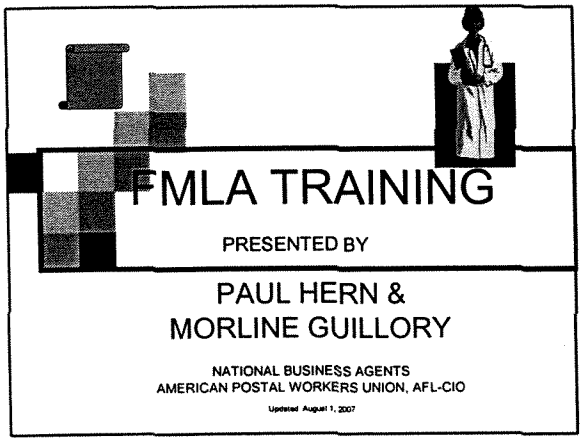
FMLA TRAINING

PRESENTED BY

PAUL HERN &
MORLINE GUILLORY

NATIONAL BUSINESS AGENTS
AMERICAN POSTAL WORKERS UNION, AFL-CIO

Updated August 1, 2007



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- The "family medical leave act of 1984"....
- FMLA as an organizing tool

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FAMILY MEDICAL LEAVE ACT

- Applies to all postal employees
  - ELM 515 states that the USPS must comply with the Family Medical Leave Act
  - Postal employees must be eligible in order to use FMLA

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WHAT FMLA IS NOT

- "There is no such thing as Family Medical Leave in the USPS...."
- Postal leave types are annual, sick, LWOP, court, military, administrative, etc.
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- FMLA is a designation given to an absence, not a postal leave type
- FMLA designation is separate and distinct from postal leave, different rules and time limits

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FMLA IS NOT SLDC

- Sick Leave Dependent Care
  provides sick leave pay to a postal employee when another human being is sick, provided:
  1. the sick person is a 'family member'
  2. the postal employee is caring for them
  3. had the postal employee had the medical condition of the family member, then the postal employee would have qualified for sick leave
  4. limited to 80 hours per leave year
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FMLA IS NOT SLDC cont.

- SLDC may be scheduled & FMLA
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- SLDC requires that the employee be providing care to a family member
- FMLA only requires that "the presence of the employee would be beneficial to the family member's recovery"

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ELIGIBILITY FOR FMLA

- **1 YEAR OF EMPLOYMENT (825.110)**
  INCLUDES ALL POSTAL SERVICE TIME INCLUDING CASUAL AND TE APPOINTMENTS
- **1250 WORK HOURS IN PRIOR 12 MONTHS (825.110) –Baron v. Runyon exception**
  INCLUDES ALL HOURS WORKED 365 DAYS PRIOR TO THE ABSENCE BEGINNING; STRAIGHT TIME, OVERTIME, HOLIDAY WORKED TIME
  TACS PRINTOUT SHOWS FMLA QUALIFYING HOURS FOR THE PRIOR 26 PAY PERIODS

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- QUALIFYING CONDITIONS
- "FMLA PROVIDES THAT, IF YOU MEET THE ELIGIBILITY REQUIREMENTS, YOU **MUST** BE ALLOWED TO TAKE TIME OFF FOR UP TO 12 WORKWEEKS IN A LEAVE YEAR FOR THE FOLLOWING CONDITIONS." **Publication 71**

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QUALIFYING CONDITIONS

825.114 and PUB. 71

A BIRTH OR PLACEMENT OF AN ADOPTED OR FOSTER CHILD

A SERIOUS HEALTH CONDITION OF THE EMPLOYEE

A SERIOUS HEALTH CONDITION OF A FAMILY MEMBER

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WHAT IS A FAMILY MEMBER?

- Same definitions for FMLA and SLDC.
- Spouse is determined by the state you live in
- Parent is biological parent or a person who "stood in the position" of a parent when you were raised
- Child is biological or a person who "stands in the position" of a child to the employee
- Guardians, foster children, stepchildren and developmentally disabled adults are included

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WHAT IS A LEAVE YEAR?

- FMLA AND SLDC BOTH USE THE POSTAL LEAVE YEAR

  FMLA allows employers to use a calendar year or fiscal year or leave year, the USPS chose to use the leave year

  A leave year begins on the first day of the first pay period that is entirely contained within a new calendar year

  So it always falls between Jan. 1-15th

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LEAVE YEAR cont.

