

City of Cabot, Arkansas



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FMLA ELIGIBILITY

It has come to our attention that you may qualify for Family and Medical Leave (FMLA) under the City's FMLA policy. The FMLA, a federal statute, was passed with the purpose of allowing employees to balance their work and family life by taking reasonable unpaid leave. The City requires employees to use accrued paid time, including vacation and sick leave as well as comp-time during FMLA leave for certain family medical reasons. Details for FMLA leave can be found in the City's personnel handbook, page 69. you may also visit the website for the Department of Labor at www.dol.gov.

Enclosed you will find the City's Leave Certification Requirements Form that lists all the steps necessary to request FMLA leave. In addition, a request form for your completion is also enclosed. Please return both of these forms to the Human Resources Department. Upon receipt of these forms, a determination will be made on your eligibility and a response will be sent to you.

Finally, a Certification of Health Care Provider Form must be completed within 15 days by your physician or your family member's physician in reference to the medical condition. This form should be returned to Human Resources once it has been completed by your Physician.

Sincerely,

Bryan Higgins
Human Resources Director

Enclosures

City of Cabot

Leave Certification Requirements

SECTION I

To request leave for the care of a child, parent, or spouse with a serious health condition.

I have attached a certification form from the health care provider who is treating my child, parent, or spouse. The certification includes the following:

- The date on which the condition commenced;
- The probable duration of the condition;
- The appropriate medical facts within the knowledge of the health care provider regarding the condition;
- An estimate of the time needed to care for the individual involved (including any recurring medical treatment); and
- A statement that the condition warrants my participation to provide care.

SECTION II

To request leave for the care of any employee's personal serious health condition.

I have attached certification from the health care provider who is treating my own serious health condition. The certification includes the following:

- The date on which my condition commenced;
- The probable duration of my condition;
- The appropriate medical facts within the knowledge of the health care provider regarding my condition; and
- A statement that I am unable to perform the functions of my position due to my condition.

SECTION III

Additional certification requirements for intermittent leave or for leave on a reduced leave schedule.

In addition to the foregoing certification from the health care provider involved, I have attached additional information from the health care provider as stipulated below:

- A. Leave for the employee
 - 1. A statement of medical necessity for my intermittent leave or reduced leave schedule and the expected duration of the schedule.
 - 2. A listing of the dates of my planned medical treatment and the duration of the treatment(s).

- B. Leave to care for a son, daughter, spouse or parent
 - 1. A statement attesting to the necessity of intermittent leave or reduced leave for me to provide care or to assist in their recovery.
 - 2. An estimate of the expected duration and schedule of my intermittent or reduced leave.

I certify by my signature that I have read and understand the City's certification policy.

Date: _____ **Name (Print):** _____

_____ **Name (Sign)**

CITY OF CABOT

REQUEST FOR FAMILY AND MEDICAL LEAVE OF ABSENCE

Employees who have worked for at least 1,250 hours during the 12-month period immediately prior to the request for leave are eligible for leave.

Name: _____
Department: _____ Hire Date: _____

TYPE OF LEAVE REQUESTED

(Check One)

_____ Employee Medical Leave of Absence

_____ Extension of Employee Medical Leave of Absence
Dates of prior-approved Family Medical Leave are:
_____ to _____

_____ Family Medical Leave of Absence

_____ Extension of Family Medical Leave of Absence
Dates of prior-approved Family Medical Leave are:
_____ to _____

The Leave (or extension) requested will begin on _____ and end on _____.
If the request is for multiple days off for recurring medical treatments of a child, parent, or spouse, or for your own medical treatments, specify dates requested:

REASON FOR LEAVE

I request a family leave of absence for the following reason:

(Check One)

- _____ 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

Certification of Health

CITY OF CABOT

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 condition¹ 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**² if different):

b. Will it be necessary for the employee to take 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 incapacitated² and the likely duration and frequency of **episodes of incapacity**²:

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 of 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:

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

² "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 therefor, or recovery therefrom.

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):

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. nor 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)

To be completed by the employee needing family leave to care for a family member:

State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule:

(Employee Signature)

(Date)

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 incapacity² or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

(a) A period of incapacity² of **more than three consecutive calendar days** (including any subsequent treatment or period of incapacity² relating to the same condition), that also involves:

- (1) **Treatment³ 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, a health care provider; or
- (2) **Treatment** by a health care provider on **at least one occasion** which results in a **regimen of continuing treatment⁴** under the supervision of the health care provider.

3. Pregnancy

Any period of incapacity due to **pregnancy**, or for **prenatal care**.

4. Chronic Condition Requiring Treatments

A **chronic condition** which:

- (1) Requires **periodic visits** for treatment by a health care provider, or by a nurse 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 a continuing period of incapacity² (e.g., asthma, diabetes, epilepsy, etc.).

5. Permanent/Long-term Conditions Requiring Supervision

A period of **incapacity²** 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.

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, 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.