

**COUNTY OF ORANGE, VIRGINIA  
PERSONNEL POLICIES MANUAL**

**FAMILY AND MEDICAL LEAVE**

**POLICY NO.: 5.3**

**EFFECTIVE DATE: 10/01/96**

**REVISED: 03/06/09**

---

**OVERVIEW:** It is the County's objective to comply with the Family and Medical Leave Act (FMLA) of 1993. 24 CFR 85. Under the FMLA, the County must provide eligible employees with up to 12 weeks of unpaid family or medical leave in a 12 month period, in order to care for a child, family member or the serious medical condition of the employee him/herself as described by any of the qualifying conditions listed below or up to 26 weeks of unpaid family leave in a 12 month period, to care for a spouse, son, daughter, parent, or next of kin who is a covered military service member with a serious injury or illness. The 12 month period is calculated by measuring forward from the first date leave is used.

**SCOPE:** This policy applies to all regular full time employees who have been employed by the County for at least 12 months and have worked at least 1250 hours in the previous 12 months. Although the 12 months of employment need not be consecutive, employment prior to a continuous break in service of seven (7) years or more will not be counted unless the seven (7) year break (i) resulted from an employee's fulfillment of National Guard or Reserve military service obligations; or (ii) a written agreement exists concerning the County's intention to rehire the employee after the break in service. An employee returning from his or her National Guard or Reserve obligation will be credited with the hours of service that would have been performed but for the military service, and the period of service will be counted toward the 12-month requirement.

**PROVISIONS:**

**A. Use of Family and Medical Leave:**

Eligible employees may request FMLA leave in the following situations:

1. to care for the employee's child upon birth
2. placement of a child in the employee's home for adoption or foster care
3. to care for an immediate family member (spouse, child, or parent) with a serious health condition,
4. because the employee's own health condition makes him/her unable to perform his job

Orange County  
Policy 5.3 (p.2)

5. because of qualifying exigencies arising out of the fact that the spouse, or a son, daughter, or parent of the employee is on active duty military or has been notified of an impending call or order to active duty.

When an employee plans to take leave under this policy, the employee is required to give a 30-day notice or, if this is not possible, as much notice as is practicable. Certification of medical necessity may be requested, and must be provided within 15 days or the County may deny FMLA leave.

Once an employee has requested leave, the Human Resources Office will notify that employee within five (5) business days of whether that leave qualifies as FMLA leave.

*Serious Health Condition* – A serious health condition means an illness, injury, impairment or physical or mental condition that involves:

- Inpatient care (i.e. an overnight stay), including any period of incapacity or any subsequent treatment in connection with the inpatient care; or
- “Continuing treatment” by a health care provider which includes any period of incapacity as a result of:
  - A health condition lasting more than three (3) full consecutive work days and any subsequent treatment or period of incapacity relating to the same condition that also includes (i) treatment two (2) or more times by or under the supervision of a health care provider occurring within 30 days of each other, unless extenuating circumstances exist; or (ii) one treatment by a health care provider with a continuing regimen of treatment;
  - Pregnancy or prenatal care, including severe morning sickness;
  - A chronic serious health condition that continues over an extended period of time, requires periodic visits to a health care provider of at least two (2) or more times a year, and may involve occasional episodes of incapacity;
  - A permanent or long-term condition for which treatment may not be effective, if the employee is under the supervision of a health care provider (but not necessarily receiving active treatment); or
  - Any absences to receive multiple treatments for restorative surgery or for a condition that would likely result in a period of incapacity of more than three (3) days in the absence of medical intervention.

Ordinarily, unless complications arise, the common cold, the flu, ear aches, upset stomach, etc., are examples of conditions that do not meet the definition of a serious health condition.

Orange County  
Policy 5.3 (p.3)

*Birth, adoption, or foster care of children.*

- FMLA leave for birth or placement for adoption or foster care must conclude within 12 months of the birth or placement. In addition, spouses who are both employed by the same employer are jointly entitled to a combined leave of 12 workweeks of parental leave in the 12-month period for the birth or placement of a child for adoption or foster care or to care for an employee's parent with a serious health condition. However, both spouses may each take their full 12 weeks of leave to care for a child with a serious health condition, regardless of whether the spouses both work for the same employer.
- The husband is also entitled to his full 12 weeks to care for the serious, pregnancy related health condition of his wife.

