CITY AND COUNTY OF SAN FRANCISCO

FMLA 1

YOUR RIGHTS
under the
FAMILY AND MEDICAL LEAVE ACT

FMLA requires the City to provide within a rolling 12-month period up to 12 weeks (480 hours) of unpaid, job-protected leave to "eligible" employees for certain family and medical reasons. You are eligible if you have worked for the City for at least one year, and for 1,250 hours over the previous 12 months. (Hours taken as sick pay, vacation or other type of leave do not count as hours worked for this calculation.)

REASONS FOR TAKING LEAVE[1]: Under the FMLA, unpaid leave must be granted for any of the following reasons:

- To care for your child after birth and to care for that child;
- For the placement with the employee of a child for adoption or foster care and to care for that child;
- To care for your spouse/domestic partner, son or daughter, or parent, who has a serious health condition; or
- For a serious health condition that makes you unable to perform your job.[2]

City policy requires that, except for authorized Workers' compensation leave or pregnancy disability leave, when leave is qualified FMLA Leave, you must concurrently use accrued sick leave time off. After sick leave with pay credits has been exhausted, an employee may elect to use accrued vacation leave to cover the remaining FMLA leave, followed by the use of floating holidays.

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

- You ordinarily must provide 30 days advance notice when the leave is "foreseeable."
- The City requires medical certification to support a request for leave because of a serious health condition, and may require second or third opinions (at the City's expense) and a fitness for duty report to return to work.
- While on leave, you may be required to furnish the City with periodic status reports.

JOB BENEFITS AND PROTECTION:

- For the duration of FMLA leave, the City will maintain your health coverage under your "group health plan." You are responsible for your share of premium costs, if any.
- Upon return from FMLA leave, you will likely be restored to your original or equivalent position with equivalent pay, benefits, and other employment terms unless you are designated a "key employee".
- The use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of your leave.

UNLAWFUL ACTS BY EMPLOYERS: FMLA makes it unlawful for the City to:

- interfere with, restrain, or deny the exercise of any right provided under FMLA;
- discharge or discriminate against you 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 that provides greater family or medical leave rights.

FOR ADDITIONAL INFORMATION: **Contact your departmental Human Resources office.**

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[1] Information on the California Family Rights Act of 1993 and the City's Pregnancy Disability Leave is provided on the reverse side of this page.

[2] The City will count a Workers' Compensation absence towards your FMLA entitlement if you suffer an on-the-job injury or illness that qualifies as a serious health condition.

CITY AND COUNTY OF SAN FRANCISCO

FAMILY CARE AND MEDICAL LEAVE (CFRA LEAVE) AND PREGNANCY DISABILITY LEAVE

Under the California Family Rights Act of 1993 (CFRA), if you have more than 12 months of service with us and have worked at least 1,250 hours in the 12-month period before the date you want to begin your leave, you may have a right to an unpaid family care or medical leave (CFRA leave). This leave may be up to 12 workweeks (480 hours) in a 12-month period for the birth of your child, and adoption or foster care placement of a child with you, or for your own serious health condition or that of your child, parent or spouse/registered domestic partner.

Even if you are not eligible for CFRA leave, if you are disabled by pregnancy, childbirth or related medical conditions, you are entitled to take a pregnancy disability leave of up to four months, depending on your period(s) of actual disability. If you are CFRA-eligible, you have certain rights to take *both* a pregnancy disability leave and a CFRA leave for reason of the birth of your child. Both leaves contain a guarantee of reinstatement to the same or to a comparable position at the end of the leave, subject to any defense allowed under the law.

If possible, you must provide at least 30 days advance notice for foreseeable events (such as the expected birth of your child or a planned medical treatment for yourself or of a family member). For events which are unforeseeable, we need you to notify us, at least verbally, as soon as you learn of the need for the leave.

Failure to comply with these notice rules is grounds for, and may result in, deferral of the requested leave until you comply with this notice policy.

We may require certification from your health care provider before allowing you a leave for pregnancy or your own serious health condition or certification from the health care provider of your child, parent or spouse/registered domestic partner who has a serious health condition before allowing you a leave to take care of that family member. When medically necessary, leave may be taken on an intermittent or reduced work schedule.

Taking a family care or pregnancy disability leave may impact certain employment benefits. If you need more information regarding your eligibility for a leave and/or the impact of the leave on your benefits, please contact your departmental Human Resources office.

