



# HALL COUNTY GOVERNMENT

## FAMILY LEAVE POLICY

President Clinton signed the Family & Medical Leave Act into law on February 5, 1993. This legislation allows employees to take up to twelve weeks of unpaid leave for various personal reasons. The following is an overview of the pertinent provisions of the Act.

### **Family and Medical Leave:**

An eligible employee may take up to 12 work weeks of unpaid leave during any 12-month period for the following reasons:

1. Birth of the employee's child;
2. Placement of a child with the employee for adoption or foster care;
3. employee's need to care for a child, spouse, or parent who has a serious health condition;
4. Employee's inability to perform the functions of his/her position because of a serious health condition.

An eligible employee may take up to 26 work weeks of unpaid leave for the following reason:

spouse, son, daughter, parent, or next of kin" to take up to 26 workweeks of leave to care for a "member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness

### **Eligibility:**

Employees employed for at least 12 months and worked at least 1,250 hours during the 12-month period before the leave is requested are eligible for family/medical leave.

### **Birth or Placement of a Child:**

An employee must provide 30 days advance notice before the date on which the leave would begin. If the employee is unable to provide 30 days advance notice, he/she must provide such notice as is practical. Leave may be taken on an intermittent or reduced basis if approved by the department director following the standard approval procedure.

If an employee and his/her spouse are both employed by the County and wish to take leave to care for a newly arrived child, their aggregate leave is limited to 12 weeks.

### **Serious Medical Condition:**

Leave for serious health conditions – either of a family member or the employee – may be taken intermittently or on a reduced schedule if medically necessary, with proper notification, but without

department approval. If leave is requested because of the illness of a child or the other spouse, each spouse is entitled to 12 weeks of leave.

Serious Health Conditions is an illness, injury, impairment, or physical or mental condition involving either inpatient care or continuing treatment by a health care provider.

In the event leave is foreseeable based on planned medical treatment, employees are required to “make a reasonable effort to scheduled the treatment so as not to unduly disrupt operations of the department”, and also are required to provide 30 days advance notice, or, if the treatment is less than 30 day, “such notice as practicable”.

### **Certification:**

Employees must provide certification of a serious health condition or his own serious health condition or that of a family member. Certification is to include the date on which the serious health condition in question began; the probable duration of the condition; appropriate medical facts regarding the condition; a statement that the employee is needed to care for a spouse, parent, or child (along with an estimate of the time required), or that the employee is unable to perform his or her functions; and in the case of intermittent leave, the dates and duration of treatments to be given.

### **Employment protections:**

An employee who completes a period of leave will be returned to the same position he/she had before or to a position equivalent in pay, benefits, and other terms and conditions of employment. Leave will not result in the loss of any previously accrued seniority or employment benefits; however, additional leave time and pension benefits do not continue to accrue while the employee is on leave. An employee must have worked 12 continuous months prior to receiving an annual merit increase.

### **Health Benefits Protection:**

Employees continue to receive health benefits, life insurance, and disability insurance for up to 12 weeks during family leave on the same terms and conditions as for active employees. The employee must continue to pay appropriate premiums, co payments, deductibles and other out-of-pocket cost.

An employee who does not return after a 12-week family leave, except in the case of the continuation, recurrence, or onset of a serious health condition, or other circumstances beyond the employee’s control, may be required to reimburse the County for premiums paid on his/her behalf during the time of unpaid leave. Exceptions are subject to certification.

An employee who does not return after a 12-week family leave is entitled to elect up to 18 months more coverage under COBRA.

### **Conclusions:**

This policy is a brief summary explaining how the Family & Medical Leave Act of 1993 applies to our local government jurisdictions. Further questions related to Family Leave should be directed to the Hall County Human Resources Department for clarification.

**PLEASE HAVE PHYSICIAN COMPLETE FORM AND RETURN TO:**

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**CERTIFICATION OF PHYSICIAN OR PRACTITIONER**

(Family and Medical Leave Act of 1993)

1. Employee's Name: \_\_\_\_\_
2. Patient's Name (If other than employee): \_\_\_\_\_
3. Diagnosis: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
4. Date condition commenced: \_\_\_\_\_
5. Probable duration of condition: \_\_\_\_\_
6. Regiment of treatment to be prescribed (indicated number of visits, general nature and duration of treatment, including referral to other provider of health services. Include schedule of visits or treatment if it is medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal schedule of hours per day or days per weeks):
  - a. By a Physician or Practitioner:
  - b. By another provider of health services, if referred by Physician or Practitioner:

IF THIS CERTIFICATION IS RELATED TO CARE FOR THE EMPLOYEE'S SERIOUSLY ILL FAMILY MEMBER, SKIP ITEMS 7, 8, & 9 AND PROCEED TO ITEMS 10 THROUGH 14. IF THIS CERTIFICATION IS RELATED TO AN EMPLOYEE'S FITNESS FOR DUTY AND ABILITY TO RETURN TO WORK OR AN EMPLOYEE'S INABILITY TO RETURN TO WORK, SKIP ITEMS 7 THROUGH 14 AND PROCEED TO ITEM 15. OTHERWISE, CONTINUE BELOW.

