CHECKLIST FOR

FMLA Eligible Leave

Leave management fax number: **410-469-3067**

For any questions, please call AskHR: **1-833-432-7547** and choose option 5

Employee Documents to Complete and Return FOR ALL COMMUNITIES

- ☐ **Leave of Absence Request Form**
- ☐ **Important Information Regarding Your Leave**
- ☐ **Benefits Summary for Leave of Absence**

Additional Documents for New Jersey Communities ONLY

☐ **New Jersey Disability/FLI Benefits Waiver**

- Only needs to be signed and returned if you will not be applying to NJ Disability or FLI Benefits and prefer to only use your PTO/ELB. If this is not returned, it will be assumed you will apply to the state as well as completing this application, and any available pay will be decreased to a max of 15% of your regular pay.

Additional Documents for Massachusetts Communities ONLY

☐ **Massachusetts Paid Family Medical Leave Waiver**

- Only needs to be signed and returned if you will not be applying for MA PFML and prefer to use your PTO/ELB. If this is not returned, it will be assumed you will apply for MA PFML and only your first week will be paid through PTO/ELB. After that, you will not receive any pay from your community in accordance with MA Law.

Documents to Have Your Doctor Complete and Return

☐ **Certification of Health Care Provider**—Not required for maternity or paternity cases unless leave needs to start prior to delivery.

- Job Description—Give to your doctor for their understanding of your job duties. No need to return Job Description.

☐ **Release to Return to Work Form**

- Required when out for a health condition that affects yourself (Including maternity leave) and must be submitted no more than within two weeks prior to your return. For maternity leave, the release should be submitted as soon as you are medically cleared.

Informational Documents—No Action Needed

- All included policies
- Notice of Eligibility
- Employee Rights Under FMLA

Erickson SENIOR LIVING®

197459

LISTA DE VERIFICACIÓN PARA LA

elegibilidad de la licencia en virtud de la Ley de Licencia Familiar y Médica (FMLA)

Número de fax de gestión de licencias: **410-469-3067**

Si tiene alguna pregunta, llame a AskHR: **1-833-432-7547** y seleccione la opción 5.

Documentos de los empleados para completar y presentar PARA TODAS LAS COMUNIDADES

- ☐ **Formulario de solicitud de licencia**
- ☐ **Información importante sobre la licencia**
- ☐ **Resumen de beneficios para la licencia**

Documentos adicionales para las comunidades de Nueva Jersey SOLAMENTE

- ☐ **Discapacidad de Nueva Jersey/exención de beneficio de seguro de licencia familiar (FLI)**
  - Solo se debe firmar y presentar si no va a solicitar los beneficios de discapacidad de Nueva Jersey (NJ) o FLI, y prefiere usar solo el tiempo libre remunerado (PTO)/banco de licencia extendida (ELB). Si no se presenta, se asumirá que presentará su solicitud al estado y completará esta solicitud, y todo pago disponible se reducirá a un máximo del 15 % del pago regular.

Documentos adicionales para las comunidades de Massachusetts SOLAMENTE

- ☐ **Exención de la licencia familiar y médica paga de Massachusetts**
  - Solo se debe firmar y presentar si no va a solicitar la licencia familiar y médica paga de Massachusetts (MA PFML) y prefiere usar solo el PTO/ELB. Si no se presenta, se asumirá que solicitará la MA PFML y solo la primera semana se pagará a través de PTO/ELB. Luego no recibirá ningún pago de su comunidad conforme a la ley de Massachusetts (MA).

Documentos para que su médico complete y presente

- ☐ **Certificación del proveedor de atención médica**: No se requiere para casos de maternidad o paternidad, a menos que la licencia deba comenzar antes del parto.
  - Descripción del trabajo: Comuníquese con su médico para que comprenda sus tareas laborales. No es necesario presentar la descripción del trabajo.
- ☐ **Formulario de autorización para regresar al trabajo**
  - Requerido cuando no trabaja por una afección de salud que lo afecta a usted (incluida la licencia por maternidad) y debe presentarse como máximo dos semanas antes de su regreso. Respecto de la licencia por maternidad, la autorización debe presentarse apenas reciba el permiso médico.

Documentos informativos: no se necesita ninguna acción.

