MEMORANDUM

TO: ALL EMPLOYEES
FROM: DIRECTOR, HUMAN RESOURCES, SAFETY & RISK
SUBJECT: FMLA POLICY PER THE PERSONNEL POLICY MANUAL
DATE: 20 JUNE 2019

A. FAMILY AND MEDICAL LEAVE ACT ("FMLA")

The City of Allentown recognizes that it sometimes may be difficult for employees to balance the demands of a job with personal and family needs. The Family Medical Leave Act of 1993 ("FMLA") requires certain employers to allow eligible employees to take up to 12 weeks of leave (paid and/or unpaid) to care for a newborn or newly adopted child, to recuperate from their own serious illness, or to care for a seriously ill family member. For purposes of this policy, "family members" include: (1) the employee's spouse, (2) the employee's parent, (3) the employee's natural or adopted child or dependent stepchild. For FMLA purposes, the year shall begin on the first date FMLA leave is taken.

An eligible employee is one who has at least 12 months of service with the City of Allentown and has worked at least 1,250 hours for the City during the previous 12-month period. Eligibility is determined at the time the employee requests the leave.

An employee of the City of Allentown who has worked for the City for at least one (1) year, and for one thousand two hundred fifty (1,250) hours over the previous twelve (12) months, and works at a worksite which employees fifty (50) or more employees within seventy-five (75) miles, is eligible for leave under the Act. Spouses, both of whom are employed by the City of Allentown, are limited to a total of twelve (12) weeks of leave between them, in any twelve (12) month period, except in circumstances where either spouse or their child is affected by a qualifying serious health condition.

Your twelve (12) weeks of leave may be taken intermittently or your weekly schedule may be reduced in hours, only if written approval from the City of Allentown is given. If you need intermittent or reduced leave schedules due to a medical necessity, your request may be accommodated, provided you make every effort to schedule your absences so as to minimize the impact on the City of Allentown business operations.

Eligible Conditions: Family and medical leave may be requested for:

- *Birth, adoption, or foster care* – A new parent or foster parent may apply for leave within one year after child is born or placed in the parent's home. If both parents work for the City of Allentown, they will be entitled to a total of 12 weeks between them.
- *The employee's serious health condition, as defined by the law*.
- *A family member's serious health condition, as defined by law*.
- *For qualifying exigencies arising out of the fact that the employee's spouse, child or parent is on active duty or call to active duty status as a member of the National Guard or Reserves in support of a contingency operation.*

A covered employer also must grant an eligible employee who is a spouse, child, parent, or next of kin of a current service member of the Armed Forces, including a member of the National Guard or Reserves, with a serious injury or illness up to a total of **26 workweeks** of unpaid leave during a "single 12-month period" to care for the service member.

Use of Paid leave Prior to FMLA Leave: For non-bargaining unit and SEIU employees, leave time will run concurrent with Family medical leave. However, for Police and Firefighters leave time will not run concurrent and employees will be allowed to take the 12 week family medical leave after leave time has been exhausted, if requested by the employee, in writing.

If an employee requests leave under FMLA because of his/her own serious health condition, the employee must first use his/her accumulated sick leave, accumulated vacation days and any accrued vacation or personal days. If an employee requests leave to care for an adopted child with a serious health condition, he/she must first use accumulated vacation and personal days and any accrued vacation days. If these days are fewer than 12 weeks required under the law, the City will grant additional days without pay but with paid medical benefits provided by the Act to a total of 12 weeks.

FMLA leave taken because of an employee's serious health condition shall not be considered when calculating occasions of sick leave used. During the term of FMLA leave, employees will accrue seniority, sick leave, vacation leave and personal days.

Prior Notice and Authorization: The City of Allentown requires that you provide the City with a thirty (30) days' advance notice when FMLA leave is needed, if your need is foreseeable. Otherwise, you must provide the City of Allentown with as much notice as is possible. The City may delay the taking of foreseeable FMLA leave until 30 days after the required notice is provided if these conditions are not met. If you are taking leave for personal illness or the illness of a family member, the City of Allentown requires that you submit medical certifications from a healthcare provider. When you request such leave, we will provide you with the appropriate forms.

Forms: When the City receives a medical certification indicating that the employee has a serious health condition and will be on medical leave for longer than five (5) days, the employee will be notified in writing that medical leave will be charged to the yearly entitlement under the provisions of the FMLA.

The employee will be required to provide medical certification of a serious health condition to the City of Allentown in accordance with FMLA and as will be further explained to the employee requesting FMLA leave at the time of such request. When an employee requests such leave, the City will provide the employee with the appropriate forms. The Department of Labor-Certification of Health Care Provider form must be completed by a healthcare professional (see definition below) and returned within 15 days following the request.

While on FMLA leave, employees are requested to report periodically to the City every 30 days regarding the status of the medical condition and their intent to return to work.