Check Yes or No in the boxes blow, as appropriate

- |    | Yes                      | No                       |   |
|----|--------------------------|--------------------------|---|
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | Is inpatient hospitalization of the employee required?  |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | Is the employee able to perform work of any kind? (If "No", skip Item 9).   |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | Is employee able to perform the functions of employee's position? (Answer after reviewing statement from employer of essential functions of employee's position, or, if none provided, after discussing with employer). |

FOR CERTIFICATION RELATING TO CARE FOR THE EMPLOYEE'S SERIOUSLY ILL FAMILY MEMBER, COMPLETE ITEMS 10 THROUGH 14 BELOW AS THEY APPLY TO THE FAMILY MEMBER AND PROCEED TO ITEM 15.

- |     | Yes                      | No                       |   |
|-----|--------------------------|--------------------------|---|
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | Is inpatient hospitalization of the family member (patient) required?   |
| 11. | <input type="checkbox"/> | <input type="checkbox"/> | Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation?  |
| 12. | <input type="checkbox"/> | <input type="checkbox"/> | After review of the employee's signed statement (see item 14 below) is the employee's presence necessary or would it be beneficial for the care of the patient? (This may include psychological comfort). |

13. \_\_\_\_\_ Estimate the period of time care is needed or the employee's presence would be beneficial.

**ITEM 14 IS TO BE COMPLETED BY THE EMPLOYEE NEEDING FAMILY LEAVE.**

14. When Family Leave is needed to care for a seriously ill family member, the employee shall state to care he or she will provide and an estimate of the time period during which this care will be provided, including a schedule if leave is to be taken intermittently or on a reduced leave schedule:

**RETURN TO WORK –CERTIFICATION**

ITEMS 15 THROUGH 21 ARE TO BE COMPLETED BY THE EMPLOYEE'S TREATING HEALTH CARE PROVIDER, TO CERTIFY WHETHER OR NOT THE EMPLOYEE IS FIT FOR DUTY AND ABLE TO RETURN TO WORK. THIS SECTION SHOULD BE COMPLETED EITHER WHEN THE EMPLOYEE IS ATTEMPTING TO RETURN TO WORK OR WHEN THE EMPLOYEE CLAIMS THAT HE/SHE IS UNABLE TO RETURN TO WORK, UPON THE EXPIRATION OF HIS/HER LEAVE, DUE TO THE CONTINUATION, RECURRENCE OR ONSET OF A SERIOUS HEALTH CONDITION OF THE EMPLOYEE OR HIS/HER FAMILY MEMBER.

- |     | Yes                      | No                       |   |
|-----|--------------------------|--------------------------|---|
| 15. | <input type="checkbox"/> | <input type="checkbox"/> | Is the employee able to perform the functions of employee's position?   |
| 16. | <input type="checkbox"/> | <input type="checkbox"/> | Are there any limitations on the employee's ability to perform any functions of employee's position?  |
| 17. |                          |                          | If there are any limitations on the employee's ability to perform any functions of employee's position, please list and explain in detail those limitations, and whether such limitations are temporary or permanent. (If temporary in nature, give an estimate as to the duration of the limitation(s).<br><br>_____<br><br>_____<br><br>_____ |
| 18. | <input type="checkbox"/> | <input type="checkbox"/> | In your medical/professional opinion, is the employee fit for duty and able to return to work?  |
| 19. | <input type="checkbox"/> | <input type="checkbox"/> | If your answer to question 18 is "Yes", skip questions 20 through 21 and proceed to item 22. If your answer to question 18 is "no", state when, if ever, you believe the employee will be fit for duty and able to return to work. _____  |
| 20. | <input type="checkbox"/> | <input type="checkbox"/> | Was the employee's inability to return to work on the date the leave expired because of continuation, recurrence or onset of a serious health condition of the employee?  |
| 21. | <input type="checkbox"/> | <input type="checkbox"/> | Was the employee's inability to return to work on the date the leave expired because of the continuation, recurrence or onset of a serious health condition of the employee's family member?  |

Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

22. Signature of Physician or Practitioner: \_\_\_\_\_ Date: \_\_\_\_\_

23. Type of Practice (Field of Specialization, if any): \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_