

**FAX**



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**FMLA**

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**To:** Denise Muse

**From:**

**Location:**

**Date:**

**Fax:** 856-528-2123

**Pages:** *(including cover)*

**Re:**

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***Any trouble or questions please call: 856-470-1161***

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**Message:**

<b>Section 1</b>	<b>Last Name</b>	<b>First Name</b>	<b>Employee ID #</b>
	<b>Address</b>		<input type="checkbox"/> Check box if this is a new address
	<b>City</b>	<b>State</b>	<b>Zip</b>
	<b>Email</b>	<b>Phone</b>	<b>DOB</b>
<b>Section 2</b>	<b>Is this request for a FML Qualifying Reason?</b>		
	1. Birth of a child? Date of the child's birth _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<b>Baby Bonding Leave</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<ul style="list-style-type: none"> <li>• Each instance of bonding requires notice to your employer.                             <ul style="list-style-type: none"> <li>○ 15 days' notice is required for intermittent leave</li> <li>○ 30 days' notice is required for block leave.</li> </ul> </li> <li>• Proof of Birth</li> </ul>		
	2. Placement of child for adoption?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	3. Placement of child for foster care?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	4. School Closure due to COVID-19		<input type="checkbox"/> Yes <input type="checkbox"/> No
	5. Care of a family member?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	6. Qualifying Exigency for Military Leave		
	<ul style="list-style-type: none"> <li>• Military Service Orders attached <input type="checkbox"/> Yes <input type="checkbox"/> No</li> </ul>		<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Serious Health Condition of Covered Service Member – for Military Family Member		<input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Serious Health Condition (The employee's own condition that prevents him/her from performing the essential function of his/her job, or the care of employee's spouse, child, or parent) involving one of the following:			
a. Inpatient Care, period of incapacity and subsequent treatment related to same?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
b. Incapacity of more than 3 calendar days with treatment 2 or more times?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
c. Incapacity of more than 3 calendar days with one treatment resulting in therapy or prescription?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
d. Prenatal care or incapacity due to pregnancy?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
e. Incapacity (or treatment) due to chronic serious health condition?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
f. Incapacity, permanent or long term, for which treatment may not be effective?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
g. Absence for multiple treatments for restorative surgery, radiation, physical therapy, etc.		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If NO to all of the above, Form WH-382 will be sent to notify you that you are ineligible for FMLA.			
If YES to any question in section 2, complete section 3, questions 2-6 below:			
<b>Section 3</b>	<b>Has Medical Certification Been Submitted to Point C?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If not already received, Point C will request employee to submit medical documentation for the medical		
	<b>Leave Request Dates</b>		
	Leave Beginning: _____ Leave Ending: _____ Last Day Worked: _____		
	<b>Is this leave request for Intermittent Leave?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, appointment verifications must be submitted to your department heads/designee for each physicians visit. All medical documentation should be submitted directly to Point C.			
<b>List all paid time you would like to utilize for this leave if applicable.</b>			
In most cases you are required to use all available accrued sick and personal leave as part of your FML. Some leaves may require the use of other available paid time off. Additional paid leave (if available) can be utilized once the required paid leave is exhausted. Please specify additional paid time you would like to use:			
<b>Sick:</b> Hours _____ / Days _____		<b>Vacation:</b> Hours _____ / Days _____	
<b>Other:</b> Hours _____ / Days _____		<b>Personal:</b> Hours _____ / Days _____	
<b>Fraud Warning:</b> Filing a claim with materially false and/or misleading information is a crime and may be subject to criminal charges in addition to disciplinary action up to and including termination from employment with the County of Monmouth.			

Submit Forms to Point C

Fax: 856-528-2123 ~ Email: [fmla@pointchealth.com](mailto:fmla@pointchealth.com) Mail: Point C

FMLA P.O.Box 25247 Overland Park, KS 66225

Certification of Health Care Provider for Employee's Serious Health Condition under the 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: 6/30/2026

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. 29 U.S.C. §§ 2613, 2614(c)(3); 29 C.F.R. § 825.305. The employer must give the employee at least 15 calendar days to provide the certification. If the employee fails to provide complete and sufficient medical certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

SECTION I - EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, this form asks the health care provider for the information necessary for a complete and sufficient medical certification, which is set out at 29 C.F.R. § 825.306. You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Additionally, you may not request a certification for FMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care.