So on the first day of the leave year, a FTR receives:

All of his annual leave for the upcoming leave year

480 hours of FMLA to use or lose for the upcoming leave year

80 hours of SLDC to use or lose for the upcoming leave year

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SERIOUS HEALTH CONDITIONS (825.114)

- **OVERNIGHT HOSPITAL STAY**
- **ABSENCE OF MORE THAN THREE CALENDAR DAYS PLUS TREATMENT**
- **PREGNANCY**
- **CHRONIC CONDITIONS REQUIRING TREATMENTS**
- **PERMANENT LONG TERM CONDITIONS REQUIRING SUPERVISION**
- **MULTIPLE TREATMENTS (NON CHRONIC)**

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Hospital Stay

- Inpatient care (i.e.. Overnight stay) in a hospital, hospice or residential medical care facility
- This includes any period of incapacitation or any subsequent treatment in connection with such inpatient care

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Absence Plus Treatment

- A period of incapacity of more than three consecutive calendar days that also involves:
- Treatment two or more times by a health care provider, or
- Treatment ONCE by a Health care provider which results in a regimen of treatment, e.g. Therapy, prescribed medication or follow up exams; not simply bed rest or 'chicken soup'
- A health care provider is anyone recognized by employer's health benefit plans.

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- ANY PERIOD OF INCAPACITATION RELATING TO PREGNANCY OR PRENATAL CARE

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CHRONIC CONDITIONS REQUIRING TREATMENT

- REQUIRES PERIODIC VISITS FOR TREATMENT
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PERMANENT LONG TERM CONDITIONS

- A CONDITION FOR WHICH TREATMENT MAY NOT BE EFFECTIVE
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TIME LIMITS:

- EMPLOYEES MUST NOTIFY MGT. OF THE NEED FOR LEAVE NO LATER THAN 2 DAYS FOLLOWING RETURN TO DUTY(825.303)
- HOW DO THEY PROVE THIS HAS BEEN DONE?
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TIME LIMITS cont.

- MGT. MUST DETERMINE ELIGIBILITY WITHIN 2 BUSINESS DAYS(825.110)
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- FMLA or NON-FMLA DESIGNATION ENDS THE TIME LIMITS
- "PENDING DOCUMENTATION" ON THE 3971 PROMPTS A NEW TIME LIMIT: THE EMPLOYEE HAS 15 DAYS TO PROVIDE FMLA DOCUMENTATION(825.305)

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- WHEN MGT. PROVIDES ANY OF THESE RESPONSES TO AN FMLA REQUEST, THEY MUST DO SO IN WRITING WITHIN 2 BUSINESS DAYS(825.301)
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2nd/3rd MEDICAL OPINIONS

- MAY BE REQUIRED UNDER CERTAIN CIRCUMSTANCES
- EMPLOYEES MUST PARTICIPATE WHEN REQUIRED(825.307)
- SUCH OPINIONS ARE AT THE EXPENSE OF THE USPS AND OFF-THE-CLOCK

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NEW DEVELOPMENTS

- MAKE WHOLE AWARDS-WORK HOUR CREDITS ARE RESTORED IF THE DISCIPLINARY ACTION IS REVERSED AND THOSE HOURS WILL NOW COUNT TOWARD THE 1250 REQUIREMENT(step 4 J94C1LC97069215....Page 120 CBR)
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- ABSENCES OF 3 DAYS OR LESS SHOULD NOT REQUIRE DOCUMENTATION IF THE CONDITION IS PRECERTIFIED AND THE CIRCUMSTANCES HAVE NOT CHANGED
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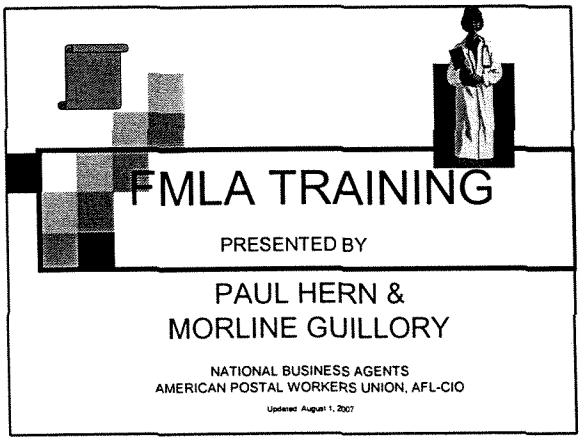

