



## CITY OF CONCORD

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## FAMILY AND MEDICAL LEAVE

### 1. PURPOSE

To provide procedures and guidelines on the administration of medical leave in accordance with Federal, State and local laws regarding family and medical leave.

### 2. DEFINITIONS

- 2.1 **12-month Period** - means a rolling 12-month period beginning with the first day of approved Family Medical Leave an employee takes while employed with the City of Concord. A new 12-month period and associated leave entitlement begins 12 months after the first day of Family Medical Leave taken.
- 2.2 **Child** - means a child under the age of 18 years of age, or 18 years of age or older who is incapable of self-care because of a mental or physical disability. An employee's child is one for whom the employee has actual day-to-day responsibility for care and includes a biological, adopted, foster or step-child.
- 2.3 **Serious health condition** - means an illness, injury impairment, or physical or mental condition that involves the following:
- 2.31 Any period of incapacity or treatment in connection with or in consequent to a hospital, hospice or residential medical care facility;
  - 2.32 Any period of incapacity requiring absence from work of more than three calendar days, that also involves continuing treatment by (or under the supervision of) a health care provider;
  - 2.33 Continuing treatment by a health care provider for a chronic or long-term health condition that is incurable or so serious that, if not treated, would likely result in a period of incapacity of more than three calendar days; or
  - 2.34 Prenatal care by a health provider.
- 2.4 **Continuing treatments** - means:
- 2.41 Two or more visits to a health care provider;
  - 2.42 Two or more treatments by a health care practitioner (e.g. physical therapist) on a referral from, or under the direction of a health care provider;
  - 2.43 OR a single visit to a health care provider that results in a regimen of continuing treatment under the supervision of the health care provider (e.g. medication therapy).

### 2. ELIGIBILITY

To be eligible for family and medical leave, an employee must have been employed by the City of Concord for at least 12 months, for at least 1250 hours of service during the 12 month period immediately preceding commencement of family and medical leave.

### 3. QUALIFYING EVENTS

Eligible employees may be entitled to unpaid family and medical leave for the following reasons:

- 3.1 The birth of a son or daughter, and to care for the newborn child;
- 3.2 The placement with the employee of a son or daughter for adoption or foster care;
- 3.4 To care for the employee's spouse, child, or parent (but not in-law) with a serious health condition; and/or
- 3.5 The employee's own serious health condition that makes the employee unable to perform the essential functions of his/her job.

### 4. AMOUNT OF LEAVE ALLOWABLE

An eligible employee may take up to 12 workweeks of unpaid leave during any 12-month period for any one, or combination, of the above qualifying events. The 12-month period is a "floating" 12 months, beginning the first day Family Medical Leave taken while an employee of the City of Concord.

Female employees disabled on the account of pregnancy, childbirth or related condition are eligible for up to four months of unpaid leave. Up to 12 weeks of this leave may be designated by the City of Concord as leave taken under the provisions of the federal Family and Medical Leave Act (FMLA). Upon the expiration of the 4-month pregnancy disability leave, the employee may, under the California Family Rights Act (FRA) take up to an additional 12 workweeks of leave during any 12-month period described above if, as of the time the employee makes such request, all the requirements set forth in the eligibility criteria above are met.

The City of Concord retains the right and may require eligible employees to substitute for family and medical leave any or all of the employee's accrued vacation or other accrued time off during this period. At the employee's request, if the employee takes leave for the care of a family member, a maximum of 240 hours of sick leave (per City policy) may be used in a floating 36 month time period. Additionally, for leave in conjunction with the employee's own illness, the City may require the use of accrued sick leave be substituted during the period of leave. The determination of the extent of paid leave to be taken shall be made on a case by case basis. The use and/or exhaustion of accrued leave will run concurrently with the leave under this policy. Leave (Job Injury and Labor Code 4850) provided under City policy and State Worker's Compensation laws do not run concurrently with FMLA leave periods and are provided exclusive of the provisions of this policy.

Any accrued paid leave, or unpaid family and medical leave, which is approved for family and medical leave benefits will be charged against an employees annual family and medical leave entitlement.

