HONORHEALTH

Leave of Absence Request

For Medical, Maternity, Family or Military

Information

Leave of Absence

Leave of absence is used to document and authorize time away from work for surgery, in-patient admission, or in excess of seven calendar days for medical leave or family care leave. This includes the need for intermittent and reduced-schedule.

Family Medical Leave Act

The Family Medical Leave Act (FMLA) gives an eligible staff member the right to take up to 12 weeks of unpaid job-protected leave in a 12-month period. Leave can be for the birth/adoption of a child, to care for a spouse, parent, or child with a serious health condition; or when the staff member is unable to work because of their own serious health condition. In addition, an eligible staff member may take up to 26 weeks of unpaid job-protected leave for military caregiver leave.

To be eligible, 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.

The FMLA entitlement is determined by a rolling 12-month period measured backwards from the date a staff member uses family leave or medical leave.

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.

A Medical Certification is required to support a staff member's medical leave and must be completed by a physician. Family medical, intermittent and reduced schedule requires Certification of Serious Health Condition from Health Care Provider.

Return to Work

If your medical (including maternity) condition keeps you off work more than 7 calendar days, you must take a copy of the written release from your treating physician to Corporate Health for drug testing and final clearance to return to work. The urine drug test may be conducted up to 14 days prior to your scheduled return to work date. We recommend allowing sufficient time to be cleared by Corporate Health.

Return to work from a family (other than maternity), military or personal leave does not require a urine drug screen.

Question & Answer

1) How do I apply for a Leave of Absence?
   Complete a Leave of Absence Request and Authorization to Release Information (if applicable). Submit forms immediately to Employee Benefits. Then, have the appropriate medical certification completed by the treating physician. It is your responsibility to ensure that Employee Benefits receives all completed forms. DO NOT SUBMIT COMPLETED FORMS TO YOUR DEPARTMENT.

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 medical leave:
   - PTO may be used to supplement payment of STD benefits which are processed by Mutual of Omaha. However, the combined total of STD and PTO may not exceed 100% of regular wages. You are responsible for notifying your department Manager/Supervisor so supplemental PTO can be entered on your timecard for payment.
   - WC payments will be paid through HonorHealth's claim administrator and PTO cannot be used.

   While on a family (including maternity), personal or educational leave:
   - PTO will be used and the amount of PTO used must be the same as normal scheduled work hours.

   While on military leave:
   - See policy HR1077 Military Deployment and Vaccines for Military Personnel.

4) Is my job protected?
   If you are not eligible for job-protected leave under the FMLA, your position may be posted and filled. If you are eligible for FMLA, your job is protected during the first cumulative 12-week period while you are on a qualifying FMLA leave. If you remain off work beyond 12 weeks, your position may be filled permanently. Please discuss the status of your position with your department manager.

   If your position is not available when you are cleared to return to work, 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 HonorHelath 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 6 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 POLICIES HR1032 (LEAVE OF ABSENCE) & 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 of Health Care Provider for Family Member's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

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

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Please complete Section I before giving this form to your employee. 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. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of 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.

Employer name and contact: _____

_____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your family member or his/her medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a covered family member with a serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Your name: _____
First Middle Last

Name of family member for whom you will provide care:_____
First Middle Last

Relationship of family member to you: _____

If family member is your son or daughter, date of birth:_____

Describe care you will provide to your family member and estimate leave needed to provide care:

_____

_____

_____

_____ ____ _____
Employee Signature Date

CONTINUED ON NEXT PAGE

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. 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 patient needs leave. Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address:_____

Type of practice / Medical specialty: _____

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

PART A: MEDICAL FACTS

1. 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, dates of admission: _____

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

   Was medication, other than over-the-counter medication, prescribed? ___No ___Yes.

   Will the patient need to have treatment visits at least twice per year due to the condition? ___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:

   _____

   _____

2. Is the medical condition pregnancy? ___No ___Yes. If so, expected delivery date: _____

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

_____

_____

_____

_____

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ___No ___Yes.

   Estimate the beginning and ending dates for the period of incapacity: _____

   During this time, will the patient need care? __ No __ Yes.

   Explain the care needed by the patient and why such care is medically necessary:

   _____

   _____

   _____

   _____

   _____

5. Will the patient require follow-up treatments, including any time for recovery? ___No ___Yes.

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   _____

   Explain the care needed by the patient, and why such care is medically necessary: _____

   _____

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? __ No __ Yes.

   Estimate the hours the patient needs care on an intermittent basis, if any:

   _____ hour(s) per day; _____ days per week from _____ through _____

   Explain the care needed by the patient, and why such care is medically necessary:

   _____

   _____

   _____

   _____

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ____No ____Yes.

   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) _____ month(s)

   Duration: _____ hours or ___ day(s) per episode

   Does the patient need care during these flare-ups? ____ No ____ Yes.

   Explain the care needed by the patient, and why such care is medically necessary: _____

   _____

   _____

   _____

   _____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

_____ _____

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. 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 Ave., NW, Washington, DC 20210.
DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.