- Todas las políticas incluidas
- Aviso de elegibilidad
- Derechos de los empleados en virtud de la FMLA

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Based on:
Notice of Eligibility and Rights & Responsibilities (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 8/31/2021

In general, to be eligible an employee must have worked for an employer for at least 12 months, meet the hours of service requirement in the 12 months preceding the leave, and work at a site with at least 50 employees within 75 miles. While use of this form by employers is optional, a fully completed Form WH-381 provides employees with the information required by 29 C.F.R. § 825.300(b), which must be provided within five business days of the employee notifying the employer of the need for FMLA leave. Part B provides employees with information regarding their rights and responsibilities for taking FMLA leave, as required by 29 C.F.R. § 825.300(b), (c)**.**

[Part A – NOTICE OF ELIGIBILITY]

TO: Yasmin Marte De Jimenez

FROM: Michael Mathis

DATE: August 02, 2022

On 08/02/2022, you informed us that you needed leave beginning on 07/20/2022 for:

Your own serious health condition.

This Notice is to inform you that you:

Are eligible for FMLA leave (See Part B below for Rights and Responsibilities)

If you have any questions, contact Michael Mathis at (833) 432-7547 or contact your Human Resources department.

[PART B-RIGHTS AND RESPONSIBILITIES FOR TAKING FMLA LEAVE]

As explained in Part A, you meet the eligibility requirements for taking FMLA leave and still have FMLA leave available in the applicable 12-month period. **However, in order for us to determine whether your absence qualifies as FMLA leave, you must return the following information to us by 08/17/2022.** (If a certification is requested, employers must allow at least 15 calendar days from receipt of this notice; additional time may be required in some circumstances.) If sufficient information is not provided in a timely manner, your leave may be denied.

Sufficient certification to support your request for FMLA leave. A certification form that sets forth the information necessary to support your request is enclosed.

Other information needed (such as documentation for military family leave): All documents included in your FMLA packet.

If your leave does qualify as FMLA leave you will have the following **responsibilities** while on FMLA leave:

Contact Michael Mathis at (833) 432-7547 to make arrangements to continue to make your share of the premium payments on your health insurance to maintain health benefits while you are on leave. You have a minimum 30-day (or, indicate longer period, if applicable) grace period in which to make premium payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse, or, at our option, we may pay your share of the premiums during FMLA leave, and recover these payments from you upon your return to work.

You will be required to use your available paid **sick**, **vacation**, and/or **other leave** during your FMLA absence. This means that you will receive your paid leave and the leave will also be considered protected FMLA leave and counted against your FMLA leave entitlement.

While on leave you will be required to furnish us with periodic reports of your status and intent to return to work every **2 weeks.**

If the circumstances of your leave change, and you are able to return to work earlier than the date indicated on the this form, you will be required to notify us at least two workdays prior to the date you intend to report for work.

If your leave does qualify as FMLA leave you will have the following **rights** while on FMLA leave:

- You have a right under the FMLA for up to 12 weeks of unpaid leave in a 12-month period calculated as: a "rolling" 12-month period measured backward from the date of any FMLA leave usage.
- Your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work.
- You must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA-protected leave. (If your leave extends beyond the end of your FMLA entitlement, you do not have return rights under FMLA.)
- 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; 2) the continuation, recurrence, or onset of a covered servicemember's serious injury or illness which would entitle you to FMLA leave; or 3) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave.
- If we have not informed you above that you must use accrued paid leave while taking your unpaid FMLA leave entitlement, you have the right to have **sick, vacation,** and/or **other leave** run concurrently with your unpaid leave entitlement, provided you meet any applicable requirements of the leave policy. Applicable conditions related to the substitution of paid leave are referenced or set forth below. If you do not meet the requirements for taking paid leave, you remain entitled to take unpaid FMLA leave.

  For a copy of conditions applicable to sick/vacation/other leave usage please refer to Leave Policy available at: Employee Handbook/ELink.

