HONORHEALTH

Leave of Absence Request

Military Duty, Qualifying Exigency for Military, Care for Military Service Member

Information

Leave of Absence
Leave of absence is used to authorize and document time away from work in excess of seven calendar days for military leave, to address certain qualifying exigencies and to provide care for a covered service member.

Staff Member Military Leave
See policy HR1077 Military Deployment and Vaccines for Military Personnel for more detailed information.

Military Family Medical Leave Entitlements under FMLA
Eligible staff members with a spouse, parent, son or daughter on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. These may include attending certain military events, arranging for alternative child care, addressing financial and/or legal matters and attending post-deployment reintegration sessions.

To be eligible for FMLA job protection, a staff member must complete 12-months of employment and have worked at least 1,250 hours during the 12-months immediately before the start of the leave.

FMLA also includes a special leave entitlement that permits eligible staff members to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. The service member must have a serious health condition incurred in the line of duty on active duty that may render the service member medically unfit to perform his/her duties. For this leave the 12-month period is measured forward.

FMLA runs concurrently with any paid leave offered by HonorHealth such as Paid Time Off (PTO), Short-Term Disability (STD), Workers' Compensation (WC). All days away from work (including intermittent absences, reduced schedule leave) will be counted toward the staff member's FMLA entitlement.

Periodic Reporting Requirements
While on leave, you may be required to furnish Employee Benefits with periodic written reports of your status and intent to return to work.

Certification is required to support a qualifying exigency or to provide care to a covered service member who has been injured in the line of duty.

Return to Work

When returning to work, please contact Employee Benefits so your records can be updated accordingly.

Question & Answer

1) How do I apply for a Leave of Absence?
   Complete the appropriate leave of absence form and return them to Employee Benefits.

2) What happens after I submit my request?
   You will receive a letter letting you know whether you are eligible for leave under the FMLA and whether your absences qualifies as job-protected leave under the FMLA.

3) Will I be paid during my leave?
   While on qualifying exigency leave or leave to care for service member:
   - PTO must be used and the amount of PTO used must be the same as your normal scheduled work hours.

4) Is my job protected?
   If you are not FMLA eligible, your position may be filled permanently.

   If you are FMLA eligible, your job is protected during the first cumulative 12-week (or 26 weeks for care of a service member) period while you are on a qualifying FMLA leave. If you remain off work beyond 12 weeks (or 26 weeks) your position may be filled permanently.

   If your position is not available upon return form leave, you may have up to 30 days to work with Recruiting to find another position for which you qualify. If a position is not secured within 30 calendar days, your employment with HonorHealth will be separated.

5) How will my HonorHealth group health insurance premiums be paid?
   When you are not receiving a paycheck from HonorHealth you will be responsible for the cost of benefit premiums. You will receive instructions on how to pay your premiums in a separate letter. Premiums you pay will be based on your years of service:
   - More than one year of service – you will be responsible for the benefit premiums normally deducted from your payroll checks for you (and your dependents) for a maximum period of 12 months.
   - Less than one year of service, you will be responsible for the total cost of benefit premiums when your leave extends beyond two unpaid pay periods.

SEE POLICIY HR1073 (FAMILY MEDICAL LEAVE (FMLA)) FOR ADDITIONAL DETAILS

HONORHEALTH

LEAVE OF ABSENCE REQUEST

For Medical Leave or Family Care Leave

Instructions – (1) This form should be completed by the staff member (or their designated personal representative) and returned to Employee Benefits as soon as possible. (2) It is the staff member's responsibility to ensure that Employee Benefits receives <u>all</u> required completed forms. DO NOT RETURN COMPLETED FORMS TO YOUR DEPARTMENT.

