NALC Form 1 - Family and Medical Leave Act

Health Care Provider: Please complete this form in order to aid the employer in making its FMLA determination.

Medical Certification—Employee's Own Serious Health Condition

The employee's health care provider must complete this form when an employee requests FMLA leave and medical documentation is required (see ELM Sections 512.41, 513.36 and 515.5). The employee must also complete and submit a PS Form 3971 - Request for or Notification of Absence.

Employee: Return the completed form to the appropriate FMLA administration HRSSC address or fax (see attached sheet) and keep a copy for your own records.

Employee's Name: _____

EIN: _____ FMLA Case # (if known): _____

1. Medical facts: The back (p. 2) of this form contains sets of medical facts that the FMLA uses to define a serious health condition. Does the employee's health condition[1] match any of these sets of medical facts? If so, please check the applicable set.

❒ 1. Hospitalization ❒ 2. Absence plus Treatment ❒ 3. Pregnancy ❒ 4. Chronic Condition ❒ 5. Permanent/Long-term ❒ 6. Multiple Treatments ❒ None of these

2. Description of medical facts: Please describe the medical facts that correspond to the set of medical facts checked above. Such medical facts may include symptoms, hospitalization, doctor visits, whether medicine has been prescribed and any regimen of continuing treatment. A specific diagnosis or prognosis is not required.

_____

3. Duration of the condition (Be as specific as you can; terms such as "lifetime," "unknown" or "indeterminate" should be used only when they reflect your best medical judgment.)

a. Approximate date condition commenced: _____ Probable duration of condition: _____

4. Is the employee able to perform the essential functions of his or her position? ❒ Yes ❒ No

If no, please describe the employee's restrictions and their duration:

_____

5. Will the employee require leave that is medically necessary on an intermittent or reduced schedule basis for planned medical treatment of the employee's serious health condition, including pregnancy? ❒ Yes ❒ No

If yes, please provide an estimate of the dates and duration of such treatment(s) and any period(s) of recovery.

Dates: _____ Duration: _____ hour(s) or _____ day(s) per episode.

Period of Recovery: _____

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

_____ hour(s) per day; _____ day(s) per week from _____ through _____.

6. Will the employee require leave that is medically necessary on an intermittent or reduced schedule basis for the employee's serious health condition, including pregnancy, that may result in unforeseeable episodes of incapacity[2] (e.g. flare-ups)? ❒ Yes ❒ No

If yes, please provide an estimate of the frequency and duration of such episodes of incapacity (e.g. 3 episodes every 2 months lasting 1-2 days):

Frequency: _____ times per _____ week(s) _____ month(s) **Duration:** _____ hours or _____ day(s) per episode

_____

Health Care Provider Signature: _____ Date:_____

Print Name: _____ _____ Phone: (_____)_____

Medical Practice/Specialty: _____ FAX: _____

Address: _____

_____

[1] Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking FMLA leave.

[2] Flare-ups or other unforeseeable leave in the case of chronic conditions or pregnancy need not require treatment by a health care provider.

"Serious Health Condition"

Definition under the Revised Family and Medical Leave Act

A "serious health condition" of a family member is defined in the FMLA regulations as any illness, injury, impairment or physical or mental condition that involves one of the following:

1. Hospital care:

This means inpatient care (that is, an overnight stay) in a hospital, hospice or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence plus treatment:

A period of incapacity[3] of **more than three full consecutive calendar days** (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:

a. Treatment[4] two or more times[5] by a health care provider, by a nurse under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or

b. Treatment (in person visit) by a health care provider on **at least one occasion[6]** which results in **a regimen of continuing treatment[7]** under the supervision of the health care provider.

3. Pregnancy:

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

4. Chronic conditions requiring treatments:

A chronic condition which

a. Requires **periodic visits[8]** for treatment by a health care provider, or by a nurse under direct supervision of a health care provider;

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

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

5. Permanent/long-term conditions requiring supervision:

A period of **incapacity** which is **permanent or long-term** due to a condition for which treatment may not be effective. The employee or family member must be under the **continuing supervision of, but need not be receiving active treatment by a health care provider.** Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

6. Multiple treatments (non-chronic conditions):

Any period of absence to receive **multiple treatments** (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider either for **restorative surgery** after an accident or other injury, or for a condition that would likely result in a period of incapacity of **more than three consecutive calendar days in the absence of medical intervention or treatment** such as cancer (chemotherapy, radiation, etc), severe arthritis (physical therapy), kidney disease (dialysis).

---

[3] **"Incapacity,"** for purposes of the FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefrom, or recovery.

