FMLASource®
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BROOK + WHITTLE
Attn: Brook + Whittle

Leave Request # 3885359

1/19/2022

ABIGAIL DIAZ
23 LEE AVENUE
BRIDGEPORT, CT 06605

Dear Abigail,

As of 1/19/2022, FMLASource has received your request for leave from your position at Brook + Whittle for your own serious health condition.

The following dates are pending decision(s):

On Continuous Leave	Beginning on 2/28/22	Ending on 3/28/22	Certification due 2/4/22
Applicable Leave Plan(s): CT Family Leave / CT Family Leave – 2 week SHC Extension / FMLA		Decision Reason: Certification Needed	

What You Need To Know

At the time of this request, you are eligible for leave under CT Family Leave / CT Family Leave – 2 week SHC Extension / FMLA but your leave is not yet approved. The following is information about the specific leaves for which you're eligible:

The CT Family Leave provides eligible employees up to two (2) weeks of unpaid, job protected leave in a 12-month period for a serious health condition resulting in incapacitation that occurs during a pregnancy. This leave extension occurs after an employee has exhausted (and is in addition to)the 12 weeks of leave provided under the CT FMLA. To be eligible, an employee must have worked for the employer for at least three continuous months preceding the leave and work at a covered employer with at least one employee. When applicable, CT Family Leave will run concurrently with Connecticut Pregnancy Disability Act (CTPDA) and FMLA.

Connecticut Family and Medical Leave Act (CT FMLA) provides eligible employees with unpaid, job-protected leave in a 12-month period for certain family and medical reasons, including up to 12 weeks of unpaid leave in a 12-month period for the birth of a child or placement of a child for adoption or foster care, for leave related to the employee's own or a family member's serious health condition, or for certain qualifying exigencies related to the deployment of a military member to covered active duty. Eligible employees also have a right to take an additional two (2) weeks of unpaid, job-protected leave for a serious health condition resulting in incapacitation that occurs during a pregnancy. Employees also have a right to take up to 26 weeks of unpaid, job-protected leave in a single 12-month period to care for a covered servicemember with a serious injury or illness. An employee must have worked for a covered employer for at least three months preceding the leave and work at a covered employer with at least one employee. When applicable, CT FMLA will run concurrently with the Connecticut Pregnancy Disability Act (CTPDA) and FMLA.

The Family and Medical Leave Act (FMLA) allows eligible employees up to a total of 12 weeks of unpaid leave in a 12-month period for certain qualifying reasons. If your leave is approved and you have FMLA time available, you will be entitled to job protection under the FMLA for the dates listed above (see "beginning on" and "ending on") and your time off work will reduce your available FMLA balance. Your employer will maintain your health benefits under the same conditions as if you continued to work. If you do not return to work following FMLA for a reason other than (1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA; or (2) other circumstances beyond your control, you may be required to reimburse your employer for their share of health insurance premiums paid on your behalf.

If your leave is supplemented by a pay replacement benefit (for example short term disability, worker's compensation and/or paid time off) that benefit will run concurrently with your leave.

What You Need To Do

Submit a complete, sufficient medical certification.
In order for your leave to be designated under CT Family Leave / CT Family Leave – 2 week SHC Extension / FMLA, you must have the attached certification completed and returned to FMLASource by the due date (see "Certification due" section) listed above. Please be advised that although you are reliant upon your health care provider to complete the certification, it is ultimately your responsibility to ensure that we receive a completed and sufficient certification. If you are having difficulty getting such certification, contact FMLASource. If a complete and sufficient medical certification is not submitted within this 15 day period, the commencement of your leave may be delayed or your leave may be denied.

Should you have any questions, please contact FMLASource by sending an email to FMLACenter@FMLASource.com or call us toll free at 877-GO2-FMLA. Please reference your leave request number # 3885359 when you contact us. You may also find information and review your leave status on our website at www.FMLASource.com. To access your record, please visit our website and create a username and password. You must have your employee ID number and the postal code (06605) on file with your employer to register. We are working to provide you with excellent service during your leave.