SECTION 1 – EMPLOYEE INFORMATION

Name (printed) _____ Employee # _____

Address _____ City _____ State _____ Zip Code _____

Wk Phone _____ Hm Phone _____ Cell Phone _____

May we communicate with you using your personal email? ☐No ☐Yes

Email: _____

SECTION 2 – JOB INFORMATION

Dept Mgr Ext Dept Supervisor Ext

SECTION 3 – REASON FOR REQUESTING LEAVE

I am requesting leave for the following reason:

☐ My own health condition – provide dates below(if applicable) Is the condition work related: Yes ☐ No ☐
Date of surgery/illness: _____ Date of in-patient admission _____

☐ Birth of my child; to care for my newborn child: Anticipated due date: _____
Do you plan to be off ☐ 6 weeks or ☐ 12 weeks?

☐ Placement of a child with me for adoption or foster care

☐ Care for a family member with a serious health condition
Relationship of family member to me: _____

☐ Military

☐ Qualifying exigency because family member is on active duty or has been called to active duty
Relationship of family member to me: _____

☐ Care for a family member who is a member of the Armed Forces and is undergoing medical treatment or recuperating from a serious injury or illness incurred while on active duty

SECTION 4 – DURATION OF LEAVE – DATES ARE REQUIRED TO BE PROVIDED

Date Leave Expected to Begin: _____ Date Leave Expected to End: _____

Will this leave be for a continuous period or intermittently? ☐Continuous ☐Intermittently/Reduced Schedule

If intermittent or reduced-leave schedule, please provide the estimated duration of scheduled leave:

SECTION 5 – SIGNATURE

I understand that all leave and duration are based on the medical certifications provided by my doctor. Failure to comply with any policies or procedures associated with my leave may result in denial of my leave and/or termination of my employment. I further understand that it is my responsibility to provide supporting documentation to Employee Benefits upon request.

Staff Member Signature **X** _____ Date _____

Mail or fax completed documents to:
HonorHealth, Employee Benefits
8125 N Hayden Rd, Scottsdale, AZ 85258
Fax: (480) 882-5802 / Email:
employeebenefits@honorhealth.com

Certification for Serious Injury or Illness of Covered Servicemember - - for Military Family Leave (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 2/28/2015

Notice to the EMPLOYER INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a serious injury or illness of a covered servicemember to submit a certification providing sufficient facts to support the request for leave. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. § 825.310. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees or employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

SECTION I: For Completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the Employee Is Requesting Leave INSTRUCTIONS to the EMPLOYEE or COVERED SERVICEMEMBER: Please complete Section I before having Section II completed. The FMLA permits an employer to require that an employee submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a serious injury or illness of a covered servicemember. If requested by the employer, your response is required to obtain or retain the benefit of FMLA-protected leave. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to do so may result in a denial of an employee's FMLA request. 29 C.F.R. § 825.310(f). The employer must give an employee at least 15 calendar days to return this form to the employer.

SECTION II: For Completion by a UNITED STATES DEPARTMENT OF DEFENSE ("DOD") HEALTH CARE PROVIDER or a HEALTH CARE PROVIDER who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed on Page 2 has requested leave under the FMLA to care for a family member who is a member of the Regular Armed Forces, the National Guard, or the Reserves who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list for a serious injury or illness. For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty that may render the servicemember medically unfit to perform the duties of his or her office, grade, rank, or rating.

A complete and sufficient certification to support a request for FMLA leave due to a covered servicemember's serious injury or illness includes written documentation confirming that the covered servicemember's injury or illness was incurred in the line of duty on active duty and that the covered servicemember is undergoing treatment for such injury or illness by a health care provider listed above. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon 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 FMLA coverage. Limit your responses to the condition for which the employee is seeking leave.

Certification for Serious Injury or Illness of Covered Servicemember - - for Military Family Leave (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

U.S. Wage and Hour Division

SECTION I: For Completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the Employee Is Requesting Leave: (This section must be completed first before any of the below sections can be completed by a health care provider.)

