Medical certification forms will <u>NOT</u> be accepted prior to the first day of a reported absence.

Please complete and return to:

Verizon West (fGTE) Employees
The FMLA Team
750 Canyon Drive Mailcode: SV1EFML
Coppell, TX 75019
Fax: (214) 285-1587
Phone: (877) 275-8947

Verizon East (fBA N/S & VIS) Employees
The Absence Reporting Center
4 West Red Oak Lane, 3rd Fl
White Plains, NY 10604
Fax: (877) 786-4500
Phone: (877) 275-8947

Family and Medical Leave Act (FMLA) Medical Certification Form

FMLA is a federal law that guarantees "eligible" employees up to twelve (12) workweeks of job-protected absence for certain family and medical reasons. You are eligible to request an FMLA absence if you have worked for the company for at least one year, worked a minimum of 1250 hours over the previous twelve (12) months, and need to be absent for one of the following reasons:

- A serious health condition that makes you unable to perform any one of the essential functions of your job.
- To care for your immediate family member (spouse, child, or parent) who has a serious health condition.
- To care for your newborn child, or placement of an adopted or foster child.

Family and Medical Leave Act Definitions for Health Care Providers

as defined by the Department of Labor's Regulations

Activities of daily living (ADLs): Examples include adaptive activities such as caring appropriately for one's grooming and hygiene, bathing, dressing and eating.

Health Care Provider (HCP): Authorized health care providers include any of the following who are authorized to practice under State law, and who are practicing within the scope of that practice: doctors of medicine or osteopathy, podiatrists, dentists, clinical psychologists, optometrists and chiropractors, nurse practitioners, nurse-midwives, clinical social workers, and any other person determined by the Secretary of Labor to be capable of providing health care services.

Incapacity: The inability to work or perform regular daily activities due to the patient's serious health condition, treatment for that condition, or recovery from that condition.

Instrumental activities of daily living (IADLs): Activities include cooking, cleaning, shopping, paying bills, maintaining a residence, using a post office and telephone.

Regimen of Continuing Treatment: Treatment including, 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.

Serious Health Condition: An illness, injury, impairment, or physical or mental condition that meets one of the following criteria:

1. **Hospital Care**: Inpatient care (e.g. 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 (Acute)**: 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:
   (A) Two or more treatments by an HCP or by a nurse or physician's assistant under direct supervision of an HCP, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, an HCP; or
   (B) At least one treatment by an HCP which results in a regimen of continuing treatment under the supervision of the HCP.
3. **Pregnancy**: Any period of incapacity due to pregnancy, or for prenatal care.
4. **Chronic Health Condition Requiring Treatments**: A chronic condition which:
   (A) Requires periodic visits for treatment by an HCP, or by a nurse or physician's assistant under direct supervision of an HCP;
   (B) Continues over an extended period of time; and
   (C) May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).
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, e.g. Alzheimer's, a severe stroke. The patient must be under the continuing supervision of, but need not be receiving active treatment by, an HCP.
6. **Scheduled Multiple Treatments**: Any period of absence to receive scheduled multiple treatments (including any period of recovery) by an HCP or by a provider of health care services under orders of, or on referral by, an HCP, 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).

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.

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INSTRUCTIONS: We estimate that it will take an average of ten (10) minutes to complete this form.

1) **Employee** – Complete Section **A**
2) **Employee's Treating Health Care Provider** – Complete Sections **B** and **D**
3) **Family Member's Treating Health Care Provider** – Complete Sections **B**, **C**, and **D**

Please note: Incomplete forms will be returned for completion.

SECTION A:

(TO BE COMPLETED BY THE **EMPLOYEE**. PLEASE BE ADVISED THAT KNOWINGLY PROVIDING FALSE OR INACCURATE INFORMATION IN THIS CERTIFICATION IS A VIOLATION OF THE COMPANY'S CODE OF BUSINESS CONDUCT.)

Employee's Name	Social Security Number	First Date of Absence
Home Address (include city, state, zip)	Home Telephone Number	Work Telephone Number
Supervisor/ Absence Administrator's Name	Supervisor/ Absence Administrator's E-Mail Address	Supervisor/ Absence Administrator's Telephone Number

Type of Leave: (check all that apply)

☐ New Request ☐ Extension/ Recertification ☐ On the Job Injury

Reason for Leave: (check one)

☐ A serious health condition that makes you unable to perform any one of the essential functions of your job.
☐ A serious health condition affecting your spouse, child, or parent for which you are needed to provide care.
☐ The birth of your child, or the placement of a child with you for adoption or foster care for the period beginning ____/____/____through ____/____/____. You must attach documentation supporting the date of your child's birth, or the date of foster placement or adoption.