Employers must generally maintain records and documents relating to medical information, 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, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

(1) Employee name: \_\_\_\_\_
First Middle Last

(2) Employer name: \_\_\_\_\_ Date: \_\_\_\_\_ (mm/dd/yyyy)
(List date certification requested)

(3) The medical certification must be returned by \_\_\_\_\_ (mm/dd/yyyy)
(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee's diligent, good faith efforts.)

(4) Employee's job title: \_\_\_\_\_ Job description [ ] is / [ ] is not attached.

Employee's regular work schedule: \_\_\_\_\_

Statement of the employee's essential job functions:

(The essential functions of the employee's position are determined with reference to the position the employee held at the time the employee notified the employer of the need for leave or the leave started, whichever is earlier.)

SECTION II - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form. Your patient has requested leave under the FMLA. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of the employee. For FMLA purposes, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves inpatient care or continuing treatment by a health care provider. For more information about the definitions of a serious health condition under the FMLA, see the chart on page 4.

You also may, but are not required to, provide other appropriate medical facts including symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment. Please note that some state or local laws may not allow disclosure of private medical information about the patient's serious health condition, such as providing the diagnosis and/or course of treatment.

Employee Name: \_\_\_\_\_

Health Care Provider's name: (Print) \_\_\_\_\_

Health Care Provider's business address: \_\_\_\_\_

Type of practice / Medical specialty: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

**PART A: Medical Information**

Limit your response to the medical condition(s) for which the employee is seeking FMLA leave. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. **After completing Part A, complete Part B to provide information about the amount of leave needed.** Note: For FMLA purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

(1) State the approximate date the condition started or will start: \_\_\_\_\_ (mm/dd/yyyy)

(2) Provide your **best estimate** of how long the condition lasted or will last: \_\_\_\_\_

(3) Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

**Inpatient Care:** The patient (  has been /  is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): \_\_\_\_\_

**Incapacity plus Treatment:** (e.g. outpatient surgery, strep throat)  
Due to the condition, the patient (  has been /  is expected to be) incapacitated for **more than** three consecutive, full calendar days from: \_\_\_\_\_ (mm/dd/yyyy) to \_\_\_\_\_ (mm/dd/yyyy).  
The patient (  was /  will be) seen on the following date(s): \_\_\_\_\_

The condition (  has /  has not) also resulted in a course of continuing treatment under the supervision of a health care provider (e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment).

- Pregnancy:** The condition is pregnancy. List the expected delivery date: \_\_\_\_\_ (mm/dd/yyyy).
- Chronic Conditions:** (e.g. asthma, migraine headaches) Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.
- Permanent or Long Term Conditions:** (e.g. Alzheimer's, terminal stages of cancer) Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).
- Conditions requiring Multiple Treatments:** (e.g. chemotherapy treatments, restorative surgery) Due to the condition, it is medically necessary for the patient to receive multiple treatments.
- None of the above:** If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed. Go to page 4 to sign and date the form.

**Employee Name:** \_\_\_\_\_

(4) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. (e.g., use of nebulizer, dialysis)

\_\_\_\_\_

**PART B: Amount of Leave Needed**

For the medical condition(s) checked in Part A, complete all that apply. 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.

(5) Due to the condition, the patient (  had /  will have) **planned medical treatment(s)** (scheduled medical visits) (e.g. psychotherapy, prenatal appointments) on the following date(s): \_\_\_\_\_

(6) Due to the condition, the patient (  was /  will be) **referred to other health care provider(s)** for evaluation or treatment(s). State the nature of such treatments: (e.g. cardiologist, physical therapy) \_\_\_\_\_

Provide your **best estimate** of the beginning date \_\_\_\_\_ (mm/dd/yyyy) and end date \_\_\_\_\_ (mm/dd/yyyy).

for the treatment(s).

Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery (e.g. 3 days/week)

\_\_\_\_\_

(7) Due to the condition, it is medically necessary for the employee to work a **reduced schedule**.

Provide your **best estimate** of the reduced schedule the employee is able to work. From \_\_\_\_\_ (mm/dd/yyyy)

to \_\_\_\_\_ (mm/dd/yyyy) the employee is able to work: (e.g., 5 hours/day, up to 25 hours a week)

\_\_\_\_\_

(8) Due to the condition, the patient (  was /  will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.

Provide your **best estimate** of the beginning date \_\_\_\_\_ (mm/dd/yyyy) and end date \_\_\_\_\_ (mm/dd/yyyy).

for the period of incapacity.