*Intermittent or reduced work schedule leave.* In certain circumstances, eligible employees may take FMLA leave intermittently (for example, in blocks of time) or by reducing their work schedule. If FMLA leave is to care for a child after the birth or placement for adoption or foster care, employees may take their FMLA leave intermittently or on a reduced work schedule only with the County's permission, and the County may temporarily transfer the employee to an alternative position that better accommodates the leave schedule. If the FMLA leave is because of the employee's serious illness or to care for a seriously ill family member, the employee may take the leave intermittently or on a reduced work schedule if it is medically necessary. In such a case, the employee should notify the County that foreseeable leave will be intermittent and the employee should make a reasonable effort to schedule any planned medical treatment so as not to disrupt unduly the operations of the County.

Family and medical leave cannot be used for short term conditions for which treatment and recovery are brief (i.e. minor illness or outpatient surgery).

Whenever possible, an employee should request FMLA leave in advance in order to assist management in planning for the employee's absence. The request should be made in writing to the Department Director or Constitutional Officer, and submitted with recommendation to the Human Resources Department. Human Resources will respond in writing, as soon as practical, as to whether the employee is eligible for leave under the FMLA.

*Family Relationships.* An adult child must be incapable of self-care due to a disability at the time leave is to commence. Both parent and child relationships can include biological, adoptive, step or foster relationships.

Orange County  
Policy 5.3 (p.4)

B. Use of Paid Leave for FMLA Purposes:

An employee will be required to use any accrued annual or sick leave to compensate for time taken for FMLA leave purposes except in the case of a serious health condition which is covered under Workers' Compensation. The use of other paid leave while receiving workers' compensation payments will not be allowed. Once an employee taking FMLA leave exhausts any accrued annual or sick leave, they will take unpaid leave for the duration of their FMLA leave.

C. Benefits Status during Family and Medical Leave

An employee's health insurance and life insurance benefits, if applicable, will remain active while on medical and family leave. The County will continue to pay its portion of the health insurance premiums. The employee portion of the health insurance premium will be expected to be paid by the employee.

An employee will not accrue sick or annual leave while on leave without pay.

Retirement contributions will only be made for pay periods in which the employee received qualifying compensation. Leave without pay for an entire pay period will result in no retirement contribution for that pay period.

D. Return to Work:

Upon completion of the family and medical leave of absence, the employee will be returned to his/her original position or a comparable position. However, an employee on FMLA leave does not have any greater right to reinstatement or to other benefits and conditions of employment than if the employee had been continuously employed during the FMLA leave period. As noted above, if the absence was due to the employee's own serious health condition, a fitness for duty report must be submitted prior to return to work.

**REQUEST FOR FAMILY OR MEDICAL LEAVE**

**Date:** \_\_\_\_\_

**Name:** \_\_\_\_\_

**Subject: Request for Family/Medical Leave**

On \_\_\_\_\_, Orange County Human Resources Office was notified of your need to take leave due to (select one):

The birth of a 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 essential functions for your job, including a health condition covered under workers' compensation

A serious health condition affecting your spouse, child, or parent for whom you are needed to provide care

A serious health condition affecting your spouse, child, parent or next of kin who is a qualifying servicemember and for whom you are needed to provide care

An exigent circumstance arising out of the fact that your spouse, child or parent is on active duty or has been notified of an impending call or order to active duty in support of a contingency operation

Request for leave to begin \_\_\_\_\_ and continue until on or about \_\_\_\_\_.

You will be required to furnish certification of within 15 days after the requested date FMLA begins. You must furnish this certification by \_\_\_\_\_.

Orange County  
Policy 5.3 (p.6)

You have a right under the FMLA for up to 12 weeks of unpaid leave in a 12-month period for the reasons listed above (or for up to 26 weeks of unpaid leave in a 12-month period for a serious health condition affecting your spouse, child, parent or next of kin who is a qualifying military servicemember and for whom you are needed to provide care). Also, your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work and 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 leave. If you do not return to work following FMLA leave for a reason other than the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FLMA leave.

If you are taking Family/Medical Leave due to your own serious medical condition, upon completion of the Family/Medical Leave, you will be required to present a return to work/fitness for duty certification stating the date you are to return and stating you are able to perform all the essential functions of your job. You will be reinstated to the same or a comparable position, with the same pay, benefits and terms and conditions of employment.