Requested FMLA: (check one)

☐ Full Time Leave – Taken in consecutive, full day increments.
☐ Intermittent Leave – Taken periodically over an extended period of time.
☐ Reduced Work Schedule – Taken on consecutive days; employee is able to work some of his/ her work schedule each day.

By placing my signature below, I authorize my health care provider to **(a)** complete this form and **(b)** clarify any information provided on the form that is incomplete or unclear, either verbally or in writing. I hereby certify that the information provided on this certification form is true and accurate.

Signature of Employee or Family Member____**Date**____/____/____

SECTION B:

(TO BE COMPLETED BY THE **TREATING HCP**. PLEASE NOTE: INCOMPLETE FORMS WILL BE RETURNED FOR COMPLETION AND MAY RESULT IN DENIAL OF FMLA.)

Patient's Name______________________________ Relationship to Employee_______________Date of Birth ____/____/____

1.A Describe the medical facts which support your certification, including a brief statement as to how the medical facts meet the criteria for a serious health condition under the FMLA (see page one). ____
____

1.B If leave is for the employee's own health condition, please describe how the health condition interferes with the performance of essential job function(s).
____
____

2. First day of incapacity covered by this certification: _____/_____/_____.

3. Probable last day of incapacity covered by this certification: _____/_____/_____.

4. This patient has been under my care for this health condition since: _____/_____/_____.

SECTION B - continued: (TO BE COMPLETED BY THE **TREATING HCP**. PLEASE NOTE: INCOMPLETE FORMS WILL BE RETURNED FOR COMPLETION AND MAY RESULT IN DENIAL OF FMLA.)

5. Does the patient's condition qualify as a "*serious health condition*" under the Family and Medical Leave Act (FMLA)? (See page one for *Family and Medical Leave Act Definitions for Health Care Providers*.)

☐ **NO**, the patient's condition does not qualify as a serious health condition under FMLA. (If you check this box, go directly to Section D.)

☐ **YES**, the patient's condition qualifies as a serious health condition according to the following category as described by FMLA regulations. (Please check all that apply, and complete the applicable information.)

a) ☐ **Hospital Care (Inpatient – overnight stay)**

- Admit Date: _____/_____/_____ Discharge Date: ____/____/____
- Follow-up Appointment Date(s): ____

b) ☐ **Absence Plus Treatment (Acute)**

The patient's period of incapacity exceeded three **(3)** consecutive calendar days and involved treatment two **(2)** or more times by the health care provider, or treatment on at least one occasion which resulted in a regimen of continuing treatment. If a regimen of continuing treatment is required under your supervision, provide a general description of the regimen (e.g., **prescribed medication, physical therapy**):____

____

____

Follow-up Appointment Date(s): ____

c) ☐ **Chronic Condition Requiring Treatment/Permanent Long Term Condition Requiring Supervision**

The patient requires periodic visits to the HCP for treatment, the condition continues over an extended period of time, and the condition may cause episodic rather than a continuing period of incapacity. The patient requires the following treatment including **prescribed medication,** examinations and/or evaluations of the condition: ______________________

____

____

"You are providing medical certification for: **(check one)**"

☐ Current Absence Only Period of incapacity of this absence ____/____/____

☐ Current Absence and Future Intermittent Absences (Please complete the following information.)

- How often do you expect this patient to be incapacitated due to their health condition? (indicate range, if applicable) ____________ times per (**circle one**: week, month, year) each lasting (indicate range, if applicable) ____________ (**circle one**: minutes, hours, days, weeks) for a period of __________ (**circle one**: weeks, months)

d) ☐ **Scheduled Multiple Treatments**

- The patient receives the following treatment: ____

  ____

  ____

- Treatments will commence on _____/_____/_____ through _____/_____/_____.
- The approximate length of the actual treatment is ___________ (**circle one:** minutes, hours).
- The treatment is ___________ times per (**circle one**: week, month).
- The period required for recovery from treatment is ___________ (**circle one:** hours, days, weeks).

SECTION B - continued: (TO BE COMPLETED BY THE **TREATING HCP**. PLEASE NOTE: INCOMPLETE FORMS WILL BE RETURNED FOR COMPLETION AND MAY RESULT IN DENIAL OF FMLA.)

e) ☐ **Pregnancy**

- The patient's pregnancy was confirmed on ____/____/____ with an estimated delivery date (EDC) of ____/____/____.
- The patient is scheduled for approximately _________ prenatal appointments
- Do you presently anticipate a need for the patient to be absent from work during her pregnancy? ☐ Yes ☐ No
  - If yes, the likely frequency of episodes of incapacity (indicate range, if applicable): ___________ times per (**circle one:** week, month), each lasting approximately ___________ (**circle one**: hours, days, weeks).

