

# FAMILY MEDICAL LEAVE REQUEST FORM



## INSTRUCTIONS FOR THE EMPLOYEE

- Complete the form and submit to HR.
- You will be notified as to whether the leave is approved or not.

EMPLOYEE INFORMATION		
Employee Name		
Employee Number	Department	Title

TYPE OF LEAVE
<p>I hereby request the following type of leave:</p> <ul style="list-style-type: none"> <li>○ Family leave for the:                             <ul style="list-style-type: none"> <li><input type="checkbox"/> Birth of my son or daughter</li> <li><input type="checkbox"/> Placement of child with me for <input type="checkbox"/> adoption <input type="checkbox"/> foster care</li> </ul>                             Anticipated date of birth or placement: _____                         </li> <li>○ Family leave to care for spouse, son, daughter, or parent with a serious health condition                              Family member's full name: _____                              Relationship to you: <input type="checkbox"/> spouse <input type="checkbox"/> parent <input type="checkbox"/> son or daughter</li> <li>○ Medical leave for my own serious health condition (specify): _____                              _____</li> <li>○ Servicemember Care</li> <li>○ Exigency Leave</li> </ul>

AMOUNT OF LEAVE
<p>(1) If request that the leave be granted for the following period of time:                              Beginning Date: _____ Ending on (date): _____</p> <p>(2) I further request that the leave be granted for the following reduced or intermittent leave schedule:                              _____</p> <p>(3) As per HR 8.0 FMLA policy, employees approved for leave must use their sick, personal and vacation accruals. (in that order)</p>

EMPLOYEE CERTIFICATION AND SIGNATURE
<p>I hereby certify that the information given above is true and correct to the best of my knowledge. I understand that misrepresentation or omission of the reason for leave or any of the facts supporting the need for leave will result in denial of the leave and will subject me to discipline up to and including termination.</p> <p>Signature: _____ Date: _____</p>

## MAINTAIN THIS FORM IN A FMLA CONFIDENTIAL FILE

HR USE ONLY		
Leave Approved? <input type="checkbox"/> Yes <input type="checkbox"/> No For what period?	Expected Return Date: _____	
Remarks: _____		
Signature: _____	Title _____	Date _____

# CITY OF CORPUS CHRISTI

## HUMAN RESOURCES DEPARTMENT

### Medical Authorization

I hereby authorize any and all physicians, surgeons, and doctors who have examined or treated me, and all hospitals in which I have ever been a patient, to furnish the City of Corpus Christi Human Resources Department any and all records, x-rays, laboratory reports and other data of information in medical history, treatment or diagnosis, past, present and future, and permit them to examine such records, x-rays, reports and medical information, and hereby authorize you to permit them to make copies thereof. Any photo static or carbon copy of this authorization shall be considered as effective and valid as the original.

**Treating physicians may be contacted and additional information may be requested in the event the medical certification and/or document submitted is not legible, incomplete or insufficient to approve the request.**

Dated this \_\_\_\_\_ day of \_\_\_\_\_

SIGNATURE \_\_\_\_\_

PRINTED NAME: \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY, STATE, ZIP CODE \_\_\_\_\_

TELEPHONE NUMBER \_\_\_\_\_

# HR 8.0 AP 1 FAMILY AND MEDICAL LEAVE ACT (FMLA)

## ACKNOWLEDGEMENT FORM

I acknowledge that I have received a copy of the City of Corpus Christi's Administrative Procedure HR 8.0 AP 1 Family and Medical Leave Act revised. I understand that compliance with this procedure is a condition of employment.

I have carefully heard and/or read this procedure and understand its content. I agree to follow this procedure. I understand that failure to do so will result in my being in violation of this procedure and will subject me to disciplinary action up to and including termination on the first offense.

\_\_\_\_\_  
Employee's Name (Printed)

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Employee's City ID Number

\_\_\_\_\_  
Department

\_\_\_\_\_  
Date

Please return to: Human Resources Department

## ACKNOWLEDGEMENT FORM

### HR 8.0 AP 2 BENEFIT COVERAGE DURING NO-PAY STATUS OR INSUFFICIENT PAY STATUS

City Administrative Procedure HR 8.0 AP 2 Benefit Coverage on No Pay Status revised December 14, 2017, has been explained to me.