If the circumstances of your leave change, and you are able to report to work prior to the date indicated or you are unable to return to work as indicated, you must notify the Orange County Administration, Human Resources Department immediately.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

Human Resources \_\_\_\_\_ Date \_\_\_\_\_

## Your Rights under the Family and Medical Leave Act of 1993

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to "eligible" employees for certain family and medical reasons. Employees are eligible if they have worked for their employer for at least one year, and for 1,250 hours over

the previous 12 months, and if there are at least 50 employees within 75 miles. The FMLA permits employees to take leave on an intermittent basis or to work a reduced schedule under certain circumstances.

### Reasons for Taking Leave:

Unpaid leave must be granted for *any* of the following reasons:

- to care for the employee's child after birth, or placement for adoption or foster care;
- to care for the employee's spouse, son or daughter, or parent who has a serious health condition; or
- for a serious health condition that makes the employee unable to perform the employee's job.

At the employee's or employer's option, certain kinds of *paid* leave may be substituted for unpaid leave.

### Advance Notice and Medical Certification:

The employee may be required to provide advance leave notice and medical certification. Taking of leave may be denied if requirements are not met.

- The employee ordinarily must provide 30 days advance notice when the leave is "foreseeable."
- An employer may require medical certification to support a request for leave because of a serious health condition, and may require second or third opinions (at the employer's expense) and a fitness for duty report to return to work.

### Job Benefits and Protection:

- For the duration of FMLA leave, the employer must maintain the employee's health coverage under any "group health plan."

u.s. Department of Labor  
Employment Standards Administration  
Wage and Hour Division  
Washington, D.C. 20210

- Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms-
- The use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

### 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 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 which provides greater family or medical leave rights.

### For Additional Information:

If you have access to the Internet visit our FMLA website: <http://www.dol.gov/esa/whd/fmla>. To locate your nearest Wage-Hour Office, telephone our Wage-Hour toll-free information and help line at 1-866- 4USW AGE (1-866-487-9243): a customer service representative is available to assist you with referral information from 8am to 5pm **in your time zone**; or log onto our Home Page at <http://www.wagehour.dol.gov>.

WH Publication 1420  
Revised August 2001

**Certification of Health Care Provider for  
Employee's Serious Health Condition  
(Family and Medical Leave Act)**

**U.S. Department of Labor**  
Employment Standards Administration  
Wage and Hour Division



OMB Control Number: 1215-0181  
Expires: 12/31/2011

**SECTION I: For Completion by the EMPLOYER**

**INSTRUCTIONS to the EMPLOYER:** 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. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to 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.

Employer name and contact: Orange County, P O Box 111, Orange, VA 22960, Karen Gibson-Human Resources 540-672-3313

Employee's job title: \_\_\_\_\_ Regular work schedule: \_\_\_\_\_

Employee's essential job functions: \_\_\_\_\_

Check if job description is attached: \_\_\_\_\_

**SECTION II: For Completion by the EMPLOYEE**

**INSTRUCTIONS to the EMPLOYEE:** Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: \_\_\_\_\_  
                    First  Middle  Last

**SECTION III: For Completion by the HEALTH CARE PROVIDER**

**INSTRUCTIONS to the HEALTH CARE PROVIDER:** Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. 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. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Provider's name and business address: \_\_\_\_\_

Type of practice / Medical specialty: \_\_\_\_\_

Telephone: (        ) \_\_\_\_\_ Fax: (        ) \_\_\_\_\_

**PART A: MEDICAL FACTS**

1. Approximate date condition commenced: \_\_\_\_\_

Probable duration of condition: \_\_\_\_\_

**Mark below as applicable:**

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

No  Yes. If so, dates of admission:

\_\_\_\_\_

Date(s) you treated the patient for condition:

\_\_\_\_\_

Will the patient need to have treatment visits at least twice per year due to the condition?  No  Yes.

Was medication, other than over-the-counter medication, prescribed?  No  Yes.

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?

No  Yes. If so, state the nature of such treatments and expected duration of treatment:

\_\_\_\_\_

2. Is the medical condition pregnancy?  No  Yes. If so, expected delivery date: \_\_\_\_\_

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her 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:

\_\_\_\_\_

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PART B: AMOUNT OF LEAVE NEEDED**

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery?  No  Yes.

If so, estimate the beginning and ending dates for the period of incapacity: \_\_\_\_\_

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition?  No  Yes.

If so, are the treatments or the reduced number of hours of work medically necessary?  
 No  Yes.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

\_\_\_\_\_

Estimate the part-time or reduced work schedule the employee needs, if any:

\_\_\_\_\_ hour(s) per day; \_\_\_\_\_ days per week from \_\_\_\_\_ through \_\_\_\_\_

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions?  No  Yes.