Part A: EMPLOYEE INFORMATION

Name and Address of Employer (this is the employer of the employee requesting leave to care for covered servicemember):

_____

Name of Employee Requesting Leave to Care for Covered Servicemember:

_____
First Middle Last

Name of Covered Servicemember (for whom employee is requesting leave to care):

_____
First Middle Last

Relationship of Employee to Covered Servicemember Requesting Leave to Care:
☐ Spouse ☐ Parent ☐ Son ☐ Daughter ☐ Next of Kin

Part B: COVERED SERVICEMEMBER INFORMATION

(1) Is the Covered Servicemember a Current Member of the Regular Armed Forces, the National Guard or Reserves? ☐ Yes ☐ No

If yes, please provide the covered servicemember's military branch, rank and unit currently assigned to:

_____

Is the covered servicemember assigned to a military medical treatment facility as an outpatient or to a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients (such as a medical hold or warrior transition unit)? ☐ Yes ☐ No If yes, please provide the name of the medical treatment facility or unit:

_____

(2) Is the Covered Servicemember on the Temporary Disability Retired List (TDRL)? ☐ Yes ☐ No

Part C: CARE TO BE PROVIDED TO THE COVERED SERVICEMEMBER

Describe the Care to Be Provided to the Covered Servicemember and an Estimate of the Leave Needed to Provide the Care:

_____

SECTION II: For Completion by a United States Department of Defense ("DOD") Health Care Provider or a Health Care Provider who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider. If you are unable to make certain of the military-related determinations contained below in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator). (Please ensure that Section I above has been completed before completing this section.) Please be sure to sign the form on the last page.

Part A: HEALTH CARE PROVIDER INFORMATION

Health Care Provider's Name and Business Address:

_____

Type of Practice/Medical Specialty: _____

Please state whether you are either: (1) a DOD health care provider; (2) a VA health care provider; (3) a DOD TRICARE network authorized private health care provider; or (4) a DOD non-network TRICARE authorized private health care provider: _____

Telephone: ( ) _____ Fax: ( ) _____ Email: _____

PART B: MEDICAL STATUS

(1) Covered Servicemember's medical condition is classified as (Check One of the Appropriate Boxes):

☐ **(VSI) Very Seriously Ill/Injured** – Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

☐ **(SI) Seriously Ill/Injured** – Illness/injury is of such severity that there is cause for immediate concern, but there is no imminent danger to life. Family members are requested at bedside. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

☐ **OTHER Ill/Injured** – a serious injury or illness that may render the servicemember medically unfit to perform the duties of the member's office, grade, rank, or rating.

☐ **NONE OF THE ABOVE** (Note to Employee: If this box is checked, you may still be eligible to take leave to care for a covered family member with a "serious health condition" under § 825.113 of the FMLA. If such leave is requested, you may be required to complete DOL FORM WH-380 or an employer-provided form seeking the same information.)

(2) Was the condition for which the Covered Service member is being treated incurred in line of duty on active duty in the armed forces? ☐ Yes ☐ No

(3) Approximate date condition commenced: _____

(4) Probable duration of condition and/or need for care: _____

(5) Is the covered servicemember undergoing medical treatment, recuperation, or therapy? ☐ Yes ☐ No. If yes, please describe medical treatment, recuperation or therapy:

PART C: COVERED SERVICEMEMBER'S NEED FOR CARE BY FAMILY MEMBER

(1) Will the covered servicemember need care for a single continuous period of time, including any time for treatment and recovery? ☐ Yes ☐ No
If yes, estimate the beginning and ending dates for this period of time: _____

(2) Will the covered servicemember require periodic follow-up treatment appointments?
☐ Yes ☐ No If yes, estimate the treatment schedule: _____

(3) Is there a medical necessity for the covered servicemember to have periodic care for these follow-up treatment appointments? ☐ Yes ☐ No

(4) Is there a medical necessity for the covered servicemember to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)? ☐ Yes ☐ No If yes, please estimate the frequency and duration of the periodic care:

_____

_____

Signature of Health Care Provider: _____ Date: _____

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years, in accordance with 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution AV, NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE PATIENT.**