CITY AND COUNTY OF SAN FRANCISCO

FMLA 1A

EMPLOYEE REQUEST FOR FAMILY AND MEDICAL LEAVE[1]

☐ New Request ☐ Request for Extension[2]

I am requesting Family and Medical Leave for the following reason (check one):

☐ A. The birth of the employee's child and to care for such child. _____ (date of birth)

☐ B. The placement with the employee of a child for adoption or foster care and to care for such child. (Attach documentation.)

☐ C. In order to care for an immediate family member because such family member has a serious health condition. (Submit "Certification of Health Care Provider" (FMLA 2) form within 15 calendar days.)

Circle one: CHILD SPOUSE/DOMESTIC PARTNER PARENT OTHER (explain)

_____

_____

☐ D. Employee's serious health condition that makes the employee unable to perform the functions of his/her job.[3] (Submit "Certification of Health Care Provider" (FMLA 2) form within 15 calendar days.)

If you checked one of the above, your request, if approved, will constitute Family Medical Leave and will be designated as such.[4] If you checked "D", the City will, as a condition of returning to work, require you to provide a medical certification of fitness to return to work. If you fail to submit the required certification, the City may refuse to return you to work until the certification is submitted.

Requested Dates: _____ (beginning date) through _____ (ending date)

_____ Employee Signature

_____ Date

_____ Employee Name (Print or Type)

_____ Social Security No.

_____ Employee Class Number and Title

_____ Dept. Name

cc: Personnel File

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[1] Refers to both Federal and State Leaves under the Family Medical Leave Act and the California Family Rights Act.

[2] Requests for an extension of FMLA Leave must be submitted two business days prior to the end of the current scheduled FMLA Leave. Failure to submit timely may delay the granting of the FMLA Leave extension.

[3] The City will count a Workers' Compensation absence against your FMLA leave if you suffer an on-the-job injury or illness that qualifies as a serious health condition.

[4] Except for authorized Workers' Compensation leave or pregnancy disability leave, an employee whose leave is qualified FMLA Leave concurrently must use accrued sick leave for time off. After sick leave accrued balance has been exhausted, an employee may request to use accrued vacation leave to cover the remaining FMLA leave, followed by the use of floating holidays.

FMLA 1B

RESPONSE TO YOUR REQUEST OF _____ FOR FAMILY AND MEDICAL LEAVE[1]

(date)

☐ New Request ☐ Request for Extension[2]

EMPLOYEE NAME: _____ **Date:** _____

This is to inform you that:

1. ☐ You are eligible for leave under FMLA.
   ☐ You are not eligible for leave under FMLA. Reason: _____

2. Leave dates requested _____ through _____.
   ☐ Will be counted toward your FMLA entitlement.
   ☐ Will not be counted toward your FMLA entitlement.

3. You ☐ will/ ☐ will not be required to furnish medical certification (Certification of Health Care Provider form FMLA 2) of a serious health condition. If required, you must submit the form by _____ *(date)*
   Note: Form 2 must be submitted within 15 calendar days after you are notified of this requirement or we may delay the commencement of your leave until the certification is submitted. We may also preliminarily designate your leave as FMLA Leave, subject to submission of the Certification of Health Care Provider (FMLA 2) form.

4. You may be requested to provide the City with a Certification of Health Care Provider (FMLA 2) form no more frequently than every thirty (30) days from the date you commence your leave as to your serious health condition or your family member's serious health condition.

Except as explained below, you have a right under the FMLA for up to 12 weeks (480 hours) of unpaid leave in a rolling 12-month period[3] for the reasons listed on the other side (FMLA 1A). Also, your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work. Unless you have been designated as a "key employee", you must be reinstated to the same or an equivalent position with the same pay, benefits, and terms and conditions of employment on your return from leave. If you do not return to work following FMLA leave for a reason other than: (1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; or (2) other circumstances beyond your control, you may be required to reimburse the City for its contribution of health insurance premiums paid on your behalf during the unpaid portion of your FMLA leave.

_____ _____

(Signature of Department HR Representative) *(Print Name)*

FOR OFFICE USE ONLY

Family and Medical Leave Expiration Notice: Leave ending _____
(date)

SENT: _____ _____
(two weeks prior to leave expiration) *(initials)*

cc: Personnel File

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[1] FMLA refers to both Federal and State leaves under the Family Medical Leave Act and the California Family Rights Act.