6. If a **Reduced Work Schedule** is necessary upon an employee's return to duty, please provide a description of the required work schedule: (i.e., number of hours per day) ____________________________ from _____/_____/_____ through _____/_____/_____.

SECTION C: (TO BE COMPLETED BY THE **TREATING HCP** IF THE LEAVE REQUEST IS **TO CARE FOR A FAMILY MEMBER**. PLEASE NOTE: INCOMPLETE FORMS WILL BE RETURNED FOR COMPLETION AND MAY RESULT IN DENIAL OF FMLA.)

7. It is necessary for the employee to be absent from work from _____/_____/_____ through _____/_____/_____ to care for the family member. (Please check one of the following and complete the applicable information.)

   ☐ **Full Time Leave –** Taken in consecutive, full day increments.

   ☐ **Intermittent Leave –** Taken periodically over an extended period of time, with a likely frequency of ________________ times per (**circle one:** week, month, year) with a probable duration of ___________ (**circle one:** minutes, hours, days, weeks).

   ☐ **Reduced Work Schedule –** Taken on consecutive days; the employee is able to work some of his/ her work schedule each day. The employee is able to work ___________ hours per day.

8. Does the patient require assistance for:

Basic Medical or Personal Needs	☐ Yes	☐ No	Transportation	☐ Yes	☐ No
Psychological Comfort	☐ Yes	☐ No	Safety	☐ Yes	☐ No

9. If leave is required to care for a child age 18 or older, the child must be incapable of self-care. The individual must require active assistance or supervision to provide daily self-care in three or more of the activities of daily living (ADLs) or instrumental activities of daily living (IADLs). If the employee has requested FMLA leave to care for a child age 18 or older, please provide at least three ADLs/ IADLs that the patient requires active assistance or supervision with. (See page one for the definition of ADL's and IADL's.) ________
   ____
   ____

SECTION D: (TO BE COMPLETED BY THE **TREATING HEALTH CARE PROVIDER**.)

We strongly recommend that you retain a copy of this form in the event clarification of its content is needed. Incomplete forms will be returned to the employee to be completed. This may result in a delay or denial of the employee's FMLA approval.

I certify that the above information is true and correct.

____

Treating Health Care Provider's Printed Name | Signature | Date

____

Type of Practice | Address | Phone # | Fax #

Fax Cover Sheet

Medical certification forms will NOT be accepted prior to the first day of a reported absence.

Employees please ensure to send the FMLA forms to the correct Processing Center:

Verizon West (fGTE) Employees
FMLA Team
750 Canyon Drive Mailcode:SV1EFML
Coppell, TX 75019
FAX 214-285-1587

Verizon East (fBA N/S & VIS) Employees
Absence Reporting Center
4 West Red Oak Lane, 3rd Fl
White Plains, NY 10604
FAX 1-877-786-4500

Employee Name: ______________________________

First Day of Absence: ___________________

Date: ___________________________________

Fax#:___________________________________

From: ___________________________________

Pages including cover sheet: _____________

CONFIDENTIAL AND PRIVATE

Your Rights
Under The
Family and Medical Leave Act of 1993

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to "eligible" employees for certain family and medical reasons.

Reasons for Taking Leave:

Unpaid leave must be granted for *any* of the following reasons:

- to care for the employee's child after birth, or placement for adoption or foster care;
- to care for the employee's spouse, son or daughter, or parent, who has a serious health condition; or
- for a serious health condition that makes the employee unable to perform the employee's job

At the employee's or the employer's option, certain kinds of *paid* leave may be substituted for unpaid leave.

Advance Notice and Medical Certification:

The employee may be required to provide advance leave notice and medical certification. Taking of lave may be denied if requirements are not met.

- The employee ordinarily must provide 30 days advance notice when the leave is "foreseeable."
- An employer may require medical certification to support a request for leave because of a serious health condition, and may require second or third opinions (at the employer's expense) and a fitness for duty report to return to work.

Job Benefits and Protection:

- For the duration of FMLA leave, the employer must maintain the employee's health coverage under any "group health plan."

Employees are eligible if they have worked for a covered employer for at least one year, and for 1,250 hours over the previous 12 months, and if there are at least 50 employees within 75 miles.

- Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.
- The use of FMLA leave cannot result in the loss of any employment benefits that accrued prior to the start of an employee's leave.

Unlawful Acts by Employers:

FMLA makes it unlawful for any employer to:

- interfere with, restrain, or deny the exercise of any right provided under FMLA:
- discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement:

- The U.S. Department of Labor is authorized to investigate and resolve complaints of violations.
- An eligible employee may bring a civil action against an employer for violations.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

For Additional Information:

Contact the nearest office of the Wage and Hour Division, listed in most telephone directories under U.S. Government, Department of Labor.