[4] **"Treatment"** includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

[5] **"Two or more times"** must be within 30 days of beginning period of incapacity and the first visit must be within 7 days of the first day of incapacity.

[6] **"one occasion"** must be within 7 days of the first day of incapacity.

[7] A **regimen of continuing treatment** includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

[8] **"Periodic visits"** must include at least 2 visits a year.

Health Care Provider: Please complete this form in order to aid the employer in making its FMLA determination.

Medical Certification—Family Member's Serious Health Condition

The covered family member's health care provider must complete this form when an employee requests FMLA leave and medical documentation is required (see ELM Sections 512.41, 513.36 and 515.5). The employee must also complete and submit a PS Form 3971 - Request for or Notification of Absence.

Employee: Return the completed form to the appropriate FMLA administration HRSSC address or fax (see attached sheet) and keep a copy for your own records.

Employee's Name: _____

EIN: _____ FMLA Case # (if known): _____

1. Patient's name (First, Middle, and Last): _____

Relationship to employee: ❒ Child (under age 18 or incapable of self care due to mental or physical disability) ❒ Spouse ❒ Parent

Date of birth: _____

2. Medical facts: Page 2 of this form contains sets of medical facts that the FMLA uses to define a serious health condition. Does the patient's health condition[1] match any of these sets of medical facts? If so, please check the applicable set.

❒ 1. Hospitalization ❒ 2. Absence plus Treatment ❒ 3. Pregnancy ❒ 4. Chronic Condition ❒ 5. Permanent/Long-term ❒ 6. Multiple Treatments ❒ None of these

3. Description of medical facts: Please describe the medical facts that correspond to the set of medical facts checked above. Such medical facts may include symptoms, hospitalization, doctor visits, whether medicine has been prescribed and any regimen of continuing treatment. A specific diagnosis or prognosis is not required:_____

_____

_____

4. Duration of the condition (Be as specific as you can; terms such as "lifetime," "unknown" or "indeterminate" should be used only when they reflect your best medical judgment.)

a. Approximate date condition commenced: _____ Probable duration of condition: _____

5. The need for the employee to care for the patient

a. Does the patient need assistance with basic medical, hygienic or nutritional needs or safety; or is the patient unable to transport himself or herself to the doctor? ❒ Yes ❒ No

b. If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery? ❒ Yes ❒ No

c. Estimate frequency and duration of the leave required to care for the family member:

_____

6. Intermittent or reduced schedule leave

a. Will the employee require leave that is medically necessary on an intermittent or reduced schedule basis to help in the care of the family member for planned medical treatment of the family member's serious health condition, including pregnancy? ❒ Yes ❒ No

If yes, please provide an estimate of the dates and duration of such treatments and any period(s) of recovery.

Dates:_____ Duration: ____ hour(s) or ____ day(s) per episode.

Period of Recovery: _____

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

____ hour(s) per day; ____ days per week from _____ through _____.

b. Will the employee require leave that is medically necessary on an intermittent or reduced schedule basis to care for family member's serious health condition, including pregnancy, that may result in unforeseeable episodes of incapacity (e.g. flare-ups)[2]? ❒ Yes ❒ No

If yes, please provide an estimate of the frequency and duration of such episodes of incapacity (e.g. 3 episodes every 2 months lasting 1-2 days):

Frequency: ____ times per ___ week(s) ____ month(s)

Duration: ____ hours or ____ day(s) per episode

c. If the employee requires leave on an intermittent or reduced schedule basis to care for a family member with a serious health condition, explain why the care is medically necessary (see 5 above):

_____

Health Care Provider Signature: _____ Date:_____

Print Name: _____ Phone:(_____)_____

Medical Practice/Specialty: _____ FAX: _____

Address: _____

[1] Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking FMLA leave.

[2] Flare-ups or other unforeseeable leave in the case of chronic conditions or pregnancy need not require treatment by a health care provider.

"Serious Health Condition"

Definition under the Revised Family and Medical Leave Act

A "serious health condition" of a family member is defined in the FMLA regulations as any illness, injury, impairment or physical or mental condition that involves one of the following:

1. Hospital care:

This means inpatient care (that is, an overnight stay) in a hospital, hospice or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence plus treatment:

A period of incapacity[3] of **more than three full consecutive calendar days** (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:

a. Treatment[4] two or more times[5] by a health care provider, by a nurse under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or

b. Treatment (in person visit) by a health care provider on **at least one occasion[6]** which results in **a regimen of continuing treatment[7]** under the supervision of the health care provider.