Once we obtain the information from you as specified above, we will inform you, within 5 business days, whether your leave will be designated as FMLA leave and count towards your FMLA leave entitlement. If you have any questions, please do not hesitate to contact:
Michael Mathis at (833) 432-7547

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

It is mandatory for employers to provide employees with notice of their eligibility for FMLA protection and their rights and responsibilities. 29 U.S.C. § 2617; 29 C.F.R. § 825.300(b), (c). 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 10 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 Ave., NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.**

{For employee to complete}

LEAVE OF ABSENCE REQUEST FORM

Employee's Name (print): Yasmin Marte De Jimenez	**Employee ID:** 099930
Job Title: Prep Cook	**Supervisor:** Salvatore Ardente
Anticipated Leave Start Date: 07/20/2022	**Anticipated Return to Work Date:**

Reason for Leave Request: (Please check one)
(if your request is for multiple reasons, fill out a separate form for each)

FMLA

- ☐ The birth of your child, or the placement of a child with you for adoption or foster care.
- ☐ A serious health condition that makes you unable to perform the functions of your job.
- ☐ A serious health condition affecting your ___spouse; ___son; ___daughter; ___parent, for which you are needed to provide care
- ☐ A qualifying exigency because your ___spouse; ___son; ___daughter; ___parent is on active duty or has been called to active duty as a member of the National Guard and Reserves or Regular Armed Forces
- ☐ A qualifying serious injury or illness affecting your ___spouse; ___son; ___daughter; ___parent; ___next of kin who is a covered military service member
- ☐ A **work-related** serious health condition that makes you unable to perform the functions of your job

NON-FMLA
Please describe:

Notification to Supervisor:

If the leave is foreseeable, employees are expected to provide at least 30-day's notice of their need for a leave of absence.

I have discussed this request for leave with my supervisor __Yes __ No

Once you are on leave, do not contact your supervisor/dept. Address any questions/concerns with your Leave Specialist.

Contacting your Physician:

In general, the employee is expected to ask their healthcare provider to complete the medical form provided to the employee in their Leave packet; however, per DOL guidelines, employers may contact an employee's healthcare provider for authentication or clarification of the medical certification.

NOTE: We may request medical documentation to support your request for a Leave of Absence. All required forms must be completed and returned to Leave Management within fifteen (15) calendar days. If you fail to timely return these forms, and no unusual circumstances justify the failure to comply, your leave may be delayed or denied and any associated absences may be considered unexcused.

Employee's Signature:	Date Signed:

{For employee to complete}

IMPORTANT INFORMATION REGARDING YOUR LEAVE
(page 1 of 2)

Erickson Senior Living and its managed communities ("Company") support the overall well-being of employees on campus and beyond. As a result, we understand that employees may need to balance work and family responsibilities by taking unpaid leave for qualifying reasons. Existing leave laws are intended to promote stability and economic security for our employees as well as to preserve the Company's commitment to delivering outstanding service to our residents. To accomplish this balance employees, along with their supervisors and managers, must shoulder the shared responsibility of complying with existing laws and Company policies maintaining open lines of communication. Detailed below are our responsibilities to facilitate a smooth leave process.
The Family and Medical Leave Act (FMLA) provides eligible employees with up to 12 workweeks of unpaid, job-protected leave in a 12-month period of time. Eligible employees may receive pay during this time is by using their Vacation, Personal/Sick and/or ELB, or other supplemental benefits, such as Short Term Disability.

The Employer's Responsibilities

The Company will inform an employee requesting leave whether they are eligible under FMLA. If the employee is eligible, the Company will notify the employee of any additional information and/or documentation required as well as the employee's rights and responsibilities. The Company will inform an employee if leave will be designated as FMLA-protected and the amount of leave counted against the employee's FMLA entitlement.

If the Company determines that the leave is not FMLA-protected, it will notify the employee and provide a reason for ineligibility and notify of any other leave types that they may be eligible for.

The Employee's Responsibilities

Consistent with the Company's policy regarding all types of leave, the following conduct is strictly prohibited in relation to FMLA leave:

- Engaging in fraud, misrepresentation or providing false information to the Company or any health care provider
- Employees on an approved leave may not engage in self-employment or work another job for the company or any other employer/entity during their approved leave period without prior authorization
- Failure to comply with the employee's obligations under this Policy
- Failure to timely return from leave

Employees who engage in conduct described above will be subject to loss of benefits, denial or termination of leave, and corrective action, up to and including termination.