I understand the procedure and acknowledge that while I am on leave without pay, I will be required to continue to pay the employee portion for the benefit coverage I have elected in order for coverage to continue. As I will not be receiving a paycheck, I acknowledge that I must send my benefits payment directly to the City of Corpus Christi to the Attention of the Accounts Receivable Division of the Financial Services Department. I understand that my insurance coverages will be retroactively terminated if any invoices become 30 days past due.

I understand that it is my responsibility to notify the Human Resources – Benefits department at 826-3300 when I return to work to discuss benefits, changes in benefits, and charges due.

Upon my return to work, I acknowledge and agree that the City of Corpus Christi will make automatic deductions from my paychecks in order to recover premiums due, if any, and that this will be based upon an established schedule for arrears payments. I understand that I may pay the full amount owed, or a portion of the amount owed, at any time, by cash or check.

I acknowledge that in the event of termination pending appeal to the Civil Service Board, if the termination is upheld, I will reimburse the City for premiums in arrears, if any, which may have occurred, and that my termination date will be recorded as the date of the board ruling.

\_\_\_\_\_  
Employee Name (printed)

\_\_\_\_\_  
Employee ID#

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Mailing Address for premium billings

\_\_\_\_\_  
Phone number

\_\_\_\_\_  
Witnessed by (printed)

\_\_\_\_\_  
Witnessed by (signature)

Certification of Health Care Provider for Employee's Serious Health Condition under the Family and Medical Leave Act

U.S. Department of Labor Wage and Hour Division



DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR. RETURN TO THE PATIENT.

OMB Control Number: 1235-0003 Expires: 6/30/2026

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. 29 U.S.C. §§ 2613, 2614(c)(3); 29 C.F.R. § 825.305. The employer must give the employee at least 15 calendar days to provide the certification. If the employee fails to provide complete and sufficient medical certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the [WHD website](http://www.dol.gov/agencies/whd/fmla) at [www.dol.gov/agencies/whd/fmla](http://www.dol.gov/agencies/whd/fmla).

SECTION I - EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, this form asks the health care provider for the information necessary for a complete and sufficient medical certification, which is set out at 29 C.F.R. § 825.306. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308.** Additionally, you may not request a certification for FMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care.

Employers must generally maintain records and documents relating to medical information, medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

(1) Employee name: \_\_\_\_\_  
First Middle Last

(2) Employer name: City of Corpus Christi Date: \_\_\_\_\_ (mm/dd/yyyy)  
(List date certification requested)

(3) The medical certification must be returned by \_\_\_\_\_ (mm/dd/yyyy)  
(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee's diligent, good faith efforts.)

(4) Employee's job title: \_\_\_\_\_ Job description  is /  is not attached.

Employee's regular work schedule: \_\_\_\_\_

Statement of the employee's essential job functions:

(The essential functions of the employee's position are determined with reference to the position the employee held at the time the employee notified the employer of the need for leave or the leave started, whichever is earlier.)

SECTION II - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form. Your patient has requested leave under the FMLA. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of the employee. For FMLA purposes, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves **inpatient care** or **continuing treatment by a health care provider**. For more information about the definitions of a serious health condition under the FMLA, see the chart on page 4.

You also may, but are **not required** to, provide other appropriate medical facts including symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment. Please note that some state or local laws may not allow disclosure of private medical information about the patient's serious health condition, such as providing the diagnosis and/or course of treatment.

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

Health Care Provider's name: (Print) \_\_\_\_\_

Health Care Provider's business address: \_\_\_\_\_

Type of practice / Medical specialty: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

**PART A: Medical Information**

Limit your response to the medical condition(s) for which the employee is seeking FMLA leave. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. **After completing Part A, complete Part B to provide information about the amount of leave needed.** Note: For FMLA purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

(1) State the approximate date the condition started or will start: \_\_\_\_\_ (mm/dd/yyyy)

(2) Provide your **best estimate** of how long the condition lasted or will last: \_\_\_\_\_

(3) Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

**Inpatient Care:** The patient (  has been /  is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): \_\_\_\_\_

**Incapacity plus Treatment:** (e.g. outpatient surgery, strep throat)  
Due to the condition, the patient (  has been /  is expected to be) incapacitated for **more than three** consecutive, full calendar days from: \_\_\_\_\_ (mm/dd/yyyy) to \_\_\_\_\_ (mm/dd/yyyy).  
The patient (  was /  will be) seen on the following date(s): \_\_\_\_\_

The condition (  has /  has not) also resulted in a course of continuing treatment under the supervision of a health care provider (e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment).