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UNITED STATES POSTAL SERVICE®

Notice for Employees Requesting Leave for Conditions Covered by the Family and Medical Leave Act

Under the Family and Medical Leave Act (FMLA), employees have certain obligations to provide notice and information such as medical certification to their employers. Failure to provide such notice, medical certification, or other required supporting information could result in denial of leave or other protections afforded under the Act.

I. Qualifying Conditions

The FMLA provides that, if you meet the eligibility requirements, you must be allowed to take time off for up to 12 workweeks in a leave year for the following conditions:

1. Because of the birth of a son or daughter (including prenatal care), or in order to care for such son or daughter. Entitlement for this condition expires 1 year after the birth.
2. Because of the placement of a son or daughter with you for adoption or foster care. Entitlement for this condition expires 1 year after the placement.
3. In order to care for your spouse, son, daughter, or parent who has a serious health condition. Also, in order to care for those who have a serious health condition and who stand in the position of a son or daughter to you or who stood in the position of a parent to you when you were a child.
4. Because of a serious health condition that makes you unable to perform the essential functions of your position.

II. Eligibility

For an absence to be covered by FMLA, you must have been employed by the Postal Service™ for a total of at least 1 year **and** must have worked a minimum of 1,250 hours during the 12-month period before the date your absence begins. Once eligible for a given condition, if your work hours subsequently fall below 1,250 during the Postal Service leave year, your eligibility for FMLA-protected absences for that condition remains in effect for the duration of the leave year. However, if a second and unrelated condition arises in the leave year, you must meet the 1,250 eligibility test anew in order to obtain FMLA-protected leave for that (i.e., second) reason.

III. Type of Leave or Pay

Absences counted toward the 12 workweeks allowed for the qualifying conditions can be any one or a combination of the following:

1. Time off you take as annual leave, sick leave, and/or leave without pay (LWOP) in accordance with current leave policies and collective bargaining agreements.
2. In the case of job-related injuries or illnesses, time off during which you are receiving continuation of pay (COP) and/or time during which you are placed on the Office of Workers' Compensation Program (OWCP) payroll.

IV. Documentation on Request for Absence

Supporting documentation is required for your absence request to receive final approval.

Documentation requirements may be waived by your supervisor in specific cases. *However, failure to provide requested medical or other documentation could result in a denial of FMLA-protected leave and/or paid leave.*

1. **For qualifying condition (1) or (2)** — you must provide the birth or placement date.
2. **For qualifying condition (3) or (4)** — you must provide documentation from the health care provider.
   a. **In both of these cases** — the medical report must include:
      (1) The health care provider's name, address, phone number, and type of practice, and the patient's name.
      (2) A certification that the patient's condition meets the FMLA definition of *serious health condition,* supporting medical facts, and a brief statement of how the medical facts meet the definition's criteria.
      (3) The approximate date the serious health condition commenced, its probable duration, and the probable duration of the patient's present incapacity, if different.
      (4) Whether it is a medical necessity that you be absent intermittently or work on a reduced schedule as a result of the serious health condition; and, if so, the probable duration of such schedule; an estimate of the probable number of, and the interval between, treatments and/or episodes of incapacity; the period required for recovery, if any; and whether the medical need for absence is best accommodated through intermittent absence or a reduced work schedule.
   b. **For absence due to pregnancy or a chronic serious health condition** — the medical certification must include whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity.
   c. **If additional or continuing treatments are required** — the medical certification must include the nature and regimen of the treatments, an estimate of the probable number of treatments, the length of absence required by the treatments, and actual or estimated dates of the treatments, if known.
   d. **For absence due to your own serious health condition, including pregnancy, a permanent or long-term condition, or a chronic condition** — the medical certification must include whether you are unable to perform work of any kind, parts of the job you are unable to perform, and whether you must be absent for treatments.
   e. **For absence to care for a family member with a serious health condition** — the medical certification must include whether the patient requires assistance for basic medical or personal needs or safety or for transportation; or, if not, whether your presence to provide psychological comfort would be beneficial to the patient or assist in the patient's recovery, and the probable duration of the need for care on an intermittent or reduced work schedule basis. You must indicate on the form the care you will provide and an estimate of the time period.
3. **If the serious health condition is a result of a job-related injury or illness** — the documentation requirements are provided separately in accordance with Injury Compensation policies and procedures.

