

.....MUNICIPAL COURT
SUPERVISOR FMLA ADMINISTRATIVE CHECKLIST

EMPLOYEE NAME _____
CLASSIFICATION _____ DATE _____
EFFECTIVE DATE OF LEAVE _____ SUPERVISOR _____

LEAVE INFORMATION

REASON FOR LEAVE	RELATIONSHIP TO PARTY	ADDITIONAL INFORMATION
<input type="checkbox"/> ILLNESS	<input type="checkbox"/> SELF	IS THIS LEAVE WORK RELATED?
<input type="checkbox"/> BIRTH	<input type="checkbox"/> CHILD	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> ADOPTION	<input type="checkbox"/> SPOUSE	
<input type="checkbox"/> INJURY	<input type="checkbox"/> PARENT	HAS THIS LEAVE BEEN, OR WILL
<input type="checkbox"/> OTHER	<input type="checkbox"/> OTHER	IT BE OVER THREE (3) DAYS
		IN DURATION?
		<input type="checkbox"/> YES <input type="checkbox"/> NO

FOR MEDICAL RELATED LEAVE

NAME OF PHYSICIAN _____

NAME OF HOSPITAL _____
(OR ATTENDING PHYSICIAN)

FOR ADOPTION PLACEMENT

NAME/JURISDICTION OF CRT _____

NAME OF ATTORNEY _____
SOCIAL WORKER'S NAME _____

SUPERVISOR'S CERTIFICATION/EMPLOYEE ACKNOWLEDGMENT

(PLEASE INITIAL ALL THAT ARE APPLICABLE)

EMPLOYEE NOTIFIED THAT ALL VACATION, SICK AND PERSONAL LEAVE MUST BE USED FIRST AS PART OF THE TWELVE (12) WEEK LEAVE. **SUPERVISOR** _____ **EMPLOYEE** _____

THE EMPLOYEE FILE HAS BEEN REVIEWED FOR PRIOR USE OF FMLA TO ENSURE ELIGIBILITY. **SUPERVISOR** _____ **EMPLOYEE** _____

NOTIFIED THE EMPLOYEE THAT A REQUEST FOR LEAVE FORM AND CERTIFICATION OF HEALTH CARE PROVIDER FORM MUST BE COMPLETED WITHIN FIFTEEN (15) CALENDAR DAYS OF THE EFFECTIVE DATE OF LEAVE. **SUPERVISOR** _____ **EMPLOYEE** _____

NOTIFIED EMPLOYEE THAT HE/SHE WILL BE RESPONSIBLE FOR CONTINUING PAYMENT OF INSURANCE PREMIUMS. **SUPERVISOR** _____ **EMPLOYEE** _____

REQUESTED POSSIBLE RETURN TO WORK DATE _____
SUPERVISOR _____ **EMPLOYEE** _____

SUPERVISOR'S SIGNATURE _____ DATE _____

..... MUNICIPAL COURT
FMLA CERTIFICATION OF LEAVE PAYROLL OFFICER

(PLEASE INDICATE ALL APPLICABLE LEAVE TIME)

EMPLOYEE NAME _____

DEPARTMENT _____

CLASSIFICATION _____

BALANCE OF LEAVE HOURS:

_____ VACATION HOURS

_____ SICK LEAVE

_____ PERSONAL LEAVE

_____ OTHER (PLEASE SPECIFY TYPE OF LEAVE) _____

PAYROLL OFFICER: _____ DATE: _____

FMLA LEAVE SUMMARY - SUPERVISOR REVIEW

_____ DAYS OF FMLA LEAVE TAKEN SINCE _____
(MEASURED 365 DAYS BACKWARD FROM PRIOR DATE OF FMLA USED)

_____ TOTAL MAXIMUM DAYS OF FMLA AVAILABLE

SUPERVISOR SIGNATURE _____ **DATE** _____

ADMINISTRATIVE REVIEW

FMLA QUALIFIED YES NO

REVIEWED/APPROVED BY _____ DATE _____

..... MUNICIPAL COURT

EMPLOYER RESPONSE TO EMPLOYEE REQUEST FOR FMLA

FAMILY AND MEDICAL LEAVE ACT OF 1993

TO: (EMPLOYEE) _____

FR: (SUPERVISOR) _____

DT: _____

RE: REQUEST FOR FAMILY/MEDICAL LEAVE

ON _____, YOU NOTIFIED THE COURT OF YOUR NEED TO TAKE FAMILY/MEDICAL LEAVE DUE TO:

- THE BIRTH OF YOUR CHILD, OR THE PLACEMENT OF A CHILD WITH YOU FOR ADOPTION OR FOSTER CARE, OR
- A SERIOUS HEALTH CONDITION THAT MAKES YOU UNABLE TO PERFORM THE ESSENTIAL FUNCTIONS OF YOUR JOB, OR
- A SERIOUS HEALTH CONDITION AFFECTING YOUR SPOUSE, CHILD OR PARENT FOR WHICH ARE YOU NEEDED TO PROVIDE CARE