Your Responsibilities While on Leave / Using Your Paid Leave

While on an approved leave, please indicate the number of hours of Vacation time (maximum of 40) you wish to save: _____

Please note that **you will stop accruing** Vacation, Personal/Sick and ELB for the duration of your leave. You will resume accruing paid leave upon your return to work.

If you are on leave for your own serious health condition and you have Short Term Disability benefits, you have the option of using your Vacation, Personal/Sick and/or ELB to supplement your lost wages up to, but not to exceed, 100% of your normal base wages. As a reminder, you are responsible for filing your disability claim with Matrix or your state plan (MA & NJ communities only).

If you are not enrolled in optional Short Term Disability coverage or do not qualify for state disability coverage, you must use accrued Vacation, Personal/Sick (if applicable), and/or ELB, if eligible while out on leave. You have the option of keeping a maximum of 40 hours of Vacation in your leave bank.

IMPORTANT INFORMATION REGARDING YOUR LEAVE

(page 2 of 2)

Your Responsibilities While on Leave / Using Your Paid Leave (continued)

Do you wish to use your paid leave while receiving disability benefits? Yes___ No ___

Workers Compensation cases are excluded from this requirement. Please refer to the Paid Leave Program Policy for more information.

Returning From a Leave of Absence

You are required to inform your Leave Admin Specialist when a return to work date is established.

If you are on a medical leave due to your own serious health condition, you will be required to provide a release to return to work from your Healthcare Provider stating you are released to return to work. This must be received by your Leave Admin Specialist prior to your return to work date. If such certification is not received, your return to work may be delayed or denied.

Upon reinstatement from an FMLA leave of absence, you will be reinstated to your original or to an equivalent position with equivalent pay, benefits and other terms and conditions of employment.

If leave extends beyond 12 weeks, every attempt will be made to reinstate you; however, the Company cannot guarantee you a position. Failure to establish a return to work date, failure to return on the scheduled return date, or failure to comply with requests for medical documentation will be considered a voluntary resignation.

Your Responsibilities With Intermittent FMLA

If you have an approved intermittent leave for which you are calling out, you must follow your normal call-out procedure by calling your Manager first, then call Ask HR at 833-432-7547, option 5. If you have to **leave a message or email your community's Leave Admin e-box, please include** the following information:

- Your first and last name
- Your Community name
- Employee ID
- Date(s) and amount of hours that you are calling out for
- Telephone number you can be reached on for any follow up questions

You do not need to give a reason for time out other than stating you are taking Intermittent FMLA. If you are out beyond your approved Frequency and Duration, you must notify your Leave Specialist, as well as provide a return to work note from your health care provider.

Please contact your Leave Admin Specialist if you have any questions.

"I have read the information provided in this notice regarding my leave of absence."

Yasmin Marte De Jimenez	099930
Employee Name	Employee ID
_____	_____
Employee Signature	Date

Please fax this form along with other required forms to 410-469-3067 or email to your community's Leave Admin e-box.

IMPORTANT BENEFITS & COVERAGE INFORMATION WHILE ON LEAVE OF ABSENCE

Continuing Benefits While on Paid or Unpaid Leave of Absence / FMLA

During **PAID FMLA** leave, employees are entitled to continued group health plan coverage under the same conditions as if they were actively working. While you are receiving pay during FMLA leave, the Company will deduct the employee portion of the group health plan premium from your paycheck in the same manner as if you were actively working.

If FMLA leave is **UNPAID** you must pay your portion of the group health premium either by payments while on leave or payroll deductions upon return. Discuss this with the Leave Admin Specialist prior to taking your leave.

Continuing Benefits While on Unpaid Leave of Absence / Non-FMLA

If your leave is **UNPAID Non-FMLA** your group health plan coverage is **not** protected. This means that your coverage can be cancelled due to non-payment. If you are enrolled in company-provided health benefits and not receiving a paycheck, the premiums/contributions to cover your benefits can not be deducted, you must remit payments while on leave. Discuss this with your Leave Admin Specialist prior to taking your leave.

This also applies to employees on a no-pay status due to a worker's compensation illness/ injury.

If your benefit coverage is cancelled due to non-payment, you may enroll again during the next open enrollment period.