If a husband and wife are both employed by the City of Concord, they can together take only a combined total of 12 weeks of family and medical leave within a 12-month period for any birth, adoption, or placement of a child for foster care. The leave can be split between them. Any such leave taken by each employee shall be charged against that employee's 12 weeks of family and medical leave for his/her own serious health condition or to care for a child or spouse with a serious health condition.

### 5. MEDICAL CERTIFICATION

Any employee seeking leave for any medical purpose (except childbirth) may be required to submit medical documentation on a Certification of Physician or Practitioner form in the following situations:

- 5.1 An initial request for personal or family medical leave (except childbirth or placement), including justification for any requested intermittent or reduced-schedule family and medical leave.
- 5.2 Before the employee returns to work from leave for a serious health condition, to ensure the employee is fit for duty in accordance with other City policy on returning to work. (See attachment 4).

- 5.3 If the City of Concord has paid the employee's health premiums during the family and medical leave and the employee does not return from such leave for a reason other than the continuation, recurrence or onset of a serious health condition that entitles the employee to family and medical care leave or other circumstances beyond the control of the employee.
- 5.4 Anytime the leave exceeds 80 hours unless the employee has been notified in writing of a requirement for certification of absences of less than 80 hours.

If leave is taken for employee's own serious health condition that is non-work related, the City of Concord may require the employee to provide medical recertification from his or her health care provider on a regular basis during such family and medical care leave. If leave is taken to care for an employee's child, spouse or parent who has a serious health condition, the City may require the employee to obtain medical recertification upon the expiration of the originally estimated duration provided by the health care provider.

If the City has reason to doubt the employee's own serious health condition precludes the employee from performing his/her essential job functions, the City can require the employee to undergo a second examination by an independent health care provider to be designated by the City at the City's expense.

Should there be a disagreement between the employee's provider and the City's examination (second examination), the matter will be resolved by a third, jointly selected provider, at the City's expense. The third examination will be final and binding for that leave request.

Medical certification forms (Attachments 1 and 2) are available from the Personnel Department.

## **6. REQUESTING AND SCHEDULING LEAVE**

Employees should request family and medical leave by completing a "Request for Family and Medical Leave" form (See attachment 3) and submitting it to the Personnel Department anytime leave is anticipated to (by Medical Authority) or actually exceeds 80 hours. Hours in excess of 80 (computed cumulatively) taken for the purposes of family or medical leave will be considered FMLA leave. Where leave is in increments of less than 80 hours, the City retains the right to charge those hours to Family and Medical leave on a case-by-case basis (for example, in cases of approved intermittent medical treatments).

The employee will be notified that his or her leave has been designated family and medical care leave before it starts, or before an extension of leave is granted, unless the City does not have sufficient information as to the reason for the leave or a "Request for Family and Medical Leave" form has not been received until after the leave commences.

Employees should provide not less than 30 days' notice for foreseeable childbirth, placement or any planned medical treatment for the employee or his/her spouse, child or parent. Medical certification may be required to accompany such notice (except for childbirth or placement). Where possible, employees must make reasonable effort to schedule foreseeable planned medical treatments so as not to unduly disrupt operations.

The eligible employee may take family and medical leave on an intermittent basis. If an employee requests such intermittent or reduced-schedule leave for foreseeable planned medical treatment, the City may temporarily transfer the employee to an alternate position, for which the employee is qualified, which has equivalent compensation, and which better accommodates such irregular leave.

## **7. INTERIM HEALTH BENEFITS**

During any period that an employee takes leave under this policy, the City will maintain coverage under its group health plan at the level and under the conditions such coverage would have been provided if the employee had continued employment. However, these interim health benefits will not exceed 12 workweeks in a 12-month period except as provided for employees who are out on an accepted Workers' Compensation claim, in which case the Workers' Compensation rules, laws and associated benefits would take precedence.

After benefit exhaustion under workers' compensation provisions, eligible employees may apply for family and medical leave benefits.