3. Pregnancy:

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

4. Chronic conditions requiring treatments:

A chronic condition which

a. Requires **periodic visits[8]** for treatment by a health care provider, or by a nurse under direct supervision of a health care provider;

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

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

5. Permanent/long-term conditions requiring supervision:

A period of **incapacity** which is **permanent or long-term** due to a condition for which treatment may not be effective. The employee or family member must be under the **continuing supervision of, but need not be receiving active treatment by a health care provider.** Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

6. Multiple treatments (non-chronic conditions):

Any period of absence to receive **multiple treatments** (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider either for **restorative surgery** after an accident or other injury, or for a condition that would likely result in a period of incapacity of **more than three consecutive calendar days in the absence of medical intervention or treatment** such as cancer (chemotherapy, radiation, etc), severe arthritis (physical therapy), kidney disease (dialysis).

---

[3] **"Incapacity,"** for purposes of the FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefrom, or recovery.

[4] **"Treatment"** includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

[5] **"Two or more times"** must be within 30 days of beginning period of incapacity and the first visit must be within 7 days of the first day of incapacity.

[6] **"one occasion"** must be within 7 days of the first day of incapacity.

[7] A **regimen of continuing treatment** includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

[8] **"Periodic visits"** must include at least 2 visits a year.

NALC Form 3 - Family and Medical Leave Act

Employee: Return the completed form to the appropriate FMLA administration HRSSC address or fax (see attached sheet) and keep a copy for your own records.

Certification of Qualifying Exigency for Military Family Leave

1. Employee's name (First, Middle, and Last): _____

EIN: _____ FMLA Case # (if known): _____

2. Name of military member on covered active duty or call to covered active duty* (First, Middle, and Last):

_____

3. Relationship of military member to employee: ❒ Spouse ❒ Parent ❒ Son or Daughter

4. Dates of military member's covered active duty: _____

5. Documents confirming the military member's covered active duty or call to covered active duty status. Please check one of the following:

❒ A copy of the military member's covered active duty orders is attached.

❒ Other documentation from the military is attached certifying that the military member is on covered active duty (or has been notified of an impending call to covered active duty).

❒ I have previously provided my employer with sufficient written documentation confirming the military member's covered active duty or call to covered active duty.

6. Qualifying reason for leave. The back of this form describes how the Family Medical Leave Act defines "qualifying exigencies." Does the need for leave qualify under any of the exigencies described? If so, please check the appropriate exigency.

❒ 1 Short notice deployment ❒ 2 Military events and related activities

❒ 3 Childcare and school activities involving a child of the military member ❒ 4 Financial and legal arrangements ❒ 5 Counseling

❒ 6 Rest and recuperation ❒ 7 Post-deployment activities ❒ 8 Parental care involving a parent of a military member ❒ 9 Additional activities

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

_____

_____

8. Documents supporting the request for leave for a qualifying exigency.

Please attach any available written documentation that 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. If leave is taken for rest and recuperation, a copy of the military member's rest and recuperation orders must be submitted. Available written documentation is attached. ❒ Yes ❒ None Available

9. Amount of leave needed.

a. Approximate date the exigency commenced or will commence: _____

b. Will you need to be absent from work for a single continuous period of time due to the qualifying exigency? ❒ Yes ❒ No
If yes, estimate the beginning and ending dates for the period of absence: _____

c. Will you need to be absent from work periodically to address this qualifying exigency? ❒ Yes ❒ No
If yes, estimate the frequency and duration of each period of absence due to the qualifying exigency (i.e. 1 deployment-related meeting every month lasting 4 hours.)

Frequency _____ time(s) per _____ week(s) _____ month(s)

Duration: _____ hour(s) or _____ day(s) per event.

10. Leave to meet with a third party. Complete this section if leave is requested to meet with a third party (such as to arrange for childcare, to attend counseling, to attend meetings with school or childcare providers, to make financial or legal arrangements, to act as the military member's representative before a federal, state or local agency for purposes of obtaining, arranging or appealing military service benefits, or to attend any event sponsored by the military or military service organizations). The employer may use this information to verify that the information on this form is accurate.

Name of Individual: _____Title: _____

Organization: _____

Address: _____

Telephone: _____Fax: _____ Email: _____

Date of Meeting/Appointment: _____

Briefly describe the nature of the meeting/appointment: _____

_____

I certify that information I provided above is true and correct.

Signature of employee: _____Date:_____

FMLA Description of a Qualifying Exigency

Eligible employees may take FMLA leave while the employee's spouse, son, daughter or parent who is a covered military member is on covered active duty for one or more of the following qualifying exigencies:

1. Short notice deployment. Eligible employees may take leave to deal with issues arising when a military member is notified of deployment in 7 or less days. Leave taken for this purpose can be used for a period of seven calendar days beginning on the date a covered military member is notified of an impending call or order to covered active duty.