(9) Due to the condition, it (  was /  is /  will be) medically necessary for the employee to be absent from work on an intermittent basis (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, episodes of incapacity are estimated to occur \_\_\_\_\_ times per (  day  week  month) and are likely to last approximately \_\_\_\_\_ (  hours  days) per episode.

Employee Name: \_\_\_\_\_

**PART C: Essential Job Functions**

If provided, the information in Section I question #4 may be used to answer this question. If the employer fails to provide a statement of the employee's essential functions or a job description, answer these questions based upon the employee's own description of the essential job functions. An employee who must be absent from work to receive medical treatment(s), such as scheduled medical visits, for a serious health condition is considered to be **not able** to perform the essential job functions of the position during the absence for treatment(s).

(10) Due to the condition, the employee (  was not able /  is not able /  will not be able ) to perform **one or more** of the essential job function(s). Identify at least one essential job function the employee is not able to perform:

Signature of Health Care Provider \_\_\_\_\_ Date: \_\_\_\_\_ (mm/dd/yyyy)

<b>Definitions of a Serious Health Condition</b> (See 29 C.F.R. §§ 825.113-.115)
<b>Inpatient Care</b> <ul style="list-style-type: none"><li>• An overnight stay in a hospital, hospice, or residential medical care facility.</li><li>• Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.</li></ul>
<b>Continuing Treatment by a Health Care Provider (any one or more of the following)</b>
<b>Incapacity Plus Treatment:</b> A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either: <ul style="list-style-type: none"><li>o Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or,</li><li>o At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.</li></ul>
<b>Pregnancy:</b> Any period of incapacity due to pregnancy or for prenatal care. _____
<b>Chronic Conditions:</b> Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.
<b>Permanent or Long-term Conditions:</b> A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.
<b>Conditions Requiring Multiple Treatments:</b> Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.

**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 15 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 Avenue, N.W., Washington, D.C. 20210.

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

# EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT

## Basic Leave Entitlement

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

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

## Military Family Leave Entitlements

Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

## Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

## Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least one year, for 1,000 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

## Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

## Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

## Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

## Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

## Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

## Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

## Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

**FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.**



For additional information:  
1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627  
[WWW.WAGEHOUR.DOL.GOV](http://WWW.WAGEHOUR.DOL.GOV)



**FAX**



# FMLA – Return to Work Certification

To: **Point C – FMLA**

From:

Fax: **856-528-2123**

Date:

**Monmouth County Employee**

Pages: **MULTI** *(including cover)*

Patient:

DOB:

***Any trouble or questions please call: 856-470-1161***

In order for the above named patient to be cleared to return to work, their return to work certification must indicate that you have reviewed their job description and have cleared them for all activities. A copy of the patient's job description is attached (if available).

By checking below you are confirming that the above named patient is or is not released to full duty in accordance with their job description:

**CHECK ONLY ONE:**

**TO RETURN TO WORK, Please check and enter return to work date below:**

- The above named patient is released to full duty on \_\_\_\_\_.
- The above named patient is released to work with limitations on \_\_\_\_\_  
*(specify below)*

If limitations apply, an end date is required: \_\_\_\_\_

- The above named patient holds a Commercial Driver's License (CDL).
- Must be able to meet the requirements to be firearms qualified and possess a firearm both on and off duty.

**LEAVE EXTENSIONS, Please check, enter anticipated return date, and complete physician's section:**

- Based on my review of the above named patients job description, he/she may not return to work at this time. It is anticipated that he/she may return on \_\_\_\_\_.

Physician's Name:  
*(please print)*

\_\_\_\_\_

Physician's Address:

\_\_\_\_\_

Physician's Phone number:

\_\_\_\_\_

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

**FRAUD WARNING**

**Filing a claim with materially false and/or misleading information is a crime and may be subject to criminal charges in addition to disciplinary action up to and including termination from employment with the County of Monmouth.**

P.O. Box 25247 Overland Park, KS 66225

1-856-470-1161 • Fax: 1-856-528-2123

email: FMLA@pointhealth.com

# **Instructions**

**for**

## **Return to Work Certification**

Prior to your Return to Work the "Return to Work Certification" must be completed by your attending physician. Once your specific job description has been reviewed by your attending physician and you have been cleared for all activities, you may fax the signed Return to Work Certification to:

### **POINT C**

attn: FMLA (856) 528-2123

Your job description may be obtained from the Monmouth County website, contacting your immediate supervisor, or contacting POINT C.