If you do not return to work within 30 calendar days at the end of the leave period (unless you are unable to return to work because of a serious health condition or other circumstances beyond your control) you will be required to reimburse the Company for the cost of the premiums the Company paid for maintaining coverage during the employee's unpaid FMLA leave.

Types of leave in the Non-FMLA category would include:

- ADA Accommodation of Leave
- Personal Leave of Absence
- Workers Compensation Leave (non-FMLA eligible)

Please review the Benefits Summary For Leave of Absence sheet carefully. If you have any questions, please contact your Leave Admin Specialist.

Maternity/Paternity/Adoption Leave of Absence

If your leave of absence is due to the birth or adoption of a child, and you would like to add your newborn to your benefit plan, you must provide proof of birth or adoption and add within **30 days** from the event date to submit the change.

To add your new dependent to your benefits coverage, submit a request to by logging onto www.Ericksonbenefits.com. You will access your account and select the option to make changes to your coverage. Add the child as a dependent, then attach to the benefits you choose to enroll in.

If you have any questions, please contact the Benefit Center at **1.888.787.0688**.

{Updated 3-8-22}

BENEFIT SUMMARY FOR LEAVE OF ABSENCE

NAME: Yasmin Marte De Jimenez EMPLID: 099930 FMLA: __X__ Non-FMLA: _____

Benefit	Benefit Code	Bi-Weekly Cost
Medical	CFA_MED_PPO	$187.33
Dental	MetLife_Dental_Standard	$12.63
Vision	EyeMed_VIS	$5.72
Opt Life - EE		$0.00
Opt Life - SP		$0.00
Opt Life - CH		$0.00
Opt AD/D		$0.00
Opt AD/D-Fam		$0.00
Short Term Disability		$0.00
Critical Illness-EE		$0.00
Critical Illness-SP		$0.00
Critical Illness-CH		$0.00
Pre-Paid Legal		$0.00
Accident Insurance		$0.00
	TOTAL BI-WEEKLY COST	**$205.68**

Your accrued leave is expected to be paid out in full by the following pay period: *TBD - depending upon the length of your leave*

You will be responsible for sending in your benefit premiums, made payable to your **Community**. Payment can be made by check or Money Order **only** in equal amounts of the Total Bi-Weekly Cost noted above. Payment should be received by the **15th of each month** for payroll deductions missed up to that date. Your benefit coverage could be cancelled if payment is more than 30 days late.

Leave Start Date: 07/20/2022
Maximum Leave End Date: 08/15/2022
Physician Certification Required

Leave Balance as of:
Vacation: 105.95
Personal/Sick: 64.00
ELB*: 219.24
**Must be qualifying FMLA event*

IMPORTANT INFORMATION:

401k Plan
Deductions will be made while you are utilizing your accrued leave time. There will be no 401(k) deductions while you are on a leave without pay.

Health & Dependent Care FSA
There will be no deductions for this plan while you are on a leave with or without pay. Deductions will resume once you return from leave and your annual election will be recalculated.

Employee Agreement:

I agree that I will remit payment for my insurance benefit premiums according to the Total Bi-Weekly Cost noted above.

Should I miss any premium payment during my leave of absence, I understand and acknowledge that my employer is entitled to recover any benefit balance as a lump-sum payroll deduction until payment is completed after I return to work, in accordancewith applicable laws.

_____
Employee Signature

_____
Human Resources

Make benefit payments payable to your Community. Send payments to:
Erickson Living / ATTN: Kim Williams / 813 Maiden Choice Lane / Catonsville, MD 21228

Leave# 2064553

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

WAGE AND HOUR DIVISION

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

OMB Control Number: 1235-0003
Expires: 6/30/2023

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 at 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: Yasmin Marte De Jimenez 099930
First Middle Last

(2) Employer name: Erickson Senior Living Date: 08/02/22 *(mm/dd/yyyy)*
(List date certification requested)

(3) The medical certification must be returned by 08/17/22 *(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: Prep Cook 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 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: Yasmin Marte De Jimenez

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: Yasmin Marte De Jimenez

(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: Yasmin Marte De Jimenez

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)*

Definitions of a Serious Health Condition *(See 29 C.F.R. §§ 825.113-.115)*
Inpatient Care
• An overnight stay in a hospital, hospice, or residential medical care facility. • Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.
Continuing Treatment by a Health Care Provider (any one or more of the following)
Incapacity Plus Treatment: 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: 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, 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.
Pregnancy: Any period of incapacity due to pregnancy or for prenatal care.
Chronic Conditions: 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.
Permanent or Long-term Conditions: 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.
Conditions Requiring Multiple Treatments: 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.