4. **If the time off requested is to care for someone other than a biological parent or child** — appropriate explanation or evidence of the relationship may be required.

Supporting information that is not provided at the time of the request for absence must be provided within 15 days of receipt of notice, unless this is not practical under the circumstances. If the Postal Service questions the adequacy of a medical certification, a second opinion may be required. If the first and second opinions differ, a third and final opinion may be required. These opinions are obtained off the clock. However, the Postal Service will pay for these opinions, plus reasonable out-of-pocket travel expenses incurred to obtain the opinions. Employees may be required to provide recertification periodically. During your absence, you must keep your supervisor informed of your intentions to return to work and status changes that affect your ability to return.

V. Benefits

Health Insurance — to continue your health insurance during your absence, you must continue to pay the employee portion of the premiums. This payment continues to be withheld from your salary. If the salary for a pay period does not cover the full employee portion, you will be invoiced and are required to make the payment.

Life Insurance — your basic life insurance and any optional life insurance that you carry continue while you are in a pay status. In an LWOP status, these are continued at no cost to you for one (1) year. After you are in a non-pay status for one (1) year, this coverage is discontinued, but you have the option to convert the coverage to an individual policy within thirty-one (31) days of the discontinuance in accordance with the Office of Personnel Management's (OPM) current Federal Employee Group Life Insurance policy on conversion. See OPM's Web site at *http://www.opm.gov/insure*.

Flexible Spending Accounts (FSAs) — if you participate in the FSA program, see your employee brochure for the terms and conditions of continuing coverage during leave without pay.

VI. Placement and Documentation on Return to Duty

At the end of your FMLA-covered absence, you will return to the same position you held when the absence began (or to an equivalent position) provided you are able to perform the essential functions of the position and would have held that position at the time you returned had you not taken the time off. If you are returning to work after an absence due to your own incapacitation, you must provide certification from your health care provider that you are able to return to work and perform the essential functions of your position.

In addition, if you are a bargaining unit employee returning to work from your own serious health condition, management may require more detailed return-to-work clearance when there is a reasonable belief, based upon reliable and objective information, that you may not be able to perform the essential functions of your position or that you may pose a direct threat to the health or safety of yourself or others due to your medical condition.

Your return-to-work medical certification must be detailed medical documentation and not simply a statement that you may return to work. There must be sufficient information to make a determination that you can perform the essential functions of your job and do so without posing a hazard to yourself or others. In addition, the documentation must note whether there are any medical restrictions or limitations on your ability to perform your job and any symptoms that could create a job hazard for you or other employees.

You should provide your return-to-work certification, whether you are a bargaining or nonbargaining unit employee, as soon as your physician anticipates your return to work, and no later than one workday before the anticipated return-to-work date. Providing this certification as early as possible will facilitate the return-to-work process and help you avoid unnecessary delays due to incomplete medical information. The medical information requested is basic to the treatment provided by the physician and should be readily available. There is no need for a diagnosis or other private information to be included.

A Postal Service medical officer will evaluate the medical information and make an individual assessment of your suitability for return to work based on the essential functions of your position.

EMPLOYEE CERTIFICATION OF OWN SERIOUS ILLNESS—FMLA

This form is to be used by employee when requesting FMLA and ***medical documentation is not required pursuant*** *to Sections 513.36 and 515.5 of the ELM.*

Employee's name _____

Description of serious health condition *(On the back of this form is a description of what is meant by a "serious health condition" under FMLA. Does your condition qualify under any of the categories described? If so, please check the applicable category.)*

(1) _____ (2) _____ (3) _____ (4) _____ (5) _____ (6) _____ None of the above _____

Date condition commenced _____

Probable duration of condition _____

The employee must provide a completed Form PS 3971 for each pay period, noting type of leave requested.

Employee's Signature _____ **Date** _____

6/26/95

APWU FORM 1

FMLA DESCRIPTION OF SERIOUS HEALTH CONDITION[1]

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 incapacity or subsequent treatment[2] in connection with or consequent to such inpatient care.