**Pregnancy:** The condition is pregnancy. List the expected delivery date: \_\_\_\_\_ (mm/dd/yyyy).

**Chronic Conditions:** (e.g. asthma, migraine headaches) Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

**Permanent or Long Term Conditions:** (e.g. Alzheimer's, terminal stages of cancer) Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

**Conditions requiring Multiple Treatments:** (e.g. chemotherapy treatments, restorative surgery) Due to the condition, it is medically necessary for the patient to receive multiple treatments.

**None of the above:** If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed. Go to page 4 to sign and date the form.

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

(4) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. (e.g., use of nebulizer, dialysis)

\_\_\_\_\_

**PART B: Amount of Leave Needed**

For the medical condition(s) checked in Part A, complete all that apply. 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 as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage.

(5) Due to the condition, the patient (  had /  will have) **planned medical treatment(s)** (scheduled medical visits) (e.g. psychotherapy, prenatal appointments) on the following date(s): \_\_\_\_\_

(6) Due to the condition, the patient (  was /  will be) **referred to other health care provider(s)** for evaluation or treatment(s). State the nature of such treatments: (e.g. cardiologist, physical therapy) \_\_\_\_\_  
Provide your **best estimate** of the beginning date \_\_\_\_\_ (mm/dd/yyyy) and end date \_\_\_\_\_ (mm/dd/yyyy) for the treatment(s).  
Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery (e.g. 3 days/week)

(7) Due to the condition, it is medically necessary for the employee to work a **reduced schedule**. Provide your **best estimate** of the reduced schedule the employee is able to work. From \_\_\_\_\_ (mm/dd/yyyy) to \_\_\_\_\_ (mm/dd/yyyy) the employee is able to work: (e.g., 5 hours/day, up to 25 hours a week)

(8) Due to the condition, the patient (  was /  will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery. Provide your **best estimate** of the beginning date \_\_\_\_\_ (mm/dd/yyyy) and end date \_\_\_\_\_ (mm/dd/yyyy) for the period of incapacity.

(9) Due to the condition, it (  was /  is /  will be) medically necessary for the employee to be absent from work on an intermittent basis (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.  
Over the next 6 months, episodes of incapacity are estimated to occur \_\_\_\_\_ times per (  day  week  month) and are likely to last approximately \_\_\_\_\_ (  hours  days) per episode.

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

**PART C: Essential Job Functions**

If provided, the information in Section I question #4 may be used to answer this question. If the employer fails to provide a statement of the employee's essential functions or a job description, answer these questions based upon the employee's own description of the essential job functions. An employee who must be absent from work to receive medical treatment(s), such as scheduled medical visits, for a serious health condition is considered to be **not able** to perform the essential job functions of the position during the absence for treatment(s).

(10) Due to the condition, the employee (  was not able /  is not able /  will not be able) to perform **one or more** of the essential job function(s). Identify at least one essential job function the employee is not able to perform:

Signature of Health Care Provider \_\_\_\_\_ Date: \_\_\_\_\_ (mm/dd/yyyy)

<b>Definitions of a Serious Health Condition</b> (See 29 C.F.R. §§ 825.113-.115)
<b>Inpatient Care</b>
<ul style="list-style-type: none"><li>• An overnight stay in a hospital, hospice, or residential medical care facility.</li><li>• Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.</li></ul>
<b>Continuing Treatment by a Health Care Provider (any one or more of the following)</b>
<b>Incapacity Plus Treatment:</b> A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either: <ul style="list-style-type: none"><li>o Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or,</li><li>o At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.</li></ul>
<b>Pregnancy:</b> Any period of incapacity due to pregnancy or for prenatal care. _____
<b>Chronic Conditions:</b> Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.
<b>Permanent or Long-term Conditions:</b> A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.
<b>Conditions Requiring Multiple Treatments:</b> Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.

**PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT**

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 15 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

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