For the portion of family and medical leave which is unpaid, the employee is responsible for payment of his/her portion of health insurance premiums during such leave, as if he/she were still on the payroll.

The same rules apply to health insurance during the leave period as if the employee were on any other leave without pay. Employees will be provided with advance notice of costs and a schedule for such interim health insurance premium payments.

If an employee's interim health insurance premium payment is more than 30 days late, the City may cease to provide health care coverage. However, the City may continue to pay the employee's share of any health premiums missed by the employee during the family and medical leave period. The City may recover via subsequent payroll deductions the employee's share of missed premium payments when he/she returns to work.

If the employee does not return from scheduled family and medical leave for a reason other than the continuation, recurrence or onset of a serious health condition that entitles the employee to family and medical care leave, or due to circumstances beyond the employee's control, the City may recover all health premiums it paid on the employee's behalf during any unpaid family and medical care leave. The City may require medical certification of such alleged continued serious health condition.

If health coverage is discontinued because the employee has not made the required interim payments while on family and medical leave, upon the employee's return from family and medical leave and payment of the appropriate amounts due, health benefits will be restored to the employee as if the leave had not been taken and the premium payments had not been missed.

#### **8. REINSTATEMENT FROM LEAVE**

An employee is entitled to return from qualifying family and medical leave to the same or equivalent position with equivalent benefits, pay, and other terms and conditions of employment, and without loss of job seniority or any other status or benefits accrued prior to family and medical leave, if all family and medical leave requirements are met; and provided the employee would still be employed if family and medical leave had not been taken. If the leave was due to the employee's own illness, a fitness for duty examination may be required before the employee is allowed to be reinstated.

Seniority, retirement service credit, and benefits other than group health and dental care do not accrue during unpaid family and medical leave.

#### **9. LIMITATIONS ON REINSTATEMENT**

Certain "key" employees may be denied reinstatement if necessary to prevent substantial and grievous economic injury to the City. A key employee is a salaried eligible employee who is among the highest paid 10% of all employees of the City.

An employee will be advised at the time of a request for, or commencement of, family and medical leave, or as soon thereafter as is practicable, that he/she qualifies as a key employee and that reinstatement may be denied if the City decides that substantial and grievous economic injury to its operations would occur if the employee elects not to return to employment. The key employee will be notified of the City's intent to refuse reinstatement at the time the City determines refusal is necessary to prevent substantial and grievous economic injury to the City. If leave has already commenced, the employee will be given a reasonable opportunity to return to work following the notice of the intent to refuse reinstatement.

An employee who gives notice of intent not to return to work will be considered to have voluntarily resigned. Such notice may be a qualifying event entitling the employee to continuation of health care coverage under COBRA.

**10. WORKERS' COMPENSATION COORDINATION**

Nothing in this policy is intended to conflict with benefits provided for under Workers' Compensation provisions of State law or local policy. Benefits provided under this policy are exclusive of those granted in relation to Workers' Compensation either by State or other laws, or bargaining agreement.

**11. TERMINATION OF EMPLOYMENT**

The City will place on leave of absence without pay any employee who has exhausted their benefit under Federal and State law and/or all available paid leave time (whichever is longer) due to their own non-industrial injury or illness for a period of up to 365 days from the date of onset of such illness or injury.

Employees who have not been released to return to work by a qualified medical provider because they are unable to perform the essential functions of their job duties with or without reasonable accommodation within 365 days of onset of injury or illness will be terminated, or, if so eligible, may elect a service/disability retirement.

The City will make efforts to find a similar vacant position within the City to accommodate such employees, but will not create new positions as an accommodation. If, after termination, the employee is released by his or her qualified medical provider to perform their regular work with or without reasonable accommodations, the City will place the employee on a re-employment list (at the employee's written request) for a maximum period of two years from the original date of termination in accordance with City of Concord Policy & Procedure No. 37, paragraph 8.9. Employees who are subsequently released to return to work after having been terminated will be treated as having been "laid off" from the date of termination for purposes of rules interpretations in accordance with all applicable City of Concord policies and procedures. If an employee is selected from such a re-employment list, a determination of reasonable accommodation (if applicable) will be required before re-employment commences.