ERICKSON LIVING
Position Description

Position Title:	**Prep Cook**	**Location:**	Community
Department:	Dining Services	**FLSA Status:**	Nonexempt
Reports Directly To:	Executive Chef, Sous Chef	**Grade:**	3
Reports Indirectly To:	Assist. Mgr., Dining	**Job Code:**	**DS0007**
Directly Supervises:	None	**Approved Date:**	May 2015
Indirectly Supervises:	None		

SUMMARY: Responsible for items listed on the work station prep sheet, to include hot and cold items. Works with cooks to expand knowledge in an effort to accept responsibility of cooks function in their absence.

ESSENTIAL DUTIES AND RESPONSIBILITIES: include the following. Other duties may be assigned.

1. Maintains the Erickson Living philosophy and ″Vision″ statement.
2. Follows proper handling, preparation and holding guidelines, takes temperatures at regular intervals and maintains foods in sufficient quantities while minimizing over-production and waste.
3. Assists in preparing all food products as scheduled in the cycle menu (including therapeutic and mechanically altered recipes as scheduled), to include regular breakfast, lunch and dinner service and any catering or other special functions using Production Sheets and approved recipes.
4. Follows HACCP procedures and practices.
5. Maintains kitchen sanitation and equipment cleaning schedule.
6. Communicates appropriately with all food service staff, supervisors and listens effectively.
7. Works safely, consistently using designated safety equipment (personal protective equipment- PPE).

QUALIFICATIONS:
To perform this job successfully, an individual must be able to perform each essential duty satisfactorily. The requirements listed below are representative of the knowledge, skill, and/or ability required. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

- Ability to initiate and implement necessary plans to assure proper food service for breakfast, lunch, dinner, catering and special events.
- **Employee will be required to work weekends and holidays**

EDUCATION and/or EXPERIENCE:

- High School Diploma or GED preferred.
- Minimum of one year experience in food preparation required.

SUPERVISORY RESPONSIBILITIES:
None

LANGUAGE SKILLS:
Must be able to read, write, understand and communicate in the English language.

LICENSES, CERTIFICATES, REGISTRATIONS:
N/A

PHYSICAL DEMANDS:
The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

- Ability to stand for long periods of time
- Walk, stoop, kneel, crouch, or crawl
- Use hands to finger, handle, or feel; or reach with hands and arms;
- Complete repetitive tasks such as slicing, dicing, peeling, mixing, cutting, serving,
- Ability to safely lift and/or move, using designated safety equipment, objects weighing up to 50 pounds
- Talk, hear, smell, taste
- Specific vision abilities required by this job include close vision, distance vision, and depth perception
- Speaking, thinking, evaluating, writing, learning new skills and information

WORK ENVIRONMENT:
The work environment characteristics described here are representative of those an employee encounters while performing the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

- Ability to work in a fast paced environment
- Ability to work in extreme temperatures including hot kitchen to refrigerators and freezers.
- Ability to work in a multi-tasked environment

- **Employee will be required to work weekends and holidays**

RELEASE TO RETURN TO WORK FORM

Employee's Name: Yasmin Marte De Jimenez	**Date:**
Healthcare Provider Name:	
Provider Phone Number:	

To be completed by Healthcare Provider:
Please review the employee's job description (copy given to employee to provide to you), including essential functions. After reviewing, if you believe the employee can safely perform their job and can return to work, please complete either Section (A) or (B) below. If you are not yet able to provide a return to work date, please complete Section (C). After completing the relevant section, please sign and date at the bottom of the page and fax to Leave Management at # provided.

(A) The employee has been released by the above-named healthcare provider to return to Full Duty as of _____ (Date) with NO RESTRICTIONS.

