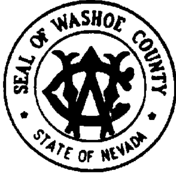


WASHOE COUNTY
APPLICATION FOR FAMILY OR MEDICAL LEAVE

Employee Name: ________________________ Employee # __________________

Home Address and Phone #____

Department: _________________ Work Tel. #: _________Supervisor:______________

Start Date of Anticipated Leave:____

Expected Date of Return to Work:____

I am requesting to take family or medical leave due to:

Check One:

Family Leave

_____ the birth of a child, or the placement of a child with you for adoption or foster care; or

Medical Leave (Serious medical condition)*

_____ a serious health condition that makes you unable to perform the essential functions of your job; or

_____ a serious health condition affecting your ☐ spouse, ☐ child, ☐ parent, for which you are needed to provide care; or (check one)

_____ Worker's Compensation/On-the-Job Injury

* In the case of FMLA Medical leave, the employee must furnish a physician's medical certification of the serious health condition on the "Certification of Health Care Provider" form. When medical leave is for the employee's own health condition, the physician must certify that the employee is unable to perform his/her essential job functions. The "Certification of Health Care Provider" form must be submitted with the "Application for Family or Medical Leave" form within 15 days of application. Failure to provide adequate certification may result in a denial or delay in the FMLA leave.

_____ Certification of Health Care Provider attached (*Required for medical leave for either employee or family member as defined by FMLA within 15 days of application for FMLA.)

Reason for Leave (Explain):____

____

____

____

LEAVE REQUESTED IN INCREMENTS OF:

__________ Weeks __________ Days __________ Intermittent

PAID OR UNPAID LEAVE:

The employee may elect to use accrued annual, sick or personal leave, in lieu of unpaid leave time for any FMLA-qualifying purpose. Sick leave may be used to care for a seriously ill family member as defined by FMLA or for the employee's own serious health condition contingent upon the circumstances meeting the requirements for use of sick leave under either County code or the terms of an applicable collective bargaining agreement.

CURRENT PAID LEAVE AVAILABLE: (Department to complete)		**I WISH TO USE**: (Employee to complete)
__________Hours	Medical Sick Leave (Code 003)	________Hours
_______ _ __Hours	Annual/Vacation Leave (Code 002)	________Hours
__________Hours	Personal Leave (Code 006)	________Hours
__________Total Hours		________Total Hours

I hereby certify that I intend to return to work at Washoe County upon the completion of my FMLA Leave. I will notify my Department Head at least two (2) workdays prior to my intended return to work date.

Employee Signature:____________________________ Date:__________________

ACKNOWLEDGED BY:

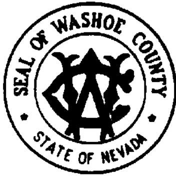
____ ______________________
Immediate Supervisor Date

____ ______________________
Department Head Date

____ ______________________
Director of Human Resources or Designee Date

DISTRIBUTION:

- Original sent to the Department of Human Resources
- Copies should be made for: Employee and Department



Authorization for Release of
Health Information to Washoe County
(For Family Medical Leave Act (FMLA) Purposes Only)

I, ____________________ [Employee Name] hereby authorize the following healthcare provider to release to Washoe County the health information as stated below.

Health Information From:

Physician/Clinic/Healthcare Provider (name and address): ______________________________
____
____
____

Phone: ________________________

Health Information About:
Patient Name: ______________________________________

Employee Name (if different from
patient):____

Purpose of Release: Leave requested under **FMLA** based on **health** condition of:

______self ______child ______spouse ______ parent (*check one)*

Release to:
Washoe County
____________________________ (*insert name of Department Head*)
Address:
____
____
____
Phone: (775) ___________
Fax: (775) ___________

Information to be released: Information is to be limited to reason employee is requesting leave under FMLA.

Expiration of Authorization: This **authorization** will expire one year from the date on which it is signed or when I am no longer requesting leave under **FMLA**, whichever is later.

Withdrawal of Authorization: I understand that I may withdraw or revoke this **authorization** at any time by giving written notice to my healthcare provider designated above. A withdrawal

of this **authorization** will not apply to records/**information** already released in reliance upon the **authorization**.