YOU NOTIFIED THE COURT YOU NEED THIS LEAVE BEGINNING _____ AND THAT YOU EXPECT LEAVE TO CONTINUE UNTIL ON OR ABOUT _____

EXCEPT AS EXPLAINED BELOW, YOU HAVE A RIGHT UNDER THE FMLA FOR UP TO TWELVE (12) WEEKS OF UNPAID LEAVE IN A 12-MONTH PERIOD FOR THE REASONS LISTED ABOVE. ALSO, YOUR HEALTH BENEFITS MUST BE MAINTAINED DURING ANY PERIOD OF UNPAID LEAVE UNDER THE SAME CONDITIONS AS IF YOU CONTINUED TO WORK, AND YOU MUST BE REINSTATED TO THE SAME OR AN EQUIVALENT JOB WITH THE SAME PAY, BENEFITS, TERMS AND CONDITIONS OF EMPLOYMENT ON YOUR RETURN LEAVE. IF YOU DO NOT RETURN TO WORK FOLLOWING FML FOR A REASON OTHER THAN (1) THE CONTINUATION, RECURRENCE OR ONSET OF A SERIOUS HEALTH CONDITION WHICH WOULD ENTITLE YOU TO FML; OR (2) OTHER CIRCUMSTANCES BEYOND YOUR CONTROL, YOU MAY BE REQUIRED TO REIMBURSE US FOR OUR SHARE OF HEALTH INSURANCE PREMIUMS PAID ON YOUR BEHALF DURING YOUR FML.

THIS IS TO INFORM YOU OF THE FOLLOWING:

1. YOU ARE ELIGIBLE NOT ELIGIBLE FOR LEAVE UNDER FMLA.
2. THE REQUESTED LEAVE WILL WILL NOT BE COUNTED AGAINST YOUR ANNUAL FMLA LEAVE ENTITLEMENT.

3. YOU WILL BE REQUIRED TO FURNISH MEDICAL CERTIFICATION OF A SERIOUS HEALTH CONDITION. IF REQUIRED, YOU MUST FURNISH CERTIFICATION BY _____ . (MUST BE AT LEAST 15 DAYS AFTER YOU ARE NOTIFIED OF THIS REQUIREMENT) OR WE MAY DELAY THE COMMENCEMENT OF YOUR LEAVE UNTIL THE CERTIFICATION IS SUBMITTED.

4. IF YOU HAVE ACCRUED PAID LEAVE WE WILL REQUIRE THAT YOU USE YOUR LEAVE AS ALL OR PART OF THE TWELVE WEEKS AND TAKE THE REMAINDER OF THE TWELVE WEEKS AS UNPAID LEAVE.

5. (A) IF YOU NORMALLY PAY A PORTION OF THE PREMIUMS FOR YOUR HEALTH INSURANCE, THESE PAYMENTS WILL CONTINUE DURING THE PERIOD OF FMLA LEAVE. ARRANGEMENTS FOR PAYMENT HAVE BEEN DISCUSSED WITH YOU AND IT IS AGREED THAT YOU WILL MAKE PREMIUM PAYMENTS AS FOLLOWS: _____.

- (B) YOU WILL HAVE A MINIMUM OF 30 DAYS GRACE PERIOD IN WHICH TO MAKE PREMIUM PAYMENTS. IF PAYMENT IS NOT MADE TIMELY, YOUR GROUP HEALTH INSURANCE MAY BE CANCELLED, PROVIDED WE NOTIFY YOU IN WRITING AT LEAST 15 DAYS BEFORE THE DATE THAT YOUR HEALTH COVERAGE WILL LAPSE.

- (C) YOU WILL BE RESPONSIBLE FOR THE PAYMENT OF ANY OTHER BENEFITS (E.G. LIFE INSURANCE, DISABILITY INSURANCE, ETC.) WHILE YOU ARE ON FML.

6. YOU WILL BE REQUIRED TO PRESENT A FITNESS-FOR-DUTY CERTIFICATE PRIOR TO BEING RESTORED TO EMPLOYMENT. IF SUCH CERTIFICATION IS *NOT RECEIVED, YOUR RETURN TO WORK MAY BE DELAYED UNTIL THE CERTIFICATION IS PROVIDED*.

7. (A) YOU ARE ARE NOT A "KEY EMPLOYEE" AS DESCRIBED IN SECTION 825.218 OF THE FMLA REGULATION. IF YOU ARE A "KEY EMPLOYEE", RESTORATION TO EMPLOYMENT MAY BE DENIED FOLLOWING FML ON THE GROUNDS THAT SUCH RESTORATION WILL CAUSE SUBSTANTIAL AND GRIEVOUS ECONOMIC INJURY TO THE COURT.

- (B) WE HAVE HAVE NOT DETERMINED THAT RESTORING YOU TO EMPLOYMENT AT THE CONCLUSION OF FML WILL CAUSE SUBSTANTIAL AND GRIEVOUS ECONOMIC HARM TO THE COURT.

8. WHILE ON LEAVE, YOU WILL BE REQUIRED TO FURNISH US WITH PERIODIC REPORTS EVERY _____ DAYS OF YOUR STATUS AND INTENT TO RETURN TO WORK. IF CIRCUMSTANCES OF YOUR LEAVE CHANGED YOU ARE ABLE TO RETURN TO WORK EARLIER THAN THE DATE INDICATED ON THE TOP SIDE OF THIS FORM, YOU WILL BE REQUIRED TO NOTIFY US AT LEAST TWO WORK DAYS PRIOR TO THE DATE YOU INTEND TO REPORT FOR WORK, WITH THE APPROPRIATE MEDICAL CERTIFICATION (FITNESS FOR DUTY).

9. YOU WILL BE REQUIRED TO FURNISH RECERTIFICATION RELATING TO A SERIOUS CONDITION.

10. BY SIGNING BELOW I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THEMUNICIPAL COURT FAMILY AND MEDICAL LEAVE ACT POLICY AND WILL FURTHER ABIDE BY THE RULES AS OUTLINED IN THIS POLICY.

SUPERVISOR _____

DATE _____

EMPLOYEE _____

DATE _____