**12. POLICY AMENDMENTS**

Recognizing the complexity of implementing the provisions of the new laws regarding Family and Medical Leave, the City retains the right to modify this policy for purposes discovered during its initial implementation and administration.

**13. REQUIRED FORMS**

- Attachment 1: Certification of Health Care Provider for a Family Member's Serious Health Condition
- Attachment 2: Certification of Health Care Provider for an Employee's Serious Health Condition
- Attachment 3: Request for Family/Medical Leave
- Attachment 4: Fitness for Duty Certification
- Attachment 5: Legal Notification

**CERTIFICATION OF HEALTH CARE PROVIDER FOR  
A FAMILY MEMBER'S SERIOUS HEALTH CONDITION**

**SECTION I. FOR COMPLETION BY EMPLOYEE**

**Employee Name:** *(please print)* \_\_\_\_\_

Name & Relationship of family member to you: \_\_\_\_\_ If son/daughter, date of birth: \_\_\_\_\_

Describe the care you will provide to your family member and estimate leave needed to provide care:  
\_\_\_\_\_  
\_\_\_\_\_

**Employee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**SECTION II. FOR COMPLETION BY HEALTH CARE PROVIDER**

**Instructions:** The employee listed above has requested leave under the FMLA to care for your patient. This form seeks information to verify the need for leave. Please 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 a "lifetime", "unknown", or indeterminate" may not be sufficient to determine FMLA coverage. *Limit your responses to the condition for which the patient needs leave. Please be sure to sign the form on the last page.*

Provider's Name: \_\_\_\_\_

Business Address: \_\_\_\_\_  
(Street) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_

**PART A. MEDICAL FACTS**

1. Approximate date condition commenced: \_\_\_\_\_ 2. Probable duration \_\_\_\_\_

**Mark below as applicable:**

a) Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?  
\_\_\_\_\_ No \_\_\_\_\_ Yes If so, dates of admission: \_\_\_\_\_

b) Date(s) you treated the patient for the condition: \_\_\_\_\_

c) Was medication, other than over-the-counter medication prescribed? \_\_\_ No \_\_\_ Yes

d) Will the patient need to have treatment visits at least twice per year due to the condition? \_\_\_ No \_\_\_ Yes

**PART B. AMOUNT OF CARE NEEDED**

When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care.

- 2. Will the patient 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 yes, please estimate the beginning and ending dates for the period of incapacity:

From \_\_\_\_\_ to \_\_\_\_\_

During this time will the patient need care? \_\_\_ No \_\_\_ Yes

- 3. Will the patient require follow-up treatments, including any time for recovery? \_\_\_ No \_\_\_ Yes

If yes, estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period.

\_\_\_\_\_

- 4. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? \_\_\_ No \_\_\_ Yes

If yes, estimate the hours the patient needs care on an intermittent basis, if any:

\_\_\_\_\_ hour(s) per day; \_\_\_\_\_ days per week from \_\_\_\_\_ through \_\_\_\_\_.

- 5. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities: \_\_\_ No \_\_\_ Yes

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.

Does the patient need care during these flare-ups? \_\_\_ No \_\_\_ Yes

- 6. It is medically necessary for the employee to assist your patient with items  (1)  (2)  (3)  (4)  (5) listed above in order to provide

assistance with basic medical or personal needs, safety, or for transportation

psychological comfort or to arrange third-party care that would be beneficial to the patient or assist in the patient's recovery

\_\_\_\_\_  
Signature of Health Care Provider

\_\_\_\_\_  
Date

**CERTIFICATION OF HEALTH CARE PROVIDER FOR  
EMPLOYEE'S OWN SERIOUS HEALTH CONDITION.**

**Employee Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(please print)

**SECTION I. FOR COMPLETION BY EMPLOYER**

**Employee's Job Title:** \_\_\_\_\_ **Regular work Schedule:** \_\_\_\_\_

**If checked, job description outlining essential functions is attached:**

\_\_\_\_\_

**SECTION II. FOR COMPLETION BY HEALTH CARE PROVIDER**

**Instructions:** Your patient has requested leave under the FMLA. This form seeks information to verify the need for leave. Please 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 a "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. Please be sure to sign the form on the last page.