(B) The employee has been released by the above-named healthcare provider to return to work on _____ (Date) with the following restrictions through_____(Date):

_____
_____
_____
_____
_____

(C) I am not yet able to provide a return-to-work date; however I have a follow-up appointment with the employee on _____ (Date). I will provide an update at that time.

My signature below indicates that I have read and understand the employee's job description and the listed tasks. My findings are based on my medical assessment of this employee's physical capabilities given the essential functions of the job. I understand Erickson Senior Living reserves the right to confirm the return to work date as needed.

Healthcare Provider Name (please print):	
Healthcare Provider Signature:	**Date:**

***** Please fax this release to Erickson Senior Living Leave Department, Confidential fax number: 410-469-3067 *****

{revised 3/8/22}

EMPLOYEE RIGHTS
UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION

LEAVE ENTITLEMENTS

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

BENEFITS & PROTECTIONS

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

ELIGIBILITY REQUIREMENTS

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

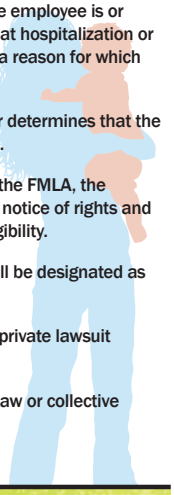
*Special "hours of service" requirements apply to airline flight crew employees.

REQUESTING LEAVE

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.



EMPLOYER RESPONSIBILITIES

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

ENFORCEMENT

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The 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 or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division

WH1420 REV 04/16

New Jersey Department of Labor and Workforce Development

Your employer is subject to the

Family Leave Insurance

provisions of the New Jersey Temporary Disability Benefits Law

New Jersey law provides up to 6 weeks of family leave insurance benefits. Beginning July 1, 2020, the law will allow up to 12 weeks of continuous family leave or 56 days of intermittent leave. Employees who are covered by family leave insurance can apply for benefits to:

- bond with a child within 12 months of the child's birth or placement by adoption or foster care. The applicant, or the applicant's spouse or domestic or civil union partner, must be the child's biological, adoptive or foster parent, unless a surrogate carried the child.
- care for a family member with a serious health condition. Supporting documentation from a health care provider is mandatory.
- care for a victim of domestic violence or a sexually violent offence or for a victim's family member.

"Family member" means a child, parent, parent-in-law, sibling, grandparent, grandchild, spouse, domestic partner, civil union partner, and any other person related by blood to the employee or with whom the employee has a close association that is the equivalent of a family relationship.

"Child" means a biological, adopted, or foster child, stepchild or legal ward of a parent. A child gained by way of a valid written contract between the parent and a surrogate (gestational carrier) is included in this definition.

State Family Leave Insurance Plan ("state plan")

You can get program information and an application for family leave benefits (form FL-1) online at *myleavebenefits.nj.gov*, by phone at 609-292-7060, or by mail: Division of Family Leave Insurance, P.O. Box 387, Trenton, NJ 08625-0387.

New mothers who receive temporary disability benefits through the state plan for their pregnancy will get instructions on how to file for family leave benefits after the child is born.

Private Family Leave Insurance Plan ("private plan")

An employer may provide family leave insurance through a private insurance carrier, if this Division approves the plan. If your employer has an approved private plan, your employer must provide information about coverage and provide the forms to apply for benefits.

Who pays for Family Leave Insurance?

Payroll contributions from employees finance this program. Family leave insurance coverage under the state plan will require contributions to be deducted from employee wages. The deductions must be noted on the employee's pay envelope, paycheck, or on some other form of notice. In 2018, the taxable wage base for family leave insurance benefits is the same as the taxable wage base for unemployment and temporary disability insurance.

Enforced by: NJ Department of Labor and Workforce Development
Division of Temporary Disability Insurance, PO Box 387, Trenton, NJ 08625-0387

This and other required employer posters are available free online at *nj.gov/labor*, or from the Office of Constituent Relations, PO Box 110, Trenton, NJ 08625-0110 • 609-777-3200.

The New Jersey Department of Labor and Workforce Development is an equal opportunity employer with equal opportunity programs. Auxiliary aids and services are available upon request to individuals with disabilities.