Is it medically necessary for the employee to be absent from work during the flare-ups?  
 No  Yes. If so, explain:

\_\_\_\_\_

\_\_\_\_\_

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: \_\_\_\_\_ times per \_\_\_\_\_ week(s) \_\_\_\_\_ month(s)

Duration: \_\_\_\_\_ hours or \_\_\_\_\_ day(s) per episode

**ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



**Certification of Health Care Provider for  
Family Member's Serious Health Condition  
(Family and Medical Leave Act)**

**U.S. Department of Labor**  
Employment Standards Administration  
Wage and Hour Division



OMB Control Number: 1215-0181  
Expires: 12/31/2011

**SECTION I: For Completion by the EMPLOYER**

**INSTRUCTIONS to the EMPLOYER:** The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees' family members, 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.

Employer name and contact: Orange County, P O Box 111, Orange, VA 22960

Karen Gibson, Human Resources, 540-672-3313

**SECTION II: For Completion by the EMPLOYEE**

**INSTRUCTIONS to the EMPLOYEE:** Please complete Section II before giving this form to your family member or his/her medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a covered family member with a serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Your name: \_\_\_\_\_

First

Middle

Last

Name of family member for whom you will provide care: \_\_\_\_\_

First

Middle

Last

Relationship of family member to you: \_\_\_\_\_

If family member is your son or daughter, date of birth: \_\_\_\_\_

Describe care you will provide to your family member and estimate leave needed to provide care:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

**SECTION III: For Completion by the HEALTH CARE PROVIDER**

**INSTRUCTIONS to the HEALTH CARE PROVIDER:** The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. 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. Limit your responses to the condition for which the patient needs leave. Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address: \_\_\_\_\_

Type of practice / Medical specialty: \_\_\_\_\_

Telephone: ( \_\_\_\_\_ ) \_\_\_\_\_ Fax:( \_\_\_\_\_ ) \_\_\_\_\_

**PART A: MEDICAL FACTS**

1. Approximate date condition commenced: \_\_\_\_\_

Probable duration of condition: \_\_\_\_\_

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

No  Yes. If so, dates of admission: \_\_\_\_\_

Date(s) you treated the patient for condition: \_\_\_\_\_

Was medication, other than over-the-counter medication, prescribed?  No  Yes.

Will the patient need to have treatment visits at least twice per year due to the condition?  No  Yes

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?

No  Yes. If so, state the nature of such treatments and expected duration of treatment:

\_\_\_\_\_  
\_\_\_\_\_

2. Is the medical condition pregnancy?  No  Yes. If so, expected delivery date: \_\_\_\_\_

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such as medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PART B: AMOUNT OF CARE NEEDED:** When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery?  No  Yes.

Estimate the beginning and ending dates for the period of incapacity: \_\_\_\_\_

During this time, will the patient need care?  No  Yes.

Explain the care needed by the patient and why such care is medically necessary:

---

---

---

---

---

5. Will the patient require follow-up treatments, including any time for recovery?  No  Yes.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

---

Explain the care needed by the patient, and why such care is medically necessary: \_\_\_\_\_

---

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery?  No  Yes.

Estimate the hours the patient needs care on an intermittent basis, if any:

\_\_\_\_\_ hour(s) per day; \_\_\_\_\_ days per week from \_\_\_\_\_ through \_\_\_\_\_

Explain the care needed by the patient, and why such care is medically necessary:

---

---

---

---

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? \_\_\_ No \_\_\_ Yes.

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: \_\_\_ times per \_\_\_ week(s) \_\_\_ month(s)

Duration: \_\_\_ hours or \_\_\_ day(s) per episode

Does the patient need care during these flare-ups? \_\_\_ No \_\_\_ Yes.

Explain the care needed by the patient, and why such care is medically necessary: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Signature of Health Care Provider**

\_\_\_\_\_  
**Date**

**PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT**

If submitted, 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 20 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 COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**

# Notice of Eligibility and Rights & Responsibilities (Family and Medical Leave Act)

U.S. Department of Labor  
Employment Standards Administration  
Wage and Hour Division



OMB Control Number: 1215-0181  
Expires: 12/31/2011

In general, to be eligible an employee must have worked for an employer for at least 12 months, have worked at least 1,250 hours 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: \_\_\_\_\_  
Employee  
FROM: Karen Gibson - Human Resources  
Employer Representative  
DATE: \_\_\_\_\_

On \_\_\_\_\_, you informed us that you needed leave beginning on \_\_\_\_\_ for:

- The birth of a child, or placement of a child with you for adoption or foster care;
- Your own serious health condition;
- Because you are needed to care for your \_\_\_\_\_ spouse; \_\_\_\_\_ child; \_\_\_\_\_ parent due to his/her serious health condition.
- Because of a qualifying exigency arising out of the fact that your \_\_\_\_\_ spouse; \_\_\_\_\_ son or daughter; \_\_\_\_\_ parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves.
- Because you are the \_\_\_\_\_ spouse; \_\_\_\_\_ son or daughter; \_\_\_\_\_ parent; \_\_\_\_\_ next of kin of a covered servicemember with a serious injury or illness.

