EMPLOYEE REQUEST FOR FAMILY OR MEDICAL LEAVE

I, _____, an employee with Sampson County_____ Department would like to request leave from _____to _____ for the following reason(s):

Medical Leave (family or self) _____
(Length of Leave Requested)

Family Maternity/Child Placement _____
(Length of Leave Requested)

I understand that I must meet the guidelines for this leave and attach a physician's certification or justification of the medical leave (whether on myself or a family member). I further acknowledge that I will be responsible for any co-payment in regard to any insurance deduction. In the event of my failure to return to work, I understand that I may have to reimburse the County for any premiums paid for Blue Cross health insurance and to Prudential for dental insurance for any premiums paid for insurance during my absence.

Pay-back will be determined by the current cost of the premium multiplied by the number of months, or partial months (based on our personnel resolution, an employee's insurance will be paid if he/she is in a leave earning capacity for at least one-half (1/2) of the month) of leave-without-pay.

I am aware that any paid leave (sick or vacation), which I have earned or will earn while on paid leave, will be exhausted before leave-without-pay will be considered.

_____ _____
Employee's Signature Date

Recommending approval/disapproval

_____ _____
Department Head's Signature Date

Recommending approval/disapproval

_____ _____
County Manager's Signature Date

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Leave Balances for Finance Office Use Only

Vacation Leave _____ Sick Leave _____ FMLA _____

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A copy of this form was returned to the employee on _____ by mail (_____) or interoffice correspondence (_____).

SAMPSON COUNTY - FAMILY AND MEDICAL LEAVE ACT
CERTIFICATION OF HEALTH CARE PROVIDER

Employee _____

Department _____

Patient's Name _____

Employee's Relationship to Patient _____

The attached sheet describes what is meant by a "serious health condition" under the Family and Medical Leave Act. Does the patient's condition[1] qualify under any of the categories described? If so, please check the applicable category.

(1) _____ (2) _____ (3) _____ (4) _____ (5) _____ (6) _____ or None _____

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

State the approximate date the condition commenced, and the probable duration of the condition (and also the probable duration of the patient's present incapacity[2] if different):

Will it be necessary for the employee to take intermittent leave as a result of the condition?
Yes_____ No _____

If yes, give the probable duration:

If the condition is a chronic condition or pregnancy, state whether the patient is presently incapacitated[2] and the likely duration and frequency of episodes of incapacity[2] :

If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments:

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

[2] **"Incapacity,"** for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefor or recovery therefrom.

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

If any of the treatments will be provided by another provider of health services (e.g., physical therapist), please state the nature of the treatments:

If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment):

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

If able to perform some work, is the employee unable to perform any one or more of the essential functions of the employee's job (information about job functions will be supplied if requested)?_____ If yes, please list the essential functions the employee is unable to perform:

If neither of the previous two conditions applies, is it necessary for the employee to be absent from work for treatment?_____

If leave is required to care for a family member of the employee with a serious health condition, does the patient require assistance for basic medical or personal needs or safety, or for transportation?_____

If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery?_____

If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need:

_____ _____

Signature of Provider Type of Practice

_____ _____

Address Telephone Number

TO BE COMPLETED BY THE EMPLOYEE NEEDING FAMILY LEAVE TO CARE FOR A FAMILY MEMBER:

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

_____ _____

Employee Signature Date

SERIOUS HEALTH CONDITION

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

1) Hospital Care

Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity[2] or subsequent treatment in connection with or consequent to such inpatient care.

2) Absence Plus Treatment

a) A period of incapacity[2] of more than three consecutive calendar days (including any subsequent treatment or period of incapacity[2] relating to the same condition), that also involves:

i) Treatment[3] two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or

i) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment[4] under the supervision of the health care provider.

3) Pregnancy

Any period of incapacity due to pregnancy, or for prenatal care.

4) Chronic Conditions Requiring Treatments

A chronic condition which:

a) Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;

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

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

b) Continues over an extended period of time (including recurring episodes of a single underlying condition); and

c) May cause episodic rather than a continuing period of incapacity[2] (e.g., asthma, diabetes, epilepsy, etc.).

5) Permanent/Long-term Conditions Requiring Supervision:

A period of incapacity[2] which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

6) Multiple Treatments (Non-Chronic Conditions)

Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity[2] of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).