

**INSTRUCTIONS - Part I**

1. Employee must fill out all of Part I, Sections A, B & C.
2. Physician must fill out all of Part II – Healthcare Provider Certification. *(Necessary except in cases of Foster Care and Adoption.)*
3. Completed Family Medical Leave applications must be submitted to the Human Resource Generalist 30 days in advance for foreseeable Family Medical Leave.
4. If the leave is not foreseeable, notice must be given to your direct Supervisor or designee as soon as practical, which ordinarily means at least verbal notification within one (1) to two (2) business days of when the need for Family Medical Leave becomes known to you, otherwise the time may be ineligible for designation as Family Medical Leave.
5. In all circumstances, the employee should submit the completed Family Medical Leave application to their Human Resources Generalist NO LATER THAN FIFTEEN (15) BUSINESS DAYS after returning to work from a qualifying Family Medical Leave condition/event.
6. Each line on the Family Medical Leave application must be completed even if the response is N/A (not applicable).
7. Employees of departments without Human Resource Generalists should submit their Family Medical Leave applications directly to the Client Services Division of Human Resources, 1500 Marilla Street, Room 6AN.
8. Employees requiring intermittent leave must attempt to schedule their leave so as not to disrupt the employer’s operations.
9. You must call in to your direct supervisor or designee and make them aware that you need to take Family Medical Leave. If the leave is for someone other than you, state who it is for. (I.e. – self, child, parent, birth, etc.)
10. Employee must exhaust all accrued sick and vacation leave (respectively) before using unpaid leave (W-Time), with the exception of adoption or foster care placement where the employee must first exhaust all accrued paid vacation before using unpaid leave (W-Time).
11. When you return to work, you must indicate on your leave slip or email who you took Family Medical Leave for. (I.e. – self, child, parent, birth, etc.)
12. When entering your time into Lawson/SEA, make sure you enter the correct code that you received on your approval letter for Family Medical Leave.
13. Employee must read Administrative Directive 3-72 (Family and Medical Leave), which can be found on the City’s Intranet or provided to you by Human Resources.
14. Human Resources, with the employees consent, maintains the right to contact your physician for purposes of clarification and authenticity of the medical certification.

***By my signature below, I certify that I have read and understand the above statements and Administrative Directive 3-72, and have, to the best of my knowledge, provided the accurate information needed to complete this application.***

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

INITIAL APPLICATION       RECERTIFICATION APPLICATION

**Part I (Continued) – Required Information**

**A. EMPLOYEE INFORMATION**

Name:	Employee #:
Dept:                      Div:                      Location & Shift:	Job Title:
Phone #:	Date of Hire:        /        /
Supervisor:	Supervisor Phone #:
Dates Leave Requested: Starting        /        /	Ending        /        /

**B. REASON FOR LEAVE**

(1)  To care for your spouse, child, or parent with a serious health condition.  
 Patient's Name: \_\_\_\_\_  
 Relationship to employee: \_\_\_\_\_  
*If the requested leave is for a child, please provide age of child \_\_\_\_\_ and D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_\_*

(2)  Your own serious health condition makes you unable to work.

(3)  Birth of a child    or     Receipt of the placement of a child (by adoption, foster care, etc.)

If the FML request is related to box #3, does your spouse work for the City of Dallas?  Yes  No

**Spouse's Name:** \_\_\_\_\_                      **Department:** \_\_\_\_\_

**C. EMPLOYEE CERTIFICATION**

I understand it is my responsibility to notify my immediate supervisor of my need to be off and of the FML dates as soon as I am aware. If my time entry is via SEA, once approved, it is my responsibility to enter the proper code. I hereby certify that all of the statements contained herein and attached are true to the best of my knowledge. I understand that omissions or misstatements may be cause for rejection of my leave request and may result in disciplinary action by the City. I understand that I may be required to use my vacation and sick leave balances during my leave. I understand it is my responsibility to monitor my leave balances and the City will not notify me when I have exhausted paid leave. Work related injuries resulting in lost time will be charged to the employee's existing FML balance. I also understand that the City of Dallas may recover from me its portion of the health insurance premiums paid during my leave if I fail to return to work for any reasons other than continuation, recurrence, or onset of a serious health condition affecting myself or immediate family member.

<b>Employee Signature:</b> _____	<b>Date:</b> _____
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**HUMAN RESOURCES APPROVAL**

Employee's leave request has been reviewed and is:  Approved  Denied for the following reasons:  
 Untimely/incomplete request     FMLA balance exhausted     Ineligible reason     Other (describe below): \_\_\_\_\_

<b>Human Resources Signature:</b> _____	<b>Date:</b> _____
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**HEALTHCARE PROVIDER CERTIFICATION – Part II**

*(The treating physician is responsible for completing this section.)*

Employee Name:

Patient's Name *(If Different)*:

**Serious Health Condition**

**DIAGNOSIS:** \_\_\_\_\_

Provide the medical facts that describe the patient's illness/condition supporting your certification. Include a brief statement as to how the medical facts meet the criteria of the applicable Serious Health Condition(s) as defined below. (If more space is needed, use the back of this page.)