Best Regards,

FMLASource

cc: ENITH MICHAUD, Senior HR Specialist Admin Benefits

Your Rights & Responsibilities
Under the Family & Medical Leave Act

FMLA requires covered employers to provide unpaid, job protected leave to "eligible" employee for certain family and medical reasons. Employees are eligible if they have worked for a covered employer for at least one year and for 1,250 hours over the previous 12 months, work at a site with at least 50 employees within 75 miles, and have leave time available.

Reasons for taking leave:
FMLA requires covered employers to provide up to 12 work weeks of unpaid, job-protected leave during a single, 12-month period measured forward from the date of your first FMLA leave usage:

- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son, daughter, or parent who has a serious health condition;
- To address certain qualifying exigencies arising from employee's spouse, son, daughter, or parent on active duty or call to active duty in the National Guard or Reserves in support of a contingency operation;
- For incapacity due to pregnancy, prenatal medical care, or post-partum recovery;
- For a serious health condition that makes the employee unable to perform his or her job.

Qualifying exigencies may include attending certain military events, arranging for alternative child-care or parental care, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post deployment reintegration briefings.

Use of Leave
The employee does not need to use this leave entitlement in one block. When medically necessary, leave may be taken on an intermittent or reduced-schedule basis. Employees must make reasonable efforts to schedule leave for planned medical treatment so as to not unduly disrupt the employer's operations.

Definition of a Serious Health Condition
A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Benefits and Protections
While on FMLA leave, the employer must maintain the employee’s health coverage under any "group health plan" on the same terms as if the employee had continued to work.

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

Use of FMLA cannot result in the loss of any employment benefit that accrued prior to the start of the employee’s leave.

Substitution of paid leave for unpaid leave
Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities
Employee must provide 30-days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedure.
Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health-care provider, or the circumstances supporting the need for military family leave.
Employees must also inform their employer if the requested leave is for a reason for which FMLA leave was previously taken or certified.
Employees may also be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities
Covered employers must inform employees requesting leave whether they are eligible under FMLA. If the employee is eligible, the notice must specify any additional information required along with a copy of this notice. If the employee is not eligible, the employer must provide a reason for the ineligibility.
Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee’s leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers
FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or related to FMLA.

Enforcement
The employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer. FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

For Additional Information
Please contact the nearest office of the Wage and Hour Division, listed in most telephone directories under US Government – Department of Labor, or contact your human resource department.

FMLASource®

Completing the FMLA or Leave of Absence
Medical Certification Employee's Serious Health Condition

Instructions for Employee

- ☐ Notify your manager of your need for leave of absence (in accordance with Brook + Whittle's FMLA and/or leave of absence policies.)
- ☐ Ask your health care provider to complete the Medical Certification and provide it (fax number is below) to FMLASource within 15 days of the date this letter was sent.
- ☐ Consider following up with your health care provider to confirm the Medical Certification was completed and faxed to FMLASource. It is your responsibility to provide timely, complete and sufficient certification. (Note: you may need to furnish your health care provider with any necessary authorization in order for the health care provider to release a complete and sufficient certification to support the FMLA request.)

FMLASource will notify you whether your leave has been approved or denied (via your preferred method of communication - email or postal mail) once we receive a complete and sufficient certification. Alternatively, we will notify you if additional information is required. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request.

Instructions for Health Care Provider

Please answer fully and completely the two sections on the following pages and sign the form.

Step 1 - PATIENT'S CONDITION. Certify whether your patient has a "serious health condition" as the term is defined under the law (note: for more information on the definition of "serious health condition", you can refer to the U.S. Department of Labor website at http://www.dol.gov/whd/fmla/). Also include information sufficient to establish that the patient cannot perform the essential functions of the patient's job as well as the nature of any other work restrictions, and the likely duration of such inability. If your patient's condition does not meet one of the definitions under the law, please indicate that. Do not provide information related to genetic tests or services.