This Notice is to inform you that you:

- Are eligible for FMLA leave (See Part B below for Rights and Responsibilities)
- Are **not** eligible for FMLA leave, because (only one reason need be checked, although you may not be eligible for other reasons):
  - You have not met the FMLA's 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately \_\_\_\_\_ months towards this requirement.
  - You have not met the FMLA's 1,250-hours-worked requirement.
  - You do not work and/or report to a site with 50 or more employees within 75-miles.

If you have any questions, contact Karen Gibson, Human Resources, 540-672-3313 or view the FMLA poster located in break room in the Gordon Building.

### [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 \_\_\_\_\_.** (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/ \_\_\_\_\_ is not enclosed.
- Sufficient documentation to establish the required relationship between you and your family member.
- Other information needed: \_\_\_\_\_

\_\_\_\_\_ No additional information requested



# Designation Notice (Family and Medical Leave Act)

U.S. Department of Labor  
Employment Standards Administration  
Wage and Hour Division



OMB Control Number: 1215-0181  
Expires: 12/31/2011

Leave covered under the Family and Medical Leave Act (FMLA) must be designated as FMLA-protected and the employer must inform the employee of the amount of leave that will be counted against the employee's FMLA leave entitlement. In order to determine whether leave is covered under the FMLA, the employer may request that the leave be supported by a certification. If the certification is incomplete or insufficient, the employer must state in writing what additional information is necessary to make the certification complete and sufficient. While use of this form by employers is optional, a fully completed Form WH-382 provides an easy method of providing employees with the written information required by 29 C.F.R. §§ 825.300(c), 825.301, and 825.305(c).

To: \_\_\_\_\_

Date: \_\_\_\_\_

We have reviewed your request for leave under the FMLA and any supporting documentation that you have provided. We received your most recent information on \_\_\_\_\_ and decided:

\_\_\_\_\_ Your FMLA leave request is approved. All leave taken for this reason will be designated as FMLA leave.

The FMLA requires that you notify us as soon as practicable if dates of scheduled leave change or are extended, or were initially unknown. Based on the information you have provided to date, we are providing the following information about the amount of time that will be counted against your leave entitlement:

\_\_\_\_\_ Provided there is no deviation from your anticipated leave schedule, the following number of hours, days, or weeks will be counted against your leave entitlement: \_\_\_\_\_

\_\_\_\_\_ Because the leave you will need will be unscheduled, it is not possible to provide the hours, days, or weeks that will be counted against your FMLA entitlement at this time. You have the right to request this information once in a 30-day period (if leave was taken in the 30-day period).

**Please be advised (check if applicable):**

\_\_\_\_\_ You have requested to use paid leave during your FMLA leave. Any paid leave taken for this reason will count against your FMLA leave entitlement.

\_\_\_\_\_ We are requiring you to substitute or use paid leave during your FMLA leave.

\_\_\_\_\_ You will be required to present a fitness-for-duty certificate to be restored to employment. If such certification is not timely received, your return to work may be delayed until certification is provided. A list of the essential functions of your position  is  is not attached. If attached, the fitness-for-duty certification must address your ability to perform these functions.

**Additional information is needed to determine if your FMLA leave request can be approved:**

\_\_\_\_\_ The certification you have provided is not complete and sufficient to determine whether the FMLA applies to your leave request. You must provide the following information no later than \_\_\_\_\_, unless it is not practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied.  
(Provide at least seven calendar days)

(Specify information needed to make the certification complete and sufficient)

\_\_\_\_\_ We are exercising our right to have you obtain a second or third opinion medical certification at our expense, and we will provide further details at a later time.

\_\_\_\_\_ Your FMLA Leave request is Not Approved.

\_\_\_\_\_ The FMLA does not apply to your leave request.

\_\_\_\_\_ You have exhausted your FMLA leave entitlement in the applicable 12-month period.

**PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT**

It is mandatory for employers to inform employees in writing whether leave requested under the FMLA has been determined to be covered under the FMLA. 29 U.S.C. § 2617; 29 C.F.R. §§ 825.300(d), (e). 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 – 30 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.**

# Designation Notice (Family and Medical Leave Act)

U.S. Department of Labor  
Employment Standards Administration  
Wage and Hour Division



OMB Control Number: 1215-0181  
Expires: 12/31/2011

Leave covered under the Family and Medical Leave Act (FMLA) must be designated as FMLA-protected and the employer must inform the employee of the amount of leave that will be counted against the employee's FMLA leave entitlement. In order to determine whether leave is covered under the FMLA, the employer may request that the leave be supported by a certification. If the certification is incomplete or insufficient, the employer must state in writing what additional information is necessary to make the certification complete and sufficient. While use of this form by employers is optional, a fully completed Form WH-382 provides an easy method of providing employees with the written information required by 29 C.F.R. §§ 825.300(c), 825.301, and 825.305(c).

To: \_\_\_\_\_

Date: \_\_\_\_\_

We have reviewed your request for leave under the FMLA and any supporting documentation that you have provided. We received your most recent information on \_\_\_\_\_ and decided:

\_\_\_\_\_ Your FMLA leave request is approved. All leave taken for this reason will be designated as FMLA leave.

The FMLA requires that you notify us as soon as practicable if dates of scheduled leave change or are extended, or were initially unknown. Based on the information you have provided to date, we are providing the following information about the amount of time that will be counted against your leave entitlement:

\_\_\_\_\_ Provided there is no deviation from your anticipated leave schedule, the following number of hours, days, or weeks will be counted against your leave entitlement: \_\_\_\_\_

\_\_\_\_\_ Because the leave you will need will be unscheduled, it is not possible to provide the hours, days, or weeks that will be counted against your FMLA entitlement at this time. You have the right to request this information once in a 30-day period (if leave was taken in the 30-day period).

**Please be advised (check if applicable):**

\_\_\_\_\_ You have requested to use paid leave during your FMLA leave. Any paid leave taken for this reason will count against your FMLA leave entitlement.

\_\_\_\_\_ We are requiring you to substitute or use paid leave during your FMLA leave.

\_\_\_\_\_ You will be required to present a fitness-for-duty certificate to be restored to employment. If such certification is not timely received, your return to work may be delayed until certification is provided. A list of the essential functions of your position  is  is not attached. If attached, the fitness-for-duty certification must address your ability to perform these functions.

\_\_\_\_\_ **Additional information is needed to determine if your FMLA leave request can be approved:**

\_\_\_\_\_ The certification you have provided is not complete and sufficient to determine whether the FMLA applies to your leave request. You must provide the following information no later than \_\_\_\_\_, unless it is not  
(Provide at least seven calendar days)  
practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied.

(Specify information needed to make the certification complete and sufficient)

\_\_\_\_\_ We are exercising our right to have you obtain a second or third opinion medical certification at our expense, and we will provide further details at a later time.

\_\_\_\_\_ Your FMLA Leave request is Not Approved.

\_\_\_\_\_ The FMLA does not apply to your leave request.

\_\_\_\_\_ You have exhausted your FMLA leave entitlement in the applicable 12-month period.

**PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT**

It is mandatory for employers to inform employees in writing whether leave requested under the FMLA has been determined to be covered under the FMLA. 29 U.S.C. § 2617; 29 C.F.R. §§ 825.300(d), (e). 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 – 30 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.**

**Certification of Qualifying Exigency  
For Military Family Leave  
(Family and Medical Leave Act)**

**U.S. Department of Labor**  
Employment Standards Administration  
Wage and Hour Division



OMB Control Number: 1215-0181  
Expires: 12/31/2011

**SECTION I: For Completion by the EMPLOYER**

**INSTRUCTIONS to the EMPLOYER:** The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a qualifying exigency to submit a certification. Please complete Section I before giving this form to your employee. Your response is voluntary, and while you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. § 825.309.

Employer name: County of Orange, P. O. Box 111, Orange, VA 22960

Contact Information: Karen Gibson - Human Resources, (540)672-3313

**SECTION II: For Completion by the EMPLOYEE**

**INSTRUCTIONS to the EMPLOYEE:** Please complete Section II fully and completely. The FMLA permits an employer to require that you submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a qualifying exigency. Several questions in this section seek a response as to the frequency or duration of the qualifying exigency. Be as specific as you can; terms such as "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Your response is required to obtain a benefit. 29 C.F.R. § 825.310.