2. **Absence Plus Treatment**
   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) *Treatment 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
   (b) *Treatment* by a health care provider on *at least one occasion* which results in a *regimen* of continuing *treatment*[3] under the supervision of the health care provider.

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

4. **Chronic Conditions Requiring Treatments**
   A *chronic condition* which;
   (a) 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;
   (b) Continues over an *extended period of time* (including recurring episodes of a *single underlying* condition); and
   (c) May cause *episodic* rather than a continuing period of incapacity[4] (e.g., *asthma, diabetes, epilepsy*).

5. **Permanent/Long-term Conditions Requiring Supervision**
   A period of incapacity[4] 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.

6. **Multiple Treatments (Non-Chronic Conditions)**
   Any period of *absence to receive multiple treatments* (including *any* period of recovery therefrom) by a health care provider or by a *provider of health care services under orders of, or on referral by, a health care provider*, either for *restorative surgery* after an accident or other injury, *or* for a condition that *would likely result in a period of incapacity*[4] *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).

---

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

[2] *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.

[3] 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.

[4] "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.

APWU FORM 1A

CERTIFICATION BY EMPLOYEE'S HEALTH CARE PROVIDER FOR EMPLOYEE'S SERIOUS ILLNESS—FMLA

This form is to be completed by employee's Health Care Provider when employee is requesting FMLA and ***medical documentation is required*** *pursuant to 512.41, 513.36 and 515.5 of the ELM.* ***Form PS 3971 must be completed by employee.***

Employee's name _____

Description of serious health condition *(On the back of this form is the description of a "serious health condition" under FMLA. Does the patient's condition qualify under any of the categories described? If so, please check the applicable category.)*

(1) _____ (2) _____ (3) _____ (4) _____ (5) _____ (6) _____ None of the above _____

Without giving a specific diagnosis or prognosis, briefly note how the medical facts meet the criteria of the category checked above. _____

_____

_____

Date condition commenced: _____

Probable duration of condition: _____

Probable duration of the present incapacity (if different): _____

Will the employee be required to be off from work intermittently or work on a reduced schedule as a result of this condition and /or treatments? _____ **Note the probable time and duration.** _____

If the condition is chronic (#4) or pregnancy (#3), note if the employee is presently incapacitated and the likely duration and frequency of episodes of incapacity.

_____

If additional or continuing treatments are required for the condition, provide the nature and regimen of the treatments, an estimate of the probable number of treatments, the length of absence required by the treatments, and the actual or estimated dates of the treatments, if known.

_____

_____

Is the employee able to perform the functions of employee's position? _____ **If no, describe the physical restrictions placed on the employee, including the duration of such restrictions.**

_____

_____

Health Care Provider's Signature _____ **Date** _____

Address _____

6/26/95 APWU FORM 2

FMLA DESCRIPTION OF SERIOUS HEALTH CONDITION[1]

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 incapacity or subsequent treatment[2] in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

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) *Treatment 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
(b) *Treatment* by a health care provider on *at least one occasion* which results in a *regimen* of continuing *treatment*[3] under the supervision of the health care provider.

3. Pregnancy

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

4. Chronic Conditions Requiring Treatments

A *chronic condition* which;

(a) 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;
(b) Continues over an *extended period of time* (including recurring episodes of a *single underlying* condition); and
(c) May cause *episodic* rather than a continuing period of incapacity[4] (e.g., *asthma, diabetes, epilepsy*).

5. Permanent/Long-term Conditions Requiring Supervision

A period of incapacity[4] 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.

6. Multiple Treatments (Non-Chronic Conditions)

Any period of *absence to receive multiple treatments* (including *any* period of recovery therefrom) by a health care provider or by a *provider of health care services under orders of, or on referral by, a health care provider,* either for *restorative surgery* after an accident or other injury, *or* for a condition that *would likely result in a period of incapacity[4] 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).

---

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

[2] *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.

[3] 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.

[4] "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.