Step 2 - DATES OF LEAVE. Provide the frequency and probable dates needed for leave.

- Consider **all of the dates** that your patient has had or will have to be out of work due to the serious health condition, even if the patient was initially treated by someone else (e.g., in an emergency room or ICU).
- If your patient's leave is intermittent (described in Step 2) **please provide your *best estimate*** of the frequency and duration of the patient's condition, treatments, etc.
- Terms such as "lifetime," "unknown" or "indeterminate" **may not be sufficient** to determine whether the patient's condition qualifies for leave.

Step 3 - SIGNATURE. Sign and date the form and provide your type of practice/medical specialty.

Return the completed form via fax to FMLASource at 1.877.309.0218 before the listed due date. If you do not complete all steps in full and return it before the due date, your patient's leave may be denied.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

FMLA or Leave of Absence Medical Certification
Employee's Serious Health Condition

Employee/Patient Name: Abigail Diaz
Employer: Brook + Whittle
Leave Request #: 3885359
Due Date: 2/4/2022
Request for leave due to: Employee's Serious Health Condition
Dates of leave requested by employee/patient:
- Continuous leave date range request: 2/28/2022 to 3/28/2022

STEP 1 - PATIENT'S CONDITION.

(A) Describe Appropriate Medical Facts*: Provide a statement or description of appropriate medical facts regarding the patient's health condition for which FMLA leave is requested (i.e., leave is medically necessary). The medical facts must be sufficient to support the need for leave.

**Such medical facts may include information on symptoms, diagnosis, hospitalization, doctor visits, whether medication has been prescribed, referrals for evaluation or treatment (physical therapy for example) or any other regimen of continuing treatment such as the use of specialized equipment (Not required in California).*

(B) Select the Appropriate Description of Condition. At least one reason from Section 1 or Section 2 must apply to qualify as a serious health condition under the FMLA and/or state law. *At least one section, and all that apply, must be completed.*

Section 1 – A single reason accounts for the patient's medically necessary absence from work:

- ☐ Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility; or any subsequent recovery or treatment in connection with such inpatient care.
- ☐ Permanent or long-term condition for which the patient is under continuing supervision of a health care provider but for which treatment may not be effective (e.g., Alzheimer's, a severe stroke)
- ☐ Out of work to undergo multiple treatments and related recovery for one of the below:
  (1) restorative surgery after an accident or other injury *or*
  (2) a condition that would likely result in a period of incapacity of more than three (3) full, consecutive calendar days in the absence of such treatment.

Section 2 - A combination of reasons account for the patient's medically necessary absence from work:

- ☐ Unable to work/perform job duties for more than three (3) consecutive, full calendar days, coupled with one of the following ***(select at least one and provide dates of treatment):***
  - ☐ 2 or more in-person treatments within the first 30 days of the employee's incapacity (if not provided by you, please note the medical specialty of the treating provider, e.g., nurse, physical therapist)
    _____
  - ☐ At least 1 examination/treatment followed by a regimen of continuing treatment (e.g. physical therapy or prescription medication), under the supervision of, or referral by a health care provider:
    _____
- ☐ A chronic health condition which continues over an extended period of time and BOTH:
  (1) requires periodic visits for treatment by a health care provider (at least two (2) visits per year) and
  (2) may cause episodic incapacity or flare-ups or would cause periods of reoccurrence without treatment (*e.g.* asthma, diabetes, epilepsy, *etc.*)

The patient does not have a qualifying serious health condition

- ☐ None of the reasons in Section 1 or Section 2 account for the patient's absence from work.

