

# **Waccamaw Economic Opportunity Council, Inc.**

## **Family Medical Leave Act (FMLA) Instructions**

1. Be sure you have notified your supervisor in writing that you will need to request leave for yourself due to a sickness or an injury or that you need to take leave to care for a sick family member. Give the approximate dates that you think you will be out of work. Ninety days are the max that you can take for FML during a twelve month period.
2. Ask your supervisor for the application for Family Medical Leave. The forms should be kept by the person in charge at each work site.
3. Page one of the application is the Request for FMLA Leave of Absence. This form should be completed by the employee and sent to the Human Resource Department at Waccamaw EOC, PO Box 1467, Conway, SC 29528.
4. Page two should be completed by the employee if you are requesting a leave of absence to care for a sick family member. This page is to be sent along with page one to Human Resources.
5. Pages three, four, five, and six are to be given to the physician to complete and sent to the Human Resource Department.
6. Page seven must be completed by your physician to be able to return to work. This form must be sent to your supervisor and a copy sent to Human Resources.
7. A letter will be sent to you to let you know the leave has been approved and to let you know your responsibilities for payment of insurance premiums if you are in an unpaid status while you are out. If you have sick or annual leave, you must use these hours while you are on leave.

# Waccamaw Economic Opportunity Council, Inc.

## Request for FMLA Leave Of Absence

Staffers who have worked for at least 1,250 hours during the 12-month period immediately prior to their request for leave are eligible for FMLA Leave of Absence.

Staffer's name: \_\_\_\_\_ SS number: \_\_\_\_\_

Program: \_\_\_\_\_ Hire date: \_\_\_\_\_

### Type of leave requested

(Check one box)

- Staffer medical Leave of Absence
- Family Medical Leave of Absence
- Leave to care for newborn or adopted child or a child placed (via state procedures for foster care).

The leave requested will begin on \_\_\_\_\_ and end on \_\_\_\_\_ .

If the request is for multiple days off for recurring medical treatments of a child, parent, spouse, or for your own medical treatments, specify dates requested.

### Reason for leave

(Check one box)

- My personal serious health condition
- Birth of my child
- Adoption of a child by me
- Placement {by the state} of a child with me for foster care
- Serious health condition of my child
- Serious health condition of my parent
- Serious health condition of my spouse

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date



## Waccamaw Economic Opportunity Council, Inc.

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

1. Employee's Name: \_\_\_\_\_
2. Patient's Name (if different from employee): \_\_\_\_\_
3. The attached sheet describes what is meant by a "serious health condition" under the Family and Medical Leave Act. Does the patient's condition<sup>1</sup> 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<sup>2</sup> if different):
- b. 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 (including for treatment described in Item 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 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 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 the 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):

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<sup>1</sup> Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking FMLA leave.

<sup>2</sup> "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 therefore, or recovery there from.

- 7.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? \_\_\_\_\_
- 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)? \_\_\_\_\_ If yes, please list the essential functions the employee is unable to perform:
- c. If neither a. or b. applies, is it necessary for the employee to be absent from work for treatment? \_\_\_\_\_
- 8.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? \_\_\_\_\_
- b. If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery? \_\_\_\_\_
- c. If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need:

\_\_\_\_\_  
Signature of Health Care Provider

\_\_\_\_\_  
Type of Practice

\_\_\_\_\_  
Address

\_\_\_\_\_  
Telephone Number

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) 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<sup>3</sup> 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, health care provider; or
- (2) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment<sup>4</sup> 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,

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

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<sup>3</sup> Treatment includes examination to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examination, eye examinations, or dental examinations.

<sup>4</sup> 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.

5. PERMANENT/LONG-TERM CONDITIONS REQUIRING SUPERVISION

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 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 there 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 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).

**Waccamaw Economic Opportunity Council, Inc.**

**Physician Statement For Return To Work**

Employee's name: \_\_\_\_\_ Date of release: \_\_\_\_\_

Physician's name and field of specialization: \_\_\_\_\_

My diagnosis for the employee is: \_\_\_\_\_

I last examined or treated the employee for that condition on: \_\_\_\_\_

I expect that the condition will continue until: \_\_\_\_\_

\_\_\_\_ In my opinion, the employee may return to work without restriction on: \_\_\_\_\_

\_\_\_\_ In my opinion, the employee may return to work with the restrictions  
described below on: \_\_\_\_\_

The Employee has the following restrictions (indicate all restrictions on the Employee's work activities, including but not limited to, hours of work, specific job duties the Employee may perform on a limited basis, and specific job duties the Employee may not perform at all):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The Employee's restrictions will continue until (indicate the date each restriction listed in the preceding answer will end):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I will next examine the Employee on: \_\_\_\_\_

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date