APWU FORM 2A

HEALTH CARE PROVIDER CERTIFICATION OF EMPLOYEE'S FAMILY MEMBER ILLNESS—FMLA

Employee's name _____

Patient's name _____

Relationship to employee ____Spouse ____ Parent ____ Child *(under age 18 or older and incapable of self care due to a mental or physical disability)*

Description of serious health condition *(On the back of this form is the description of a "serious health condition" under FMLA. Does the patient's condition qualify under any of the categories described? If so, please check the applicable category.)*

(1) ____ (2) ____ (3) ____ (4) ____ (5) ____ (6) ____ None of the above ____

Without giving a specific diagnosis or prognosis, briefly note how the medical facts meet the criteria of the category checked above._____

_____

_____

Date condition commenced:_____

Probable duration of condition:_____

Probable duration of the present incapacity (if different): _____

Will the employee be required to be off from work intermittently or work on a reduced schedule as a result of the patient's condition and /or treatments?_____ **Note the probable time and duration.**_____

If the condition is chronic (#4) or pregnancy (#3), note if the patient is presently incapacitated (inability to perform regular daily activities) and the likely duration and frequency of episodes of incapacity._____

If additional or continuing treatments are required for the condition, provide the nature and regimen of the treatments, an estimate of the probable number of treatments, the length of absence required by the treatments, and the actual or estimated dates of the treatments, if known._____

_____

_____

Does the patient require assistance for basic medical, hygiene, nutritional needs, safety, or transportation?_____ **If no, would the employee's presence to provide psychological comfort be beneficial to the patient's recovery?**_____ **Note the probable duration of the need.**

_____

Health Care Provider's Signature _____ **Date** _____

Address _____

6/26/95 APWU FORM 3

FMLA DESCRIPTION OF SERIOUS HEALTH CONDITION[1]

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 incapacity or subsequent treatment[2] in connection with or consequent to such inpatient care.

2. **Absence Plus Treatment**
   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) *Treatment 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
   (b) *Treatment* by a health care provider on *at least one occasion* which results in a *regimen* of continuing *treatment*[3] under the supervision of the health care provider.

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

4. **Chronic Conditions Requiring Treatments**
   A *chronic condition* which;
   (a) 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;
   (b) Continues over an *extended period of time* (including recurring episodes of a *single underlying* condition); and
   (c) May cause *episodic* rather than a continuing period of incapacity[4] (e.g., *asthma, diabetes, epilepsy*).

5. **Permanent/Long-term Conditions Requiring Supervision**
   A period of incapacity[4] 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.

6. **Multiple Treatments (Non-Chronic Conditions)**
   Any period of *absence to receive multiple treatments* (including *any* period of recovery therefrom) by a health care provider or by a *provider of health care services under orders of, or on referral by, a health care provider*, either for *restorative surgery* after an accident or other injury, *or* for a condition that *would likely result in a period of incapacity*[4] *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).

---

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

[2] *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.

[3] 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.

[4] "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.

APWU FORM 3A

NOTICE OF NEED FOR INTERMITTENT LEAVE OR FOR A REDUCED WORK SCHEDULE—FMLA

The Employer must approve absences needed for intermittent leave or a reduced work schedule to care for a sick immediate family member or for an employee's own serious health condition that has been properly certified by a health care provider when required pursuant to 513.36 and 515.5 of ELM. Intermittent or reduced schedule for birth or placement of a child may be scheduled only if the Employer agrees.

If the need is for a seriously ill family member: *Attach Medical Documentation APWU Form 3, when required pursuant to Section 513.36 and 515.5 of the ELM.* **If the need is for the employee's own serious health condition:** *Attach Medical Documentation APWU Form 3.*

Name _____

Relationship to employee _____

Required reduced or intermittent schedule, including duration: _____

_____

_____

_____

_____

_____

The employee must provide a completed Form PS 3971 for each pay period noting type of leave requested.

Employee's Signature _____ **Date** _____

6/26/95 APWU FORM 4

FMLA DESCRIPTION OF SERIOUS HEALTH CONDITION[1]

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 incapacity or subsequent treatment[2] in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

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) *Treatment 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
(b) *Treatment* by a health care provider on *at least one occasion* which results in a *regimen* of continuing *treatment*[3] under the supervision of the health care provider.

3. Pregnancy

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

4. Chronic Conditions Requiring Treatments

A *chronic condition* which;

(a) 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;
(b) Continues over an *extended period of time* (including recurring episodes of a *single underlying* condition); and
(c) May cause *episodic* rather than a continuing period of incapacity[4] (e.g., *asthma, diabetes, epilepsy*).