In accordance with our uniform medical leave of absence policy, if you take FMLA leave for personal illness, the City of Allentown will also require a medical certification, on a City of Allentown Medical Certification form, indicating whether you are able to return without restrictions or unable to return from leave due to your health condition. Restoration may be denied until such certification is provided.

Return from FMLA Leave: At the conclusion of FMLA leave, most employees will be restored to their original or equivalent positions with the equivalent pay, benefits and other terms and conditions of employment. The City of Allentown is not obligated to restore any employee whose job position has been eliminated during the leave period. The City of Allentown reserves the right to deny restoration to certain highly compensated employees if necessary to avoid substantial and grievous economic injury to the City of Allentown's operations. These "key" employees are among the ten percent (10%) most highly compensated employees and will be notified of their status as "key" employees at the time they make their request for family medical leave. If it is anticipated that it may be necessary to deny restoration to a "key" employee, the City of Allentown will notify that employee and offer him/her an opportunity to return to work. If that employee elects not to return to work, the City of Allentown will nevertheless reconsider at the end of the leave period whether or not it will be possible to reinstate that employee without suffering substantial and grievous economic injury.

Health Care Coverage: During the period of your FMLA leave, the City of Allentown will continue your health care coverage as if you were continuously employed. Failure to make timely co-payments, for those required, may result in the termination of your health care coverage. Provisions for the payment of your health care co-payments will be made at the time of your leave request. The use of FMLA leave will not affect your exempt status under the Fair Labor Standards Act if you are already considered exempt. If you fail to return to work at the conclusion of your leave period, you are obligated to repay the City of Allentown the cost of your health care premiums paid for by the City during the period of your leave.

Other Terms and Conditions: The City of Allentown will not interfere with, or restrain or deny the exercise of any right provided under the FMLA. We will not discharge or discriminate against any person for opposing any practice made unlawful by the FMLA nor will we discriminate against or discharge any person because of involvement in any proceeding under or related to the FMLA. The Secretary of Labor is authorized to investigate and attempt to resolve complaints of violations and may bring an action in any federal or state court against a company for violating the FMLA. The FMLA will be enforced by the Department of Labor's Wage and Hour Division. An eligible employee may also bring a civil suit for violations of the FMLA. It should be noted that the FMLA does not affect any federal or state law prohibiting discrimination, nor does it supersede any state or local law which provides for greater family medical leave benefits. The FMLA does not affect an employer's obligation to provide greater leave benefits if that is required under a collective bargaining agreement or employment benefit plan or contract. No rights provided for under the FMLA may be diminished or waived by the agreement, plan or contract. A copy of your rights under the FMLA is posted at the City of Allentown, and we are always happy to answer any questions concerning the FMLA or other concerns you may have as an employee. When FMLA is requested, we will provide you with a summary of your rights and obligations, and the expectations that we have of you in exercising leave. If an employee should find that an additional leave of absence is needed at the end of the FMLA leave period, that employee should feel free to contact the City of Allentown Human Resource Department. Requests for additional leave of absence will be handled on an individualized basis.

TERMS:

Healthcare provider: A FMLA ruling recognizes any health care provider accepted by the employer's group health (or equivalent) plan and adds clinical social workers to the extent authorized under State law to independently diagnose and treat serious health conditions without supervision. Physician assistants are not specifically included, as they are ordinarily limited to practicing under a doctor's supervision, but any services or treatments they furnish under the supervision of a doctor, and any services recognized by the employer's health plan furnished on referral and under continuing supervision of a health care provider as defined, would qualify as medical treatment for purposes of FMLA.

Certification of Health Care Provider for Employee's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor

Wage and Hour Division

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT

OMB Control Number: 1235-0003
Expires: 8/31/2021

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 due to a serious health condition to submit a medical certification issued by the employee's health care provider. 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 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, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: City of Allentown, Human Resources, 435 W. Hamilton St., Allentown, PA 18101; Fax: 610-437-7675, Phone: 610-437-7523

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions: _____

_____

Check if job description is attached:

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your 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 due to your own 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. 29 C.F.R. § 825.305(b).

Your name: _____
First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. 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. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b). 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: _____

   Mark below as applicable:
   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:

   _____

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

   Was medication, other than over-the-counter medication, prescribed? ___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. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

   Is the employee unable to perform any of his/her job functions due to the condition: ____ No ____ Yes.

   If so, identify the job functions the employee is unable to perform:

   _____

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

   _____

   _____

   _____

   _____

   _____

   _____

   _____

CONTINUED ON NEXT PAGE

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___No ___Yes.

   If so, estimate the beginning and ending dates for the period of incapacity: _____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ___No ___Yes.

   If so, are the treatments or the reduced number of hours of work medically necessary?
   ___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:

   _____

   Estimate the part-time or reduced work schedule the employee needs, if any:

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

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ____No ____Yes.

   Is it medically necessary for the employee to be absent from work during the flare-ups?
   ____ No ____Yes. If so, explain:

   _____

   _____

   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

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

CONTINUED ON NEXT PAGE

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.**