(C) Confirm employee cannot perform the essential functions of the job.
Your patient should provide you with a description of their job functions.
Is the employee unable to perform any of his/her job functions due to the condition? ___No ___Yes
If so, identify the job functions the employee is unable to perform and the nature of the work restrictions and the duration of such inability: _____

Continued on next page

Employee/Patient Name: ABIGAIL DIAZ LR#: 3885359

STEP 2 - DATES OF LEAVE

Consider all dates the patient has been or will be unable to work by checking and completing either of the below sections that apply. Dates requested by the patient are listed above. *At least one section, and all that apply, must be completed.* ***Answers of "unknown," "indeterminate" or "lifelong" may not be sufficient to determine FMLA coverage.***

☐ **Continuous Leave:** *Is the patient unable to work for a single, continuous period of time?*

i. Start date of incapacity ____ / ____ / _____ (MM/DD/YYYY)

ii. Estimated end date of incapacity ____ / ____ / _____ (MM/DD/YYYY)

iii. Will the employee require follow-up appointments? *If so, please indicate the frequency of incapacity below in section iii under "Intermittent Leave"*

AND/OR

☐ **Intermittent Leave:**
Is the patient able to work but needs occasional time off for a single illness or injury?

i. Start date for leave or initial appointment date
____ / ____ / _____ (MM/DD/YYYY)

ii. Probable end date for leave
____ / ____ / _____ (MM/DD/YYYY) ***or***

☐ Condition is lifelong (**check if applicable**)

iii. **Appointments/treatments -** Will the patient need to miss work for appointments or treatments?

☐ No

☐ Yes - Estimate treatment schedule:

Frequency: Up to ____ times per _____ (week/month/year)

Duration: Lasting up to _____ hours **OR** _____ days

Please include the dates of any scheduled appointments and the time required for each appointment:

_____

iv. **Flare-ups/Episodes -** Will the patient need to miss work for episodes of incapacity/flare-ups of the health condition?

☐ No

☐ Yes - Estimate of absences needed for episodes:

Frequency: Up to ____ times per _____ (week/month/year)

Duration: Lasting up to _____ hours **OR** _____ days

v. Dates you have already treated the patient for the condition:

_____

_____

☐ **Reduced Schedule Leave:**
Is the patient working on a <u>FIXED</u> part-time schedule or taking predictable regularly scheduled absences?

Start date of Leave
____ / ____ / _____ (MM/DD/YYYY)

Probable End Date of Leave
____ / ____ / _____ (MM/DD/YYYY)

Please indicate the hours of time the patient will need to miss each day.

Sunday_____

Monday_____

Tuesday_____

Wednesday_____

Thursday_____

Friday_____

Saturday_____

<u>Step 3 - SIGNATURE</u> Health Care Provider Information:

Name:

Practice/Specialty/Credentials:

Street Address:

Fax Number:

City, State, ZIP Code:

Signature:

Phone Number:

Date:

FMLASource Phone: 877-GO2-FMLA **FMLASource Fax:** 877-309-0218
FMLASource Email: FMLACenter@FMLASource.com
To mail: FMLASource, 455 N. Cityfront Plaza Drive, Chicago, IL 60611-5322

GINA prohibits employers from requesting genetic information. See instructions on first page.

Plastic Surgery Form

Patient Name: Abigail Diaz Leave Request #: 3885359

Dear Medical Professional:

FMLASource received the attached medical certification for your patient from your medical practice. Before a determination can be made regarding this patient's qualification for FMLA, we must verify whether the treatment provided meets the necessary criteria.

Please answer the following questions. Then sign this document and return it to FMLASource.

1. Is the procedure a medical necessity? (A medical necessity might include the following: Restorative procedure following injury; Mastectomy; Correction of birth defect; Complications resulting from a cosmetic procedure; Restorative removal of a cancerous growth)

   ☐ Yes ☐ No

   Please provide the appropriate facts supporting the medical need.

   _____

   _____

   _____

2. Does the patient's health insurance covers the treatments/appointments provided at your office?

   ☐ Yes ☐ No

3. Is the procedure purely cosmetic?

   ☐ Yes ☐ No

Signature: _____Phone: _____Fax: _____

Print Name: _____ Type of Practice: _____

Please fax this completed coversheet with the attached medical certification directly to FMLASource at 877-309-0218 or 877-309-0217