Print Form

City of Berkley
Employee Family Medical Leave Act (FMLA) Request Form

EMPLOYEE ELIGIBILITY: Eligible employees are entitled, under FMLA, to take from 12 and up to 26 weeks of job-protected leave for certain medical and family reasons. Submit this request form to the City Manager's Office at least 30 days before the leave is to begin, when possible. If 30 days advance submission is not an option, submit this form as soon as possible. The request may be denied or postponed as permitted under federal and state law if adequate notice is not provided.

SECTION 1: EMPLOYEE INFORMATION

Employee Name	Home Address *(include city, state, zip)*	Telephone
		Home:
		Work:
		Cell:
Department Name	**Supervisor Name**	**Supervisor Phone Number**
Dates of Leave Requested:	**From:**	**To:**

1. Reason for Leave Request:

- ☐ My own serious health condition.
- ☐ A serious health condition affecting my: ☐ spouse ☐ child ☐ parent
- ☐ Birth of my child, to care for newborn child.
- ☐ Placement of a child by: ☐ adoption ☐ foster care
- ☐ A qualifying exigency arising from my ☐ spouse ☐ child ☐ parent being called to active duty in the armed forces (including the National Guard, Reserves).
- ☐ To care for a family member who is also a member of the armed forces, or a covered veteran undergoing medical treatment, recuperation or therapy for a serious illness or injury. Provide name and relationship):

_____

NOTE: *If circumstances change and you can return early, you must notify the City Manager's Office and provide medical clearance from your physician at least two business days before you report to work.*

2. Reduced Schedule or Intermittent Leave: *(*If a reduced schedule or intermittent leave is requested, briefly describe why it is needed and the proposed schedule: (*Limit 400 characters. Attach additional pages if needed.)*

EMPLOYEE CERTIFICATION: I CERTIFY THAT THE ABOVE INFORMATION IS ACCURATE AND TRUE TO THE BEST OF MY ABILITY.

Employee Signature:	**Date:**

Return completed form (Section 1 and Section 2) to the City Manager's Office for processing.
Section 2 must be completed by the Health Care Provider

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INSTRUCTIONS TO HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Please respond to the following questions related to the frequency or duration of a condition, treatment, etc. Provide your best estimate based on 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 eligibility for 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.

SECTION 2: HEALTH CARE PROVIDER

Provider's Name	Business Address *(include city, state, zip)*	Telephone
		Work:
		Fax:
Type of Practice	**Medical Specialty**	**Employee *(Patient)* Name**

PART A: MEDICAL FACTS

Approximate date condition commenced:	
Probable duration of condition:	

Was the patient admitted for an overnight stay in a hospital, hospice or residential medical care facility?

☐ No ☐ Yes If so, date(s) of admission: _____

_____

Date(s) you treated the patient for this condition: _____

Will the patient need treatment 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:

_____

_____

Is the medical condition pregnancy? ☐ No ☐ Yes If so, what is the expected delivery date? _____

If the Employer has not provided a list of the employee's essential functions or job description, answer the following questions based on the employee's 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:

_____

_____

Employee Name: _____

SECTION 2: HEALTH CARE PROVIDER *(continued)*

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

_____

_____

_____

_____

_____

_____

PART B: AMOUNT OF LEAVE NEEDED

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: _____

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

If so, are the treatments or 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 ach appointment, including recovery period:

_____

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

_____ Hour(s) per day; _____ Days per week from _____ through _____

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, please 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) _____ Months(s)

Duration: _____ Hours or _____ day(s) per episode

Employee Name: _____

SECTION 2: HEALTH CARE PROVIDER *(continued)*

ADDITIONAL INFORMATION: Use this space to provide additional information in response to the previous questions in Section 2. Identify the question number that corresponds to the added comments

_____ _____

Signature of Health Care Provider Date