While you are not required to provide this information, failure to do so may result in a denial of your request for FMLA leave. Your employer must give you at least 15 calendar days to return this form to your employer.

Your Name: \_\_\_\_\_  
                                    First                                    Middle                                    Last

Name of covered military member on active duty or call to active duty status in support of a contingency operation:  
\_\_\_\_\_  
                                    First                                    Middle                                    Last

Relationship of covered military member to you: \_\_\_\_\_

Period of covered military member's active duty: \_\_\_\_\_

A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes written documentation confirming a covered military member's active duty or call to active duty status in support of a contingency operation. Please check one of the following:

- A copy of the covered military member's active duty orders is attached.
- Other documentation from the military certifying that the covered military member is on active duty (or has been notified of an impending call to active duty) in support of a contingency operation is attached.
- I have previously provided my employer with sufficient written documentation confirming the covered military member's active duty or call to active duty status in support of a contingency operation.

**PART A: QUALIFYING REASON FOR LEAVE**

1. Describe the reason you are requesting FMLA leave due to a qualifying exigency (including the specific reason you are requesting leave):

---

---

---

---

---

---

---

---

2. A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes any available written documentation which supports the need for leave; such documentation may include a copy of a meeting announcement for informational briefings sponsored by the military, a document confirming an appointment with a counselor or school official, or a copy of a bill for services for the handling of legal or financial affairs. Available written documentation supporting this request for leave is attached.  Yes  No  None Available

**PART B: AMOUNT OF LEAVE NEEDED**

1. Approximate date exigency commenced: \_\_\_\_\_

Probable duration of exigency: \_\_\_\_\_

2. Will you need to be absent from work for a single continuous period of time due to the qualifying exigency?  No  Yes.

If so, estimate the beginning and ending dates for the period of absence:

---

3. Will you need to be absent from work periodically to address this qualifying exigency?  No  Yes.

Estimate schedule of leave, including the dates of any scheduled meetings or appointments: \_\_\_\_\_

---

---

Estimate the frequency and duration of each appointment, meeting, or leave event, including any travel time (i.e., 1 deployment-related meeting every month lasting 4 hours):

Frequency: \_\_\_\_\_ times per \_\_\_\_\_ week(s) \_\_\_\_\_ month(s)

Duration: \_\_\_\_\_ hours \_\_\_\_\_ day(s) per event.



# Certification for Serious Injury or Illness of Covered Servicemember - - for Military Family Leave (Family and Medical Leave Act)

U.S. Department of Labor  
Employment Standards Administration  
Wage and Hour Division



OMB Control Number: 1215-0181  
Expires: 12/31/2011

**Notice to the EMPLOYER INSTRUCTIONS to the EMPLOYER:** The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a serious injury or illness of a covered servicemember to submit a certification providing sufficient facts to support the request for leave. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. § 825.310. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees or employees' family members, 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.

**SECTION I: For Completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the Employee Is Requesting Leave INSTRUCTIONS to the EMPLOYEE or COVERED SERVICEMEMBER:** Please complete Section I before having Section II completed. The FMLA permits an employer to require that an employee submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a serious injury or illness of a covered servicemember. If requested by the employer, your response is required to obtain or retain the benefit of FMLA-protected leave. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to do so may result in a denial of an employee's FMLA request. 29 C.F.R. § 825.310(f). The employer must give an employee at least 15 calendar days to return this form to the employer.

**SECTION II: For Completion by a UNITED STATES DEPARTMENT OF DEFENSE ("DOD") HEALTH CARE PROVIDER or a HEALTH CARE PROVIDER who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider INSTRUCTIONS to the HEALTH CARE PROVIDER:** The employee listed on Page 2 has requested leave under the FMLA to care for a family member who is a member of the Regular Armed Forces, the National Guard, or the Reserves who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list for a serious injury or illness. For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty that may render the servicemember medically unfit to perform the duties of his or her office, grade, rank, or rating.

A complete and sufficient certification to support a request for FMLA leave due to a covered servicemember's serious injury or illness includes written documentation confirming that the covered servicemember's injury or illness was incurred in the line of duty on active duty and that the covered servicemember is undergoing treatment for such injury or illness by a health care provider listed above. Answer, fully and completely, all applicable parts. 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. Limit your responses to the condition for which the employee is seeking leave.