[2] Requests for an extension of FMLA Leave must be submitted two business days prior to the end of the current scheduled FMLA Leave. Failure to submit timely may delay the granting of the FMLA Leave extension.

[3] Each time you take FMLA leave, your remaining leave entitlement will be the balance of the 12 weeks you have not used during the immediately preceding 12 months. For example, if you took four weeks on 9/01/05, four weeks on 12/1/05 and four weeks on 3/1/06, you would not be entitled to any additional FMLA Leave until 9/1/06.

CITY AND COUNTY OF SAN FRANCISCO

FMLA 2

Certification of Health Care Provider

(Family and Medical Leave Act of 1993 & California Family Rights Act.)

Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking FMLA/CFRA leave. "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.

1. Employee's Name: _____

2. Patient's Name (if different from employee): _____

3. The attached sheet describes what is meant by a "serious health condition" under the Family and Medical Leave Act. Does the patient's condition(s) qualify under any of the categories described? If so, please check the applicable category.

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

4. Describe the medical facts which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories:[1]

   a. If the employee is the patient (if not, skip to Question 5) state the approximate date the condition commenced, and the probable duration of the condition (and also the probable duration of the patient's present incapacity if different):

   b. Will it be necessary for the employee to work only intermittently or to work on a less than full schedule as a result of the condition (including for treatment described in Item 6 below)?

      If yes, give the recommended reduction in schedule and the probable duration: _____

   c. If the condition is a chronic condition (condition 4) or pregnancy, state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity:

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[1] **This certification should not disclose the underlying diagnosis without the patient's consent**

Employee's Name: _____

Patient's Name: _____

Certification of Health Care Provider

5. If the employee is **not** the patient:

   a. The date, if known, on which the serious health condition commenced: _____

   b. The probable duration of the condition: _____

   c. An estimate of the amount of time which you believe the employee needs to care for the child, parent or spouse/domestic partner:

   d. Does the serious health condition warrant the participation of the employee, including but not limited to, providing psychological comfort and arranging third party care as well as directly providing or participating in medical care:

      No_____ Yes _____

6. a. If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments:

   b. If any of these treatments will be provided by another provider of health services (e.g., physical therapist), please state the nature of the treatments:

   c. If the patient will be absent from work or other daily activities because of treatment on an intermittent or part-time basis, also provide an estimate of the probable number and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any:

   d. If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment):

Employee's Name: _____

Patient's Name: _____

Certification of Health Care Provider

7. a. If medical leave is required for the employee's absence from work because of the employee's own condition (including absences due to pregnancy or a chronic condition), is the employee unable to perform work of any kind?

b. If able to perform some work, is the employee unable to perform any one or more of the essential functions of the employee's job (the employee or the employer should supply you with information about the essential job functions)? If yes, please list the essential functions the employee is unable to perform:

c. If neither a. nor b. applies, is it necessary for the employee to be absent from work for treatment?

_____ _____

(Signature of Health Care Provider) (Type of Practice)

_____ _____

(Print Name of Health Care Provider) (License No.)

_____ _____

(Address) (Date)

_____ _____

(City) (State) (Zip Code) (Telephone number)

Patient's Name: _____

Certification of Health Care Provider

TO BE COMPLETED BY THE ***EMPLOYEE*** NEEDING FAMILY LEAVE TO CARE FOR A FAMILY MEMBER:

State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule:

_____ _____

(Employee Signature) (Date)

_____

(Employee Name -- *print*)

_____ _____

(Classification Number and Title) (Dept.)

Certification of Health Care Provider Definitions

A "Serious Health Condition" means an illness, injury, impairment, or physical or mental condition that involves one of the following:

CATEGORY 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 any subsequent treatment in connection with or consequent to such inpatient care.

"Incapacity" means an inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment thereto, or recovery therefrom. "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. 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.

CATEGORY 2: Absence Plus Treatment

(a) 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:

(1) 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

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

CATEGORY 3: Pregnancy

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

CATEGORY 4: Chronic Conditions Requiring Treatments

A chronic condition which:

(1) 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;

(2) Continues over an extended period of time (including recurring episodes of a single underlying condition); and

(3) May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

CATEGORY 5: Permanent/Long-term Conditions Requiring Supervision

A period of incapacity 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.

CATEGORY 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 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).

