

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

Dear Employee,

You may be eligible for leave under the Family and Medical Leave Act (FMLA) as described in the attachment, "Employee Rights and Responsibilities Under the Family and Medical Leave Act ". The enclosed materials describe your rights and obligations under FMLA. The company will comply also with any applicable state laws and contractual bargaining agreements. In order to be approved for FMLA, you must complete and submit the enclosed *Family and Medical Leave Act (FMLA) Certification for Serious Injury or Illness of Covered Servicemember for Military Family Leave Form*.

It is your responsibility to ensure that your completed *Family and Medical Leave Act (FMLA) Certification for Serious Injury or Illness of Covered Servicemember for Military Family Leave Form* is received by our office, via fax or mail, within 25 days (calendar days) of your first day of absence or 25 days (calendar days) from the date the absence was reported. Please allow for appropriate mail time. We strongly recommend that you retain a copy of the application and proof of mailing/ faxing for your records.

We will notify you of the status of your FMLA request after receiving and reviewing the completed *Family and Medical Leave Act (FMLA) Certification for Serious Injury or Illness of Covered Servicemember for Military Family Leave Form*.

If approved:

- The period of your approved leave (which can be up to 26 weeks in a single 12 month period) will be counted toward your FMLA allotment, and state allotment, if applicable.
- Your FMLA leave will run concurrent with any periods of approved payments under any applicable plan, policy, program, or collective bargaining agreement.
- If you are not entitled to payment during FMLA leave, you may supplement your leave with other available paid time off, such as vacation or personal days, otherwise, your leave will be unpaid.
- Recertification will be required if your leave exceeds the approved period.
- If you fail to return to work upon the expiration of your FMLA leave, and you have not made any alternative arrangements, the company may treat your failure to return as a voluntary resignation.

Your FMLA request may be denied, and therefore, the absence may be subject to the provisions of the established attendance plan and practices in your area, if:

- The completed form is not received by our office within 25 days (calendar days) from the first day of absence or 25 days (calendar days) from the date the absence was reported.
- Your absence exceeds your remaining FMLA entitlement.

Please remember that it is your responsibility to ensure the completed form is received by our office within 25 days (calendar days) from the first day of absence or 25 days (calendar days) from the date the absence was reported. You are responsible for communicating with your Supervisor/ Absence Administrator during your absence period.

If you have any questions, please contact the FMLA Administrator at (877) 275-8947 or visit the Verizon e-web and search for FMLA.

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

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

Please complete and return to:

Verizon West ( fGTE) Employees	Verizon East ( fBA N/S & VIS) Employees
The FMLA Team 700 Hidden Ridge Mailcode: HQW03H65 Irving, TX 75038 Fax: (214) 285-1587 Phone: (877) 275-8947	The Absence Reporting Center 500 Summit Lake Drive, 4 <sup>th</sup> Floor, Valhalla, NY 10595 Fax: 877-786-4500 Phone: (877) 275-8947

**Employee's Name:** \_\_\_\_\_ **First Day of Absence** \_\_\_\_\_ **BAID** \_\_\_\_\_

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

**FOR SIGNATURE BY COVERED SERVICEMEMBER**

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 Family Member**

\_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**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**

Type of Leave:       **New Request**                                       **Recertification/Extension**

**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**

**Requested FMLA:** (check all that apply)

\_\_\_\_\_ Full Time Leave - Taken in consecutive, full day increments.  
 \_\_\_\_\_ Intermittent Leave - Taken periodically over an extended period of time.

**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 following information with respect to the servicemember's current assignment:

Military Branch: \_\_\_\_\_  
 Rank: \_\_\_\_\_  
 Unit: \_\_\_\_\_

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: \_\_\_\_\_

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

**Employee's Name:** \_\_\_\_\_ **First Day of Absence** \_\_\_\_\_ **BAID** \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

Provide an Estimate of the Leave Needed to Provide the Care:  
From \_\_\_/\_\_\_/\_\_\_ To \_\_\_/\_\_\_/\_\_\_

**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: HEALTHCARE PROVIDER INFORMATION:**

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.

<b>Health Care Provider's Name</b>	<b>Business Address</b>	<b>Telephone Number</b>
	Fax	E-Mail

**Type of Practice/Medical Specialty:** \_\_\_\_\_

Please state whether you are either a:

<input type="checkbox"/> <b>DOD health care provider</b>	<input type="checkbox"/> <b>DOD TRICARE network authorized private health care provider</b>
<input type="checkbox"/> <b>VA health care provider</b>	<input type="checkbox"/> <b>DOD non-network TRICARE authorized private health care provider</b>

**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 will be required to complete the **FMLA Medical Certification Form 20-1923**.)

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

**Employee's Name:** \_\_\_\_\_ **First Day of Absence** \_\_\_\_\_ **BAID** \_\_\_\_\_

2. Was the condition for which the Covered Servicemember 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:

From \_\_\_\_/\_\_\_\_/\_\_\_\_ Through : \_\_\_\_/\_\_\_\_/\_\_\_\_

2. Will the covered servicemember require periodic follow-up treatment appointments?

If yes, estimate the treatment schedule with a likely frequency of:

(#)\_\_\_\_ times per (circle one: week, month, year ) with a probable duration of (#)\_\_\_\_ (circle one: minutes, hours, days, weeks) for a period of (#) \_\_\_\_ (circle one: weeks, months)

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 coveredservice member 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:

(#)\_\_\_\_ times per (circle one: week, month, year ) with a probable duration of (#)\_\_\_\_ (circle one: minutes, hours, days, weeks) for a period of (#) \_\_\_\_ (circle one: weeks, months)

\_\_\_\_\_  
**Signature of Health Care Provider:**

\_\_\_\_\_  
**Date**

# 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  
700 Hidden Ridge Mailcode:HQW03H65  
Irving, TX 75038  
FAX 214-285-1587

Verizon East ( fBA N/S & VIS) Employees  
Absence Reporting Center  
500 Summit Lake Drive 4<sup>th</sup> Fl  
Valhalla, NY 10595  
FAX 1-877-786-4500

**Employee Name:** \_\_\_\_\_

**BAID:** \_\_\_\_\_

**First Day of Absence:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Fax#:** \_\_\_\_\_

**From:** \_\_\_\_\_

**Pages including cover sheet:** \_\_\_\_\_

**CONFIDENTIAL AND PRIVATE**

**Employee Rights and Responsibilities**  
Under the Family and Medical Leave Act

**Basic Leave Entitlement**

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- 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.

**Military Family Leave Entitlements**

Eligible employees with a spouse, son, daughter, or parent 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. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

**Benefits and Protections**

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

**Eligibility Requirements**

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

**Definition of Serious Health Condition**

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities. Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

**Use of Leave**

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

**Substitution of Paid Leave for Unpaid Leave**

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with an employer's normal paid leave policies.

**Employee Responsibilities**

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

**Employer Responsibilities**

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility. Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

**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**

An employee may file a complaint with the US Department of Labor or may bring a private lawsuit against an employer.

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.

**FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures**

**For Additional Information:**

1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627

[WWW.WAGEHOUR.DOL.GOV](http://WWW.WAGEHOUR.DOL.GOV)

U.S. Department of Labor/Employment Standards Administration/Wage and Hour Division