NEW JERSEY DEPARTMENT OF LWD LABOR AND WORKFORCE DEVELOPMENT
nj.gov/labor

Display this poster in a conspicuous place

LEARN MORE AT:
myLeaveBenefits.nj.gov

CASH BENEFITS

FOR HEALTH CONDITIONS AND PREGNANCY/CHILDBIRTH RECOVERY

NJ TEMPORARY DISABILITY INSURANCE

Temporary Disability benefits can partially replace your wages when you have to stop working due to a physical or mental health condition or other disability unrelated to your work, including pregnancy/childbirth and COVID-19.

Most New Jersey workers qualify

To be eligible you must:

- have earned at least $12,000 total or $240 weekly for 20 weeks total in employment in the 18 months prior to the start of your claim;
- stop working due to an illness/injury that is not caused by your job; and
- be under the care of a licensed medical provider.

For work-related disabilities, see: **myleavebenefits.nj.gov/workrelated**

Apply for benefits online at myleavebenefits.nj.gov

It's your responsibility to ensure that all of this information – including the medical provider portion – is submitted to the Department's Division of Temporary Disability Insurance.

If you're planning ahead, you can start the application up to 60 days in advance and save it as a draft. Once your leave begins, you must return to your draft to certify and submit your application. If applying after your leave begins, you have 30 days from your first day of leave to file your application.

It can take two to six weeks to approve a claim and pay benefits, once we have a complete application.

Receive up to 85% of your average wages, up to $993/week

Your medical provider certifies how long you need to recover from your medical condition, up to a maximum of 26 weeks. After you start receiving Temporary Disability benefits, we may ask you to provide us with proof of your continuing disability to keep receiving benefits.

Learn about how you'll be paid at myleavebenefits.nj.gov/yourpayment

Temporary Disability Insurance for COVID-19

If your healthcare provider certifies that you are unable to work because you are at high risk for COVID-19 due to an underlying health condition, you may be eligible for Temporary Disability benefits.

Temporary Disability Insurance for pregnancy/childbirth recovery

Temporary Disability provides cash benefits for pregnant parents when they need to stop working before giving birth and while recovering afterward. Parents can transition directly from Temporary Disability to bonding benefits, also known as Family Leave Insurance. Learn more at **myleavebenefits.nj.gov/maternity.**

Covered employers and employees

Employers must participate in the State Temporary Disability Insurance plan and deduct your payroll taxes for it, or provide a private plan. The federal government is exempt and it is optional for local governments (for example counties, municipalities and school districts). Generally, employees that work a significant amount of time outside of NJ are not covered, but are encouraged to apply to find out if they are eligible.

If you are covered under a private plan, your employer's insurance carrier is responsible for processing and paying benefits on your disability claim. Reach out to your employer to learn more about your coverage and get an application.

Job protection

Temporary Disability Insurance is a wage replacement program and does not provide job protection. However, your job may be protected under the Federal Family & Medical Leave Act (FMLA), which is separate and which is enforced by the U.S. Department of Labor. Generally, employers with at least 50 employees are covered under FMLA and must provide up to 12 weeks of job-protected, unpaid medical leave. You may need to provide notice to your employer if you're taking leave under this law.

In addition, if an employer retaliates against you for taking or seeking to take Temporary Disability benefits, you have the right to take private legal action.

For more information, visit **myleavebenefits.nj.gov/jobprotection.**

For further assistance

T: 609-292-7060

MONDAY-FRIDAY
8:00 am – 4:30 pm

F: 609-984-4138

Temporary Disability and Family Leave Insurance

PO Box 387 | Trenton | NJ | 08625

Hearing-impaired individuals may inquire about their claim via the Telecommunication Device for the Deaf **(TDD): 609-292-8319,** or the NJ Relay Service at **1-800-852-7899.**

DISABILITY WAIVER

COMPLETE ONLY IF YOU ARE NOT APPLYING FOR NJ STATE DISABILITY BENEFITS

Date _____

I, _____, hereby certify that I have been advised of my rights to apply for NJ State Temporary Disability Benefits by Alexis Greer, Senior Specialist, Leave Administration. I have also received a copy of the NJ State Temporary Disability Benefits Claim.

I understand that I have the right to apply for New Jersey State Temporary Disability Benefits; however, I have decided to waive my right.

_____ _____

Employee Signature Date Signed

Version 07-01-2021