2. Military events and related activities. Eligible employees may take leave for any official ceremony, program or event covered active duty that is sponsored by the military; or may take leave to attend family support or assistance programs sponsored by military service organizations or the American Red Cross that are related to covered active duty.

3. Childcare and school activities involving a child of the covered military member. Eligible employees may take leave to arrange for alternative school or child care, to provide childcare on an urgent non-routine basis, to transfer or enroll a child in a new school or day care facility and to attend meetings with school or daycare staff if the reasons for leave arise out of the military member's covered active duty.

4. Financial and legal arrangements. Eligible employees may take leave to make or update financial and legal arrangements to address a military member's absence such as preparing and executing powers of attorney, transferring bank account signature authority, or preparing a living will or trust. They may also take leave to act as the military member's representative before a federal, state or local agency for purposes of obtaining, arranging, or appealing military service benefits while the military member is on covered active duty and for a period of 90 days after the termination of the military member's covered active duty.

5. Counseling. Eligible employees may take leave to attend counseling by someone other than their own health care provider for the military member, or for the son or daughter of the covered military member if the need for counseling arises from the covered active duty of the military member.

6. Rest and recuperation. Eligible employees may take up to 15 calendar days of leave as a continuous block or intermittently to spend time with a military member each time he or she is on rest and recuperation leave during deployment.

7. Post-deployment activities. Eligible employees may take leave to attend arrival ceremonies, reintegration briefings and events, and other official ceremonies or programs sponsored by the military for a period of 90 days following the termination of the military member's covered active duty and also to address issues arising from the death of a military member, including attending a funeral.

8. Parental care involving a parent of a military member. Eligible employees may take leave for parental care if the call to covered active duty requires them: 1) to arrange for alternative care when the parent is incapable of self-care, 2) provide care on an urgent, immediate need basis when the parent is incapable of self-care, 3) to admit or transfer the parent to a care facility, 4) to attend meetings with staff at a care facility, such as hospice or social service providers.

9. Additional activities. Any other event that arises out of the military member's covered active duty that the eligible employee and the employer agree is a qualifying exigency and agree to both the timing and duration of such leave.

*** *Covered active duty or call to covered active duty status* means:**

(1) In the case of a member of the Regular Armed Forces (includes the National Guard), *duty under a call or order to active duty (or notification of an impending call or order to covered active duty)* during the deployment of the member with the Armed Forces to a foreign country; and,

(2) In the case of a member of the reserve components of the Armed Forces, duty under a call or order to active duty (or notification of an impending call or order to active duty) during the deployment of the member with the Armed Forces to a foreign country under a Federal call or order to active duty under a provision of law referred to in section 101(a)(13)(B) of Title 10, United States Code. *See also* 29 CFR § 825.126(a).

NALC Form 4 Family and Medical Leave Act Form

Employee: Return the completed form to the appropriate FMLA administration HRSSC address or fax (see attached sheet) and keep a copy for your own records.

Certification for Serious Injury or Illness* of Current Covered Servicemember for Military Caregiver Leave

Section 1: For completion by the employee and/or the covered servicemember for whom the employee is requesting leave.

A. Name (First, Middle, and Last) of the employee requesting leave to care for covered servicemember:

_____

EIN: _____ FMLA Case # (if known): _____

B. Name (First, Middle, and Last) of covered sevicemember (for whom employee is requesting leave to care for):

_____

C. Relationship of covered servicemember to employee:
❒ Spouse ❒ Parent ❒ Son ❒ Daughter ❒ Next of Kin

D. Has an ITO (Invitational Travel Order) or ITA (Invitational Travel Authorization) been issued to a family member of the covered servicemember (the employee need not be the family member named)? ❒ Yes ❒ No

If yes, the period of time specified in the ITO or ITA: from _____ to _____

If the requested leave to care for the covered servicemember falls within the time period specified on the ITO or ITA, present a copy of the ITO or ITA to the appropriate Postal Service Supervisor. No further certification is required. However, in order for the employee to take military caregiver leave outside the period indicated on the ITO or ITA, the rest of this form must be completed.

E. 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:

_____

F. Is the covered servicemember assigned to 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:

_____

G. Is the covered servicemember on the Temporary Disability Retired List (TDRL)? ❒ Yes ❒ No

H. Describe the care to be provided to the covered servicemember and an estimate of the leave needed to provide the care:

_____

_____

*SERIOUS INJURY OR ILLNESS.—The term 'serious injury or illness' means an injury or illness that was incurred by the covered servicemember in the line of duty on active duty in the Armed Forces (or existed before the beginning of the covered servicemember's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces) and that may render the covered servicemember medically unfit to perform the duties of his or her office, grade, rank, or rating.