**Provider's Name:** \_\_\_\_\_

**Business Address:** \_\_\_\_\_

**Phone** (\_\_\_\_) \_\_\_\_\_ **Fax** (\_\_\_\_) \_\_\_\_\_

**PART A. MEDICAL FACTS**

1. Approximate date condition commenced: \_\_\_\_\_

2. Probable duration of condition: \_\_\_\_\_

**Mark below as applicable:**

a) Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

No \_\_\_\_\_ Yes \_\_\_\_\_ If so, dates of admission: \_\_\_\_\_

b) Date(s) you treated the patient for the condition: \_\_\_\_\_

c) Was medication, other than over-the-counter medication prescribed? \_\_\_ No \_\_\_ Yes

d) Will the patient need to have treatment visits at least twice per year due to the condition? \_\_\_ No \_\_\_ Yes

e) Is the medical condition pregnancy? \_\_\_ No \_\_\_ Yes If so, expected delivery date: \_\_\_\_\_

3. Use the employer information in **Section I** to answer this question. If the employee 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 yes, please identify the job functions the employee is unable to perform. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**PART B. AMOUNT OF LEAVE NEEDED.**

4. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition(s), including any time for treatment and recovery?  No  Yes

If yes, please estimate the beginning and ending dates for the period of incapacity:

From \_\_\_\_\_ to \_\_\_\_\_

5. 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(s)?  No  Yes

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

\_\_\_\_\_ hour(s) per day; \_\_\_\_\_ days per week from \_\_\_\_\_ through \_\_\_\_\_

6. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions?  No  Yes

a. If yes, 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.

\_\_\_\_\_  
Signature of Health Care Provider

\_\_\_\_\_  
Date

**Additional Information: Should you need additional room to respond, please identify question number below or on an additional paper clearly marked with patient's name.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ATTACHMENT 3**

CITY OF CONCORD  
REQUEST FOR FAMILY/MEDICAL LEAVE

Purpose: to document an employee's request for Family/Medical Leave entitlements and justification of request for all leaves exceeding/anticipated to exceed 80 hours in a 12 month period.

NAME	DEPT	DATE
HIRE DATE	CLASSIFICATION	SSN
<p>I request a Family/Medical leave for the following reason (check one):</p> <p><input type="checkbox"/> The birth of child and/or care of such child. Birth date _____</p> <p><input type="checkbox"/> The placement of a child for adoption or foster care.</p> <p>In order to care for an immediate family member because such family member has a serious health condition.</p> <p>Check one:   <input type="checkbox"/> Child                      <input type="checkbox"/> Spouse                      <input type="checkbox"/> Parent</p> <p>Medical certification required with application. If it is an emergency situation, medical certification is required within 15 calendar days.</p> <p><input type="checkbox"/> Employee's own serious health condition that makes the employee unable to perform the essential functions of his/her position. Medical certification required with application. If it is an emergency situation, medical certification is required within 15 calendar days.</p>		
<p>Leave will be taken on a:</p> <p><input type="checkbox"/> Consecutive basis</p> <p><input type="checkbox"/> Intermittent or Reduced Leave Schedule as follows:</p> <p><input type="checkbox"/> Request use of leave as follows:</p> <p style="padding-left: 40px;"><input type="checkbox"/> Sick    <input type="checkbox"/> Vacation    <input type="checkbox"/> Comp Time    <input type="checkbox"/> LWOP</p> <p>Date leave begins _____</p> <p>Expected date to return _____</p>		
EMPLOYEE'S SIGNATURE	DATE	SUPERVISOR'S SIGNATURE
		DATE
<b>PERSONNEL DEPARTMENT</b>		
<p><input type="checkbox"/> Certification required</p> <p><input type="checkbox"/> Certification received. Date _____ Health Plan _____</p> <p><input type="checkbox"/> Health and Dental Benefits continued through (month/year) _____</p> <p>Employee pays \$ _____ per month for health plan    \$ _____ City life insurance</p> <p style="padding-left: 400px;">\$ _____ Private life insurance</p> <p><input type="checkbox"/> Change leave as follows:    Sick _____ hrs.    Vacation _____ hrs.</p> <p style="padding-left: 100px;">Comp Time _____ hrs.    LWOP _____ hrs.</p>		



