annual leave						
<input type="checkbox"/> Accrued sick leave						
<input type="checkbox"/> Advance sick leave						
Purpose: <input type="checkbox"/> Illness/injury/incapacitation of requesting employee <input type="checkbox"/> Medical/dental/optical examination of requesting employee <input type="checkbox"/> Care of family member, including medical/dental/optical examination of family member, or bereavement <input type="checkbox"/> Care of family member with a serious health condition <input type="checkbox"/> Other						
<input type="checkbox"/> Compensatory time off						
<input type="checkbox"/> Other paid absence (specify in remarks)						
<input type="checkbox"/> Leave without pay						

6. Remarks

7. **Certification:** I certify that the leave/absence requested above is for the purpose(s) indicated. I understand that I must comply with my employing agency's procedures for requesting leave/approved absence (and provide additional documentation, including medical certification, if required) and that falsification of information on this form may be grounds for disciplinary action, including removal.

7a. Employee signature	7b. Date signed
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8a. Official action on request  Approved  Disapproved *(If disapproved, give reason. If annual leave, initiate action to reschedule.)*

8b. Reason for disapproval:

8c. Signature	8d. Date signed
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**Privacy Act Statement**  
 Section 6311 of title 5, United States Code, authorizes collection of this information. The primary use of this information is by management and your payroll office to approve and record your use of leave. Additional disclosures of the information may be: To the Department of Labor when processing a claim for compensation regarding a job connected injury or illness; to a State unemployment compensation office regarding a claim; to Federal Life Insurance or Health Benefits carriers regarding a claim; to a Federal, State, or local law enforcement agency when your agency becomes aware of a violation or possible violation of civil or criminal law; to a Federal agency when conducting an investigation for employment or security reasons; to the Office of Personnel Management or the General Accounting Office when the information is required for evaluation of leave administration; or the General Services Administration in connection with its responsibilities for records management.

Public Law 104-134 (April 26, 1996) requires that any person doing business with the Federal Government furnish a social security number or tax identification number. This is an amendment to title 31, Section 7701. Furnishing the social security number, as well as other data, is voluntary, but failure to do so may delay or prevent action on the application. If your agency uses the information furnished on this form for purposes other than those indicated above, it may provide you with an additional statement reflecting those purposes.

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



OMB Control Number: 1215-0181  
Expires: 12/31/2011

**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.

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: \_\_\_\_\_

**Mark below as applicable:**

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?  
 No  Yes. If so, dates of admission:

\_\_\_\_\_

Date(s) you treated the patient for condition:

\_\_\_\_\_

Will the patient need to have treatment visits at least twice per year due to the condition?  No  Yes.

Was medication, other than over-the-counter medication, prescribed?  No  Yes.

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?  
 No  Yes. If so, state the nature of such treatments and expected duration of treatment:

\_\_\_\_\_

2. Is the medical condition pregnancy?  No  Yes. If so, expected delivery date: \_\_\_\_\_

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition:  No  Yes.

If so, identify the job functions the employee is unable to perform:

\_\_\_\_\_

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PART B: AMOUNT OF LEAVE NEEDED**

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery?  No  Yes.

If so, estimate the beginning and ending dates for the period of incapacity: \_\_\_\_\_

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition?  No  Yes.

If so, are the treatments or the reduced number of hours of work medically necessary?  
 No  Yes.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

\_\_\_\_\_

Estimate the part-time or reduced work schedule the employee needs, if any:

\_\_\_\_\_ hour(s) per day; \_\_\_\_\_ days per week from \_\_\_\_\_ through \_\_\_\_\_

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions?  No  Yes.

Is it medically necessary for the employee to be absent from work during the flare-ups?  
 No  Yes. If so, explain:

\_\_\_\_\_

\_\_\_\_\_

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: \_\_\_\_\_ times per \_\_\_\_\_ week(s) \_\_\_\_\_ month(s)

Duration: \_\_\_\_\_ hours or \_\_\_\_\_ day(s) per episode

**ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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