CITY AND COUNTY OF SAN FRANCISCO

FMLA 1C

EMPLOYEE REQUEST FOR EXTENSION OF FAMILY AND MEDICAL LEAVE[1]

I requested and was approved for FMLA Leave from _____ through _____.

I am requesting additional Leave for the reason noted below. I understand that if I fail to submit this request two business days prior to the end of my scheduled leave, that my failure may delay the granting of the leave extension.

I also understand that I am entitled to only 12 weeks (480 hours) of FMLA Leave during a rolling 12-month period. I am requesting only that period still available to me under the FMLA. I understand that upon expiration of an FMLA Leave, if no additional FMLA Leave is available, I must return to work unless I am granted some other leave available under existing City rules, policies, and/or collective bargaining agreements.

☐ A. The birth of the employee's child and to care for such child (date of birth).

☐ B. The placement with the employee of a child for adoption or foster care and to care for such child. (Attach documentation.)

☐ C. In order to care for an immediate family member because such family member has a serious health condition. (Submit *updated* "Certification of Health Care Provider" *(FMLA 2)* within 15 calendar days)

Circle one: CHILD / SPOUSE / DOMESTIC PARTNER / PARENT / OTHER (explain)

_____

☐ D. Employee's own serious health condition that makes the employee unable to perform the functions of his/her position.[2] (Submit *updated* "Certification of Health Care Provider" *(FMLA 2)* within 15 calendar days)

If you checked one of the above, your request, if approved, will constitute Family Medical Leave and will be designated as such.[3] If you checked "D", the City will, as a condition of returning to work, require you to provide a medical certification of fitness to return to work. If you fail to submit the required certification, the City may refuse to return you to work until the certification is submitted.

Extension Requested: _____ (beginning date) through _____ (ending date)

_____ Employee Signature

_____ Date

_____ Employee Name (Print or Type)

_____ Social Security No.

_____ Employee Class Number and Title

_____ Department Name

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[1] Refers to both Federal and State Leaves under the Family Medical Leave Act and the California Family Rights Act.

[2] The City will count a Workers' Compensation absence against your FMLA leave if you suffer an on-the-job injury or illness that qualifies as a serious health condition.

[3] Except for authorized Workers' Compensation leave or pregnancy disability leave, an employee whose leave is qualified FMLA Leave concurrently must use accrued sick leave for time off. After sick leave accrued balance has been exhausted, an employee may request to use accrued vacation leave to cover the remaining FMLA leave, followed by the use of floating holidays.

cc: Personnel File

STATE DISABILITY INSURANCE DEPARTMENTAL NOTIFICATION

INSTRUCTIONS TO EMPLOYEES

Your State Disability Insurance (SDI) payments will be automatically supplemented with sick pay credits (if you have sick pay credits and are eligible to use them) to provide up to your normal salary *UNLESS:*

- you choose not to supplement, or
- you choose to supplement with either compensatory time off or vacation, or
- you choose not to apply for SDI.

If you choose any of the above options, you must notify your departmental Payroll Office *within seven calendar days of your first day of absence,* by filing out the information below. [The above ruling is outlined in Civil Service Commission Rule 22, Section 22.02(F)].

TO BE COMPLETED BY EMPLOYEE

(Check one:)

☐ 1. I do **not** wish to supplement SDI.

☐ 2. I wish to supplement SDI with sick pay, vacation and/or compensatory time* in the order listed:

1st _____ 2nd _____ 3rd _____

☐ 3. I do not wish to apply for SDI benefits. Instead, I wish to receive full salary from any sick pay, vacation, or compensatory time* credits I have coming to me. I understand that, if at any time in the future I file for SDI benefits for the injury or illness that occurred on the date below ("First full day of absence"), I must notify my department Payroll Office *the next business day after filing;* otherwise, I will be in violation of State law.

Signature	Date	
Printed Name	Home Address (Street, City, Zip Code)	
First full day of absence	Date SDI applied for (*fill out unless Box 3 above is checked*)	Employee Number
Classification	Department Name	
Work Phone Number	Home Phone Number	

**Use of compensatory time requires your Appointing Officer's approval. If you choose this option, your departmental Payroll or Personnel Office will contact your Appointing Office to obtain approval.*

FOR DEPARTMENTAL USE ONLY

Appointing Officer's Signature_____ Date_____
(for comp time approval only)