**FITNESS FOR DUTY CERTIFICATION**

An employee on Family and Medical Leave because of his/her own serious medical condition must present this release to his/her supervisor prior to or on the day he/she returns to work.\*

You are required to provide this fitness for duty certification and intent to return to work to the health care provider who is knowledgeable regarding your reason for using FMLA.

Employee Name: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Expected Date of Return: \_\_\_\_\_ Department: \_\_\_\_\_

**TO BE COMPLETED ONLY BY THE HEALTH CARE PROVIDER**

I have reviewed a job description of the above named patient's job duties.  Yes  No

I have examined the above named patient and certify that she/he is able to resume working:

Full time  Less than full-time

Date patient is able to return to work: \_\_\_\_\_

The patient can return to work with no restrictions.

The patient can return to work with time, duty, or other restrictions. (If restrictions, complete page 2)

Expected duration of the restrictions: \_\_\_\_\_

\_\_\_\_\_  
Signature of Health Care Provider

\_\_\_\_\_  
Type of practice/specialty

\_\_\_\_\_  
Date

\_\_\_\_\_  
Telephone

\*Refers to both Federal and State Leaves under the Family Medical Leave Act and the California Family Rights Act.

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

(Complete this section if the employee is being released to modified duty.)

Physical Examinations	Full Restrictions	Partial Restrictions	No Restrictions
Sedentary–Lifting 0 to 10 pounds			
Light–Lifting 10-20 pounds			
Moderate–Lifting 20 to 50 pounds			
Heavy–Lifting 50 to 100 pounds			
Pulling/Pushing, Carrying			
Reaching or working above shoulder			
Walking (hrs.)			
Standing (hrs.)			
Sitting (hrs.)			
Stooping (hrs.)			
Kneeling (hrs.)			
Repeated Bending (hrs.)			
Climbing (hrs.)			
Operating a motor vehicle, crane, tractor, etc.			
Other:			
Exposure Limitation (Specify):			

I hereby certify that the foregoing facts are true and correct, and that this form is executed under penalty of perjury

at \_\_\_\_\_, this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.  
(List City and State) (Month) (Year)

\_\_\_\_\_  
 Signature of Health Care Provider

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Print Name of Health Care Provider

\_\_\_\_\_  
 Phone Number

\_\_\_\_\_  
 Type of Practice

\_\_\_\_\_  
 License No.

\_\_\_\_\_  
 Address

\_\_\_\_\_  
 City State Zip

**Return to:**  
**City of Concord**  
**1950 Parkside Dr., M/S 30**  
**Concord, California 94519**

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. Employees are eligible if they have worked for a covered employer for at least one year, and for 1250 hours over the previous 12 months, and if there are at least 50 employees within 75 miles.

**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.

For a serious health condition that makes the employee unable to perform the employee's job.

**ADVANCE NOTICE AND MEDICAL CERTIFICATION:** The employee may be required to provide advance leave notice and medical certification. Taking of FMLA leave may be denied if requirements are not met.

The employee ordinarily must provide 30 days advance notice when leave is “foreseeable.”

An employer may require medical certification to support a request for leave because of a serious health condition and may require 2nd or 3rd opinions (at the City'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.”

Upon return from FMLA leave, most employees must be restored to their original or equivalent position with equivalent pay, benefits, and other employment terms.

The use of FMLA leave cannot result in the loss of any employment benefit 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 the 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 Personnel Department or the nearest office of the Wage and Hour Division, listed in most telephone directories under U.S. Government, Department of Labor.