ATTACHMENT A
JEFFERSON COUNTY
REQUEST FOR FAMILY/MEDICAL LEAVE RIGHTS & RESPONSIBILITIES

1. Name _____ SS. # _____
2. Position _____ Dept. _____
   Hire Date _____ Phone # _____
3. Reason for requested leave:
   a. ☐ for the birth of my child, and to care for such child
   b. ☐ for the placement of a child with me for adoption or foster care
   c. ☐ to care for my spouse, child or parent with a serious health condition
   d. ☐ for my own serious health condition which has made me unable to perform my job functions
   e. ☐ because of a qualifying exigency arising out of the fact that my spouse, son or daughter, or parent is on covered active duty or call to covered active duty status with the Armed Forces; or
   f. ☐ because I am the spouse, son or daughter, parent, next of kin of a covered servicemember with a serious injury or illness.
4. Date on which you ☐ wish to begin ☐ began leave: _____
5. Date of anticipated return to work: _____
6. Are you requesting leave on an intermittent or reduced schedule? ☐ Yes ☐ No
   If yes, please give schedule or when you anticipate you will be unavailable for work.

_____

I understand that I must provide 30 days' advance notice for requesting FMLA leave when the leave is foreseeable.
I also understand that a Certification of Health Care Provider Form (Attachment C)/Certification of Qualifying Exigency For Military Family Leave Form (WH-384)/ Certification for Serious Injury or Illness of a Current Servicemember for Military Family Leave Form (WH-385)/Certification for Serious Injury or Illness of a Veteran for Military Caregiver Leave (WH-385-V) must be completed by my health care professional and returned within 15 days after I notify you of this leave. I understand that my leave may be delayed until I provide such certification from a physician. I understand that falsification of any document or failure to produce required certifications relating to leave will result in discipline, up to and including termination.
If my request for leave falls under 3e above, I understand a copy of the active duty orders or other documentation from the military certifying the covered military member is on active duty (or has been notified of an impending call to active duty) should be submitted within 15 days after I notify you of this leave by completing the Qualifying Exigency For Military Family Leave Form (WH-384).
I hereby agree that while I am on leave I will continue to pay my portion of dependent health insurance premiums and voluntary benefit premiums unless I elect to discontinue such coverage. I also agree that if I fail to return to work at the end of the leave period, I will reimburse Jefferson County for the cost of health benefits provided by Jefferson County during my leave, unless I fail to return to work because of the continuation, recurrence or onset of a serious health condition or because of other circumstances beyond my control. If I am unable to return to work because of a serious health condition, I will provide medical certification from the appropriate health care provider stating that I am unable to perform the functions of my position on the date that my leave expired or that I was needed to care for a covered relation because he/she has a serious health condition on the date that my leave expired. Employees seeking to return to work after a leave because of their own serious illness (3.d) must furnish to the County a return-to-work release from the attending physician before being allowed to resume work.
I understand I will be required to use all available paid leave in the following order; sick leave; compensatory time; vacation; and personal leave, prior to being eligible for unpaid leave. All forms of paid leaves used run concurrently with FMLA leave.

Signature _____ Date _____

Note: Nothing herein shall be construed as contradicting or superseding any portion of the FMLA or Jefferson County Policy. Any questions arising from use of this form should be directed to the Human Resources Director.

ATTACHMENT B
JEFFERSON COUNTY
EMPLOYER NOTICE OF ELIGIBILITY/RIGHTS & RESPONSIBILITIES/DESIGNATION OF FAMILY/MEDICAL LEAVE

Date: _____

To: _____ SS# _____
(Employee's Name)

Subject: Designation of Family/Medical Leave

On _____, you notified us/we became aware of your need to take family/medical leave due to:
(date)

- o a. the birth of a child, or the placement of a child for adoption or foster care; or
- o b. a serious health condition that you need to care for; or
- o c. a serious health condition affecting your o spouse, o child, o parent for which you are needed to provide care; or
- o d. because of a qualifying exigency arising out of the fact that your o spouse, o son or daughter, or o parent is on covered active duty or call to covered active duty status with the Armed Forces; or
- o e. because you are the o spouse, o son or daughter, o parent, o next of kin of a covered servicemember with a serious injury or illness.

This leave o will begin o began on or about _____ and you expect the leave to continue until on or about _____.
(date) (date)

You have a right under the FMLA for up to 12 workweeks of unpaid leave in a rolling 12-month period (unless you have paid leave available to you) for the reasons listed above (under a, b, c, and d).