Re-disclosure: I understand that once the above **information** is disclosed, it may be re-disclosed by the designated recipient and the **information** may no longer be protected by Federal privacy laws and regulations.

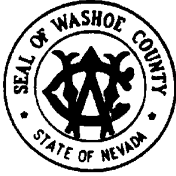
A photocopy or faxed copy of this signed **authorization** shall constitute a valid **authorization**.

I understand that the healthcare provider who is releasing this **information** to Washoe County will not condition my treatment, payment, enrollment or eligibility for benefits on whether I sign this **authorization**.

Signature of Employee: ______________________________ Date: __________________

Personal Representatives section
If a Personal Representative executes this form, that Representative warrants that he or she has authority to sign this form on the basis of: ________________________________
____
____

NOTE: This form is mandatory for employees requesting FMLA for a serious health condition. Failure to submit the Release of Health Information could delay your FMLA or cause your FMLA to be denied. The completion and submission of this Release of Health Information authorizes your attending physician to release all information requested on the Certification of Health Care Provider.



Certification of Health Care Provider
(Family and Medical Leave Act of 1993)

NOTE: Failure to fully complete this form could result in an initial denial of an FMLA leave or a delay in approval of an FMLA leave for the employee.

The information sought relates only to the condition for which the employee is taking FMLA leave. Complete this form, sign, and return to their Department HR Representative. If the leave is "foreseeable", a 30-day advance notice of the need for a leave is requested to the supervisor/depatment head along with the completed forms.

1. Employee's Name:

2. Patient's Name (if different from employee):

3. Page 4 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 of the above_________

4. 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:

5. 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**[1] 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 the treatment described in #6 below)?

   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:**

6. a. If additional **treatments**[2] 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 or health service** (e.g., physical therapist) please state the nature of the treatments:

c. **If a regimen of continuing treatment**[3] by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment):

7. a. If a 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 employer or employee should supply you with information about the essential job functions)? ☐ yes ☐ no

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

c. If neither of the above applies, is it necessary for the employee to be **absent from work for treatment**?
☐ yes ☐ no

8. a. If leave is required for **care for an employee's family member** with a serious health condition, **does the patient require assistance** for basic medical or personal needs, 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, indicate the probable **duration** of this need:

Health Care Provider (Please Print Name)

Signature of Health Care Provider	Type of Practice
Address	Telephone Number
City, State, Zip Code	Date

TO BE COMPLETED BY 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

Adapted from: U.S. Department of Labor, Form WH-380

[1] Incapacity for purposes of FMLA means the inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment for, or recovery from

[2] 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 examinations

[3] 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 of treatment 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

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[1] or subsequent treatment in connection with or consequent to such inpatient care

2. **Absence Plus Treatment**

a period of incapacity[1] 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[2] two or more times by a health care provider, by a nurse of 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 that results in a regimen of continuing treatment[3] under the supervision of the health care provider

3. Pregnancy

any period of incapacity[1] due to pregnancy, or for prenatal care

4. Chronic Conditions Requiring Treatments

a chronic condition that:

(a) requires periodic visits for treatment[1] by a health care provider, or by a nurse or physician's assistant under direct supervision of 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[1] (e.g., asthma, diabetes, epilepsy, etc.)

5. Permanent/Long-term Conditions Requiring Supervision

a period of incapacity[1] 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 (e.g., 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 from) 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[1] 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)

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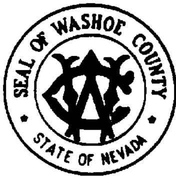
[1] Incapacity for purposes of FMLA means the inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment for, or recovery from

[2] 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 examinations

[3] 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 of treatment 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.



WASHOE COUNTY
PHYSICIAN'S RELEASE
RETURN TO WORK FORM

Employee Name: ________________________________

TO BE COMPLETED BY HEALTH CARE PROVIDER:

The above employee is hereby released to full duty, as s/he is able to perform the essential job functions as recorded on the accompanying "Essential Job Functions" form without limitation.

________________________________ Health Care Provider (Please Print Name)	________________________________ Type of Practice
________________________________ Address	________________________________ Telephone Number
________________________________ City, State, Zip Code	
________________________________ Signature of Health Care Provider	________________________________ Date