**Certification for Serious Injury or Illness  
of Covered Servicemember - - for  
Military Family Leave (Family and  
Medical Leave Act)**

**U.S. Department of Labor**  
Employment Standards Administration  
Wage and Hour Division



**SECTION I: For Completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the Employee Is Requesting Leave:** (This section must be completed first before any of the below sections can be completed by a health care provider.)

**Part A: EMPLOYEE INFORMATION**

Name and Address of Employer (this is the employer of the employee requesting leave to care for covered servicemember):

---

Name of Employee Requesting Leave to Care for Covered Servicemember:

\_\_\_\_\_  
First Middle Last

Name of Covered Servicemember (for whom employee is requesting leave to care):

\_\_\_\_\_  
First Middle Last

Relationship of Employee to Covered Servicemember Requesting Leave to Care:

Spouse  Parent  Son  Daughter  Next of Kin

**Part B: COVERED SERVICEMEMBER INFORMATION**

(1) Is the Covered Servicemember a Current Member of the Regular Armed Forces, the National Guard or Reserves?  Yes  No

If yes, please provide the covered servicemember's military branch, rank and unit currently assigned to:

---

Is the covered servicemember assigned to a military medical treatment facility as an outpatient or to a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients (such as a medical hold or warrior transition unit)?  Yes  No If yes, please provide the name of the medical treatment facility or unit:

---

(2) Is the Covered Servicemember on the Temporary Disability Retired List (TDRL)?  Yes  No

**Part C: CARE TO BE PROVIDED TO THE COVERED SERVICEMEMBER**

Describe the Care to Be Provided to the Covered Servicemember and an Estimate of the Leave Needed to Provide the Care:

---

**SECTION II: For Completion by a United States Department of Defense (“DOD”) Health Care Provider or a Health Care Provider who is either: (1) a United States Department of Veterans Affairs (“VA”) health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider. If you are unable to make certain of the military-related determinations contained below in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator). (Please ensure that Section I above has been completed before completing this section.) Please be sure to sign the form on the last page.**

**Part A: HEALTH CARE PROVIDER INFORMATION**

Health Care Provider’s Name and Business Address:

---

Type of Practice/Medical Specialty: \_\_\_\_\_

Please state whether you are either: (1) a DOD health care provider; (2) a VA health care provider; (3) a DOD TRICARE network authorized private health care provider; or (4) a DOD non-network TRICARE authorized private health care provider: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_ Email: \_\_\_\_\_

**PART B: MEDICAL STATUS**

(1) Covered Servicemember’s medical condition is classified as (Check One of the Appropriate Boxes):

- (VSI) Very Seriously Ill/Injured** – Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)
- (SI) Seriously Ill/Injured** – Illness/injury is of such severity that there is cause for immediate concern, but there is no imminent danger to life. Family members are requested at bedside. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)
- OTHER Ill/Injured** – a serious injury or illness that may render the servicemember medically unfit to perform the duties of the member’s office, grade, rank, or rating.
- NONE OF THE ABOVE** (Note to Employee: If this box is checked, you may still be eligible to take leave to care for a covered family member with a “serious health condition” under § 825.113 of the FMLA. If such leave is requested, you may be required to complete DOL FORM WH-380 or an employer-provided form seeking the same information.)

(2) Was the condition for which the Covered Service member is being treated incurred in line of duty on active duty in the armed forces?  Yes  No

(3) Approximate date condition commenced: \_\_\_\_\_

(4) Probable duration of condition and/or need for care: \_\_\_\_\_

(5) Is the covered servicemember undergoing medical treatment, recuperation, or therapy?  Yes  No. If yes, please describe medical treatment, recuperation or therapy:

**PART C: COVERED SERVICEMEMBER'S NEED FOR CARE BY FAMILY MEMBER**

- (1) Will the covered servicemember need care for a single continuous period of time, including any time for treatment and recovery?  Yes  No  
If yes, estimate the beginning and ending dates for this period of time: \_\_\_\_\_
- (2) Will the covered servicemember require periodic follow-up treatment appointments?  
 Yes  No If yes, estimate the treatment schedule: \_\_\_\_\_
- (3) Is there a medical necessity for the covered servicemember to have periodic care for these follow-up treatment appointments?  Yes  No
- (4) Is there a medical necessity for the covered servicemember to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)?  Yes  No If yes, please estimate the frequency and duration of the periodic care:  
\_\_\_\_\_  
\_\_\_\_\_

**Signature of Health Care Provider:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT**

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years, in accordance with 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 20 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 AV, NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE PATIENT.**