**CHECK ONE OR MORE OF THE APPLICABLE SERIOUS HEALTH CONDITION(S) AS DEFINED BELOW:**

**1. Hospital Care**

Hospital care is in-patient 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 in-patient care.

**2. Absence Plus Treatment**

Absence plus treatment is 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:

1. Treatment two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a healthcare provider, or by a provider of healthcare services (e.g., physical therapist) under orders of, or on referral by, a healthcare provider; or
2. Treatment by a healthcare provider on at least one occasion which results in a regimen of continuing treatment\*\*\* under the supervision of the health provider.

**3. Pregnancy**

Any period of incapacity due to pregnancy, prenatal care or bonding with newborn.

**4. Chronic Conditions Requiring Treatments**

A chronic condition which:

1. Requires periodic visits for treatment by a healthcare provider, or by a nurse or physician's assistant under direct supervision of healthcare provider;
2. Continues over an extended period of time (including recurring episodes of a single underlying condition); and
3. May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

**5. Permanent/Long-term Conditions Requiring Supervision**

A permanent/long-term condition requiring supervision is a period of incapacity 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 healthcare provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

**HEALTHCARE PROVIDER CERTIFICATION – Part II (Continued)**

*(The treating physician is responsible for completing this section.)*

Employee Name:

Patient's Name *(If Different)*:

**6. Multiple Treatments (Non-chronic Conditions)**

Any period of absence to receive multiple treatments (including any period of recovery) by a healthcare provider or by a provider of healthcare services under orders of, or on referral by, a healthcare provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity 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) and kidney disease (dialysis).

\* Family Medical Leave approvals are contingent upon the employee meeting the eligibility requirements for Family Medical Leave.

\*\* 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.

\*\*\* A regimen of continuing treatment includes a course of prescription medicine (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, salves, bed-rest, drinking fluids, exercise, and/or other similar activities that can be initiated without a visit to a healthcare provider.

\*\*\*\* "Incapacity" for purposes of Family Medical Leave is defined to mean inability to work, attend school, or perform other regular daily activities due to the serious health condition, treatment thereof, or recovery there from.

**Condition/Treatment/Duration**

*(The treating physician is responsible for completing this section.)*

***(Employees may be asked to provide additional medical documentation to support absences that vary from listed dates.)***

1. a. Date condition began: \_\_\_\_/\_\_\_\_/\_\_\_\_
- b. Probable duration of the patient's present incapacity: From: \_\_\_\_/\_\_\_\_/\_\_\_\_ to: \_\_\_\_/\_\_\_\_/\_\_\_\_
- c. Probable duration of employee's Family Medical Leave: From: \_\_\_\_/\_\_\_\_/\_\_\_\_ to: \_\_\_\_/\_\_\_\_/\_\_\_\_ including any expected follow-up.

2. Will it be necessary for the employee to work only intermittently or to work on a less than full schedule as a result of the condition?

YES    NO

If YES, give the probable duration and/or hours per day employee can work:

3. If the condition is a chronic condition or pregnancy, state the likely duration and frequency of episodes of incapacity\*\*\*\*:

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

**Condition/Treatment/Duration (Continued)**

*(The treating physician is responsible for completing this section.)*

**4a.** If the employee will be absent from work because of treatment on an intermittent or part-time basis, provide:

- 1) an estimate of the probable number of treatments: \_\_\_\_\_
- 2) interval(s) between such treatments: \_\_\_\_\_
- 3) actual or estimated dates of treatment, if known: \_\_\_\_\_
- 4) period required for recovery, if any: \_\_\_\_\_

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

**5.** If leave is required to care for a family member of the employee with a serious health condition:

**a.** Does the patient require assistance for basic medical or personal needs, or for transportation?

YES     NO

**b.** If no, is the employee's presence necessary for the patient's psychological comfort or to assist in the patient's recovery?

YES     NO

**c.** Will the patient need care only intermittently or on a part-time basis?

YES     NO    If yes, please indicate the probable duration of this need: \_\_\_\_\_

**HEALTHCARE PROVIDER CERTIFICATION**

\_\_\_\_\_  
(Original Signature of Healthcare Provider)

\_\_\_\_\_  
(Please Print Name)

\_\_\_\_\_  
(Type of Practice)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(City, State, Zip Code)

\_\_\_\_\_  
(Telephone No.)

\_\_\_\_\_  
(State Licensing/Certifying Agency)

\_\_\_\_\_  
(License/Certificate No.)

\_\_\_\_\_  
(Date)

The City of Dallas reserves the right to revise the FML form as needed to comply with city policies and/or local, state and federal laws, regulations and guidelines. Employees do not have the right to modify or change this form. Revised 11/06