MONTGOMERY COUNTY REQUEST FOR LEAVE

Name: Last _____ **First** _____ **Middle/MI** _____ **Department** _____

I request leave Beginning: Date ____/____/____ Time _____ am/pm

Ending: Date ____/____/____ Time _____ am/pm

CHECK TYPE OF LEAVE REQUESTED

___Paid Personal Leave (PPL)	_____Hours
___ Long Term Sick Leave	_____Hours
___Vacation Leave	_____Hours
___Personal Leave	_____Hours
___Short ___ Long Term Military Leave	_____Hours
___Court Leave/Jury Duty	_____Hours
___Leave Without Pay	_____Hours
___Wage Continuation	_____Hours
___Work Related Injury/Illness Leave (For day of injury/illness only)	_____Hours
Total Hours Requested	**_____Hours**

PURPOSE OF LEAVE

___Illness, Injury or Medical Appointment for Employee

Preplanned Medical Appointment ____ Yes ____ No

___Illness, Injury or Medical Appointment for Immediate Family Member

___FMLA for Employee (see reverse)

___Serious Illness in Immediate Family FMLA (see reverse)

___Bereavement :

Relationship_____ Date of Death___/___/20___

___Work Related Injury/Illness

Include nature of illness for Medical Certification, FMLA, & LWOP :_____

_____

_____

Military Leave, Court Leave/Jury Duty, and Leave Without Pay all require documentation. Please check with your supervisor if you have questions.

I understand that application for leave with intent to defraud may result in removal from employment and repayment of any salary, wages, or compensation paid as a result.

_____ ____/____/____

Employee's Signature Date

MEDICAL PROVIDER'S REPORT

Patient Name:_____ Date Examined:____/____/_____

Date of Illness/Injury: ____/____/_____ Nature of Illness/Injury:_____

Job Title: _____

As the Doctor/Medical Provider, I examined the above-named patient, and I certify the use of the employee's leave beginning: ____/____/_____ with an estimated ending date of:____/____/_____.

The above person:

☐ May return to full duty on ____/____/_____ and perform all the essential functions of the above job title without limitations.

☐ Will have some difficulty performing essential functions of the above title. **List Limitations:**_____

_____

Patient to be re-evaluated on Date: ____/____/_____ Time _____a.m./p.m.

Other dates of treatment: ____/____/_____ ____/____/_____ ____/____/_____

☐ I certify that the employee's presence is necessary for care of seriously ill family member. Beginning ____/____/____ Ending ____/____/____

Is requested leave for a **Family Medical Leave (FMLA)** qualifying event? _____ NO _____ YES (see reverse side)

_____ Date____/____/_____

Doctor/Medical Provider's Signature, person authorized to sign physician's name with initials, or signature stamp with initials:

Print Name: _____

**Information can also be provided on medical provider's official stationery (instructions on reverse) or Ohio Bureau of Workers' Compensation Medco 14 Form.*

ADMIN ACTION

☐ Recommended ☐ Not Recommended _____Hours ☐ Approved ☐ Disapproved _____Total FMLA Hrs Approved

_____ ____/____/_____ _____ ____/____/_____

Supervisors's Signature Date Department Head/Manager's Signature Date

Comments:_____

_____

IF LEAVE IS FOR A WORK RELATED INJURY/ILLNESS, PLEASE FAX A COPY OF THIS FORM TO RISK MANAGEMENT AT 496-7875.

* MEDICAL CERTIFICATION REQUIREMENTS

Must be on medical provider's official stationery.

1) Statement specifying nature of your inability to work in sufficient detail to establish the legitimacy of the absence or to ensure that you are fit to perform your job.
2) Date(s) you were examined by treating specialist.
3) Date(s) you were unable to work and date you are released to work with no restrictions.
4) Any limitations or restrictions with beginning and end dates,
5) Signature of the treating physician, person authorized to sign physician's name with initials, or signature stamp with initials.
6) FMLA treating specialist certification may be required.

Family and Medical Leave Act of 1993 (FMLA)

FMLA provides certain employees with up to twelve (12) weeks of unpaid FMLA leave in a twelve (12) month period. You qualify for FMLA leave if you have been employed by Montgomery County for a total of twelve (12) months, and have been in an active work status at least 1,250 hours during those twelve (12) months and the leave is used for the following reasons:

-for the birth of your child;
-for placement of a child with you for adoption or foster care;
-when you are needed to care for a child, spouse, or parent who has a serious health condition; or
-when you, due to your own serious health condition, are unable to perform the essential functions of your job.

Your health benefits are maintained during any period of FMLA leave under the same conditions as if you continued to work, and you will be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from leave.

If you qualify, you are able to take up to twelve (12) workweeks in the twelve (12) month period measured forward from the date your first FMLA leave begins. FMLA leave runs concurrently with other County leave policies. If you are entitled to paid leave under another policy, you must take the paid leave first, unless there is a statutory exception. All approved leave taken for a FMLA qualifying event must be counted toward the twelve (12) weeks of available FMLA leave.

You are required to furnish medical documentation certifying a serious health condition. The treating medical provider must complete either:

-The Department of Labor's Certification of Health Care Provider form;
-Medical Provider's Report on the front of this form; or
-Provide medical certification on official stationery as described in the box at the top of the page.

The documentation should be submitted at least thirty (30) days in advance of the effective date of the leave or in accordance with the notice provision for type of leave being requested. If this is an urgent situation, the certification should be submitted as soon as possible, but no later than fifteen (15) days after the leave is requested.

You must maintain contact with your immediate supervisor with periodic reports on your status and intent to return to work every thirty (30) days. You must also furnish medical recertification every thirty (30) days or upon earlier expiration of leave.

If the leave is for your own serious health condition, you are required to present medical certification releasing you to work with no restrictions prior to returning to work.

In accordance with existing County policy, your health coverage will continue during the period of FMLA leave as long as the employee portion of the premium is paid. If you are no longer receiving pay from Montgomery County, you will receive a notice from the Benefits Office with specific information on when you need to start making health, dental or Choice Spending Account payments. You will need to contact the Payroll Department for payment of any life insurance premiums due.