5. Permanent/Long-term Conditions Requiring Supervision

A period of incapacity[4] 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.

6. Multiple Treatments (Non-Chronic Conditions)

Any period of *absence to receive multiple treatments* (including *any* period of recovery therefrom) by a health care provider or by a *provider of health care services under orders of, or on referral by, a health care provider*, either for *restorative surgery* after an accident or other injury, *or* for a condition that *would likely result in a period of incapacity*[4] *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).

---

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

[2] *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.

[3] 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.

[4] "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.

APWU FORM 4A

DESIRED OR NEEDED ABSENCES FOR BIRTH OR PLACEMENT OF SON OR DAUGHTER UNDER FMLA

Note: *Entitlement to Family and Medical Leave because of (1) birth, (2) placement for adoption or (3) placement for foster care of a son or daughter expires 12 months after the birth, placement or adoption. Employees may use up to 12 weeks each postal leave year as long as the leave is continuous and the absence is within the first year of the birth, placement or adoption.*

An absence due to care for a new son or daughter or the placement of a son or daughter is not a serious medical condition and does not require certification by a health care provider, but it may require documentation. Intermittent leave or a reduced schedule for this purpose requires approval by the employer. FMLA leave for birth, placement or adoption must be continuous unless an intermittent or reduced schedule is approved by the employer.*

Employee's name _____

Date of birth, placement or foster care of this son or daughter* _____

Schedule desired or needed *(employee is entitled up to 12 weeks)*

From:_____ To:_____

The employee must provide a completed Form PS 3971 for each pay period, noting type of leave requested.

** Documentation may be required of the father if unmarried or not living with spouse, or of employee for adoption or placement under foster care.*

Employee's Signature _____ **Date** _____

6/26/95 APWU FORM 5

USPS VERIFICATION OF VETERAN'S TREATMENT

Dear_____:

I _____, SS#_____ am a disabled veteran under treatment by the_____VA facility. As required by my medical condition, it will be necessary that I be absent from work on occasion to receive medical treatment. My absence(s) to attend to the required treatment are covered by the Family and Medical Leave Act which permits the employer to demand medical certification of my treatment and condition.

The Veterans' Hospitals' have a policy of not completing FMLA forms. Due to this policy it will not be possible for me to provide documentation at your request; however, consistent with the provisions of the Family and Medical Leave Act, the employer's physician may contact the employee's physician with the consent of the employee. This letter is intended as my consent to have your designated physician contact my physician to verify:

- ✓ Whether my condition meets the definition of a Serious Health Condition
- ✓ The date of treatment
- ✓ Duration of condition
- ✓ Will I be off work intermittently or work a reduced schedule, if continuing treatments are required
- ✓ The nature and regimen of treatments, if continuing treatments are required, length of absence required and estimated dates of treatments, if known and any physical restrictions, including duration.
- ✓ Nature of my illness.

This is not to be interpreted that I am authorizing the employer or the employer's physician to inquire of the diagnosis or prognosis of my condition.

_____ _____

Employee's Signature Dated

MANAGEMENT REQUEST FOR CLARIFICATION OF MEDICAL CERTIFICATION

Employee's name_____

Date of Original Medical Certification _____

Supervisor _____

You verbally requested on _____ that I obtain clarification of my medical certification. I shall need more specific information regarding your request. The Family and Medical Leave Act provides that you are entitled to:

*The name of my health care provider and the type of medical practice
* A certification of which part of the definition applies to my condition
*A brief statement as to how the medical facts meet the criteria of the definition
*The date the serious health condition commenced and its probable duration,
*Whether my absence will be intermittent or require a reduced work schedule
*Additional treatments, if necessary
*If pregnancy or chronic condition, will I require a reduced leave schedule or intermittent leave
*The nature of treatments provided by a different provider
*The regimen of continuing treatment if required
*Whether of not I can perform work of any kind or the essential functions of my position

The Family and Medical Leave Act requires that ***you provide me with advance written notice detailing the specific expectations and obligations.*** This is to request that you provide me in writing whether you request the opportunity to contact my physician and the specific clarification of my certification that you seek.

_____

Employee's Signature