For a serious injury or illness of a covered servicemember (military caregiver leave) you have a right under the FMLA for up to 26 workweeks of unpaid leave in a 12-month period (unless you have paid leave available to you) for the reason listed above under e. For an eligible employee with a spouse, son, daughter, or parent on covered active duty as an active duty servicemember or call to covered active duty status Armed Forces you may use the 12 workweek leave entitlement to address certain qualifying exigencies.

Also, your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work, and you must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from leave. If you do not return to work following FMLA leave for a reason other than: (1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; or (2) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave.

This is to inform you that (check appropriate boxes; explain where indicated):

1. You are o eligible o not eligible for leave under the FMLA.

2. The requested leave o will o will not be counted against your annual FMLA leave entitlement.

3. You are required to furnish medical certification of a serious health condition and you must furnish this certification within 15 days after you are notified of this requirement or we may delay the commencement of your leave until the certification is submitted. If sufficient information is not provided in a timely manner, your leave may be denied.

4. In accordance with County policy, any useable accrued paid leave must be used first, in the following order during the 12 workweek or 26 workweek leave period to care for an injured or ill servicemember: 1) sick leave, 2) compensatory time, 3) vacation or 4) personal leave, where applicable. **An employee who is taking leave for the adoption or foster care of a child or military FMLA leave for a qualifying exigency must use all paid compensatory time, vacation and personal leave prior to being eligible for unpaid leave**. Once any paid leave is used up, the remainder of the 12 workweeks will be unpaid.

5. If you normally pay a portion of the premiums for your dependent's health/dental insurance, and/or other optional benefits, these payments must continue during the period of FMLA leave. Your premium payments are due on regularly scheduled County paydays.

6. You will be required to present a fitness-for-duty certificate prior to being restored to employment. If such certification is not received, your return to work may be delayed until such certification is provided.

7. You are required to furnish us with periodic reports of your status and intent to return to work every 30 days while on FMLA leave.

8. You are required to furnish recertification every six (6) months in relation to a serious health condition.

9. Failure to comply with any of the above conditions may result in disciplinary action.

The above information has been reviewed with me and I agree to comply with the provisions herein.

Leave approved by: _____ Date _____

(Department Head's Signature)

_____

Employee's Signature

ATTACHMENT C
JEFFERSON COUNTY
CERTIFICATION OF HEALTH CARE PROVIDER
FAMILY AND MEDICAL LEAVE ACT

Employer name and contact: Human Resources Department, Jefferson County Courthouse, 1225 Pearl Street, Suite 201, Beaumont, Texas 77701. Contact number: (409) 839-2391 / Fax number: (409) 839-2399

1. Employee's Name: _____
2. Patient's Name: _____
3. Relationship of family member to you: _____

4. The attached sheet describes what is meant by a **"serious health condition"** under the Family and Medical Leave Act.

5. Describe the **medical facts**, which support your certification, including a brief statement as to how the medical facts meet the criteria of a serious health condition. Limit your responses to the condition for which the employee is seeking leave. 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). Please be sure to sign the form on the last page.

_____

_____

_____

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

_____

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

☐ Yes ☐ No

If yes, give the probable duration: _____

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

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

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

_____

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

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

_____

_____

8.a. If medical leave is required for the employee's **absence from work** because of the **employee's own condition** (including absences due to pregnancy or a chronic condition), is the employee **unable to perform work** of any kind? ☐ Yes ☐ No

b. If able to perform some work, is the employee **unable to perform any one or more of the essential functions of the employee's job** (the employee or the employer should supply you with information about the essential job functions)? ☐ Yes ☐ No

If yes, please list the essential functions the employee is unable to perform:

_____

c. If neither a. nor b. applies, is it necessary for employee to be **absent from work for treatment**?
☐ Yes ☐ No

9.a. If leave is required to **care for a family member** of the employee with a serious health condition, **does the patient require assistance** for basic medical or personal needs or safety, or for transportation?
☐ Yes ☐ No

b. If no, would the employee's presence to provide **psychological comfort** be beneficial to the patient or assist in the patient's recovery? ☐ Yes ☐ No

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

_____

Please return this signed form to Human Resources with the completed "Certification of Health Care Provider" Form.

(**Printed** Name of Health Care Provider)	(Business Address)	
(**Signature** of Health Care Provider)	(Type of Practice)	(Date)
Telephone #	Fax #	

Employee Signature _____ **Date:**_____

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

_____
_____
_____

(Employee's Signature) (Date)

ATTACHMENT C
CERTIFICATION OF HEALTH CARE PROVIDER
FAMILY AND MEDICAL LEAVE ACT

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 or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

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

   a. **Treatment 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

   b. **Treatment** by a health care provider on **at least one occasion** which results in a **regimen of continuing treatment** 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 and

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