NALC Form 4 Family and Medical Leave Act Form

Employee: Return the completed form to the appropriate FMLA administration HRSSC address or fax (see attached sheet) and keep a copy for your own records.

Certification for Serious Injury or Illness of Current Covered Servicemember for Military Caregiver Leave

Section 2: For completion by 1) a United States Department of Defense ("DOD") health care provider or health care provider who is either: 2) a United States Department of Veterans Affairs ("VA") health care provider, 3) a DOD TRICARE network authorized private health care provider, 4) a DOD non-network TRICARE authorized private health care provider, or 5) a health care provider under the FMLA (as defined in 29 CFR 825.125). Please be sure to sign the form in the place provided at the end.

A. Health care provider information

Health care provider's name (please print): _____

Health care provider's business address: _____

Telephone: (____) _____ Fax: _____ Email: _____

Type of practice/medical specialty: _____

Please indicate whether you are: ❒ 1. a DOD health care provider ❒ 2. a VA health care provider
❒ 3. a DOD TRICARE network authorized provider ❒ 4. a DOD non-network TRICARE authorized healthcare provider
❒ 5. a health care provider under the FMLA

B. Medical status

If you are unable to make certain of the military-related determinations contained in Part B below, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator) or an authorized VA representative.

1) Was the covered servicemember's injury or illness incurred or aggravated in the line of duty on active duty? ❒ Yes ❒ No

2) Approximate date the serious injury or illness commenced or was aggravated: _____

3) Probable duration of the serious injury or illness and/or need of care: _____

4) Briefly state the medical facts regarding the covered servicemember's health condition for which FMLA leave is requested:

_____

_____

5) Does the injury or illness render the covered service member medically unfit to perform the duties of his or her office, grade, rank or rating? ❒ Yes ❒ No

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

_____

_____

C. Covered servicemember's need for care by family member

1) Does the patient require assistance for basic medical, hygiene, nutritional needs, safety, transportation? ❒ Yes ❒ No

2) If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery? ❒ Yes ❒ No

3) 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: _____

4) Will the covered servicemember require periodic follow-up treatment appointments? ❒ Yes ❒ No.
If yes, estimate the treatment schedule: _____

5) Is there a medical necessity for the covered servicemember to have periodic care for these follow-up treatment appointments? ❒ Yes ❒ No

6) 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 (e.g.: 2 times per week for 8 months lasting 1 day):

Frequency: _____ times per _____ week(s) _____ month(s)
Duration: _____ hour(s) or _____ day(s) per event.

Signature of health care provider: _____ Date: _____

NALC Form 5 Family and Medical Leave Act Form

Employee: Return the completed form to the appropriate FMLA administration HRSSC address or fax (see attached sheet) and keep a copy for your own records.

Certification for Serious Injury or Illness* of a Veteran for Military Caregiver Leave (FMLA)

Section 1: For completion by the employee and/or the veteran for whom the employee is requesting leave.

A. Name (First, Middle, and Last) of the employee requesting leave to care for veteran:

_____

EIN: _____ FMLA Case # (if known): _____

B. Name (First, Middle, and Last) of veteran (for whom employee is requesting leave to care for):

_____

C. Relationship of veteran to employee:
❒ Spouse ❒ Parent ❒ Son ❒ Daughter ❒ Next of Kin

D. Veteran Information

1) Date of the veteran's discharge: _____

2) Was the veteran **dishonorably** discharged or released from the Armed Forces (including the National Guard or Reserves)?
❒ Yes ❒ No

3) Please provide the veteran's military branch, rank and unit at the time of discharge:

_____

4) Is the veteran receiving medical treatment, recuperation or therapy for an injury or illness? ❒ Yes ❒ No

E. Describe the care to be provided to the veteran and an estimate of the leave needed to provide the care:

_____

_____

*SERIOUS INJURY OR ILLNESS—A serious injury or illness means an injury or illness incurred by the servicemember in the line of duty on active duty in the Armed Forces (or that existed before the beginning of the servicemember's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces) and manifested itself before or after the servicemember became a veteran, and is:

(i) a continuation of a serious injury or illness that was incurred or aggravated when the covered veteran was a member of the Armed Forces and rendered the servicemember unable to perform the duties of the servicemember's office, grade, rank, or rating; or

(ii) a physical or mental condition for which the covered veteran has received a U.S. Department of Veterans Affairs Service Related Disability Rating (VASRD) of 50 percent or greater, and such VASRD rating is based, in whole or in part, on the condition precipitating the need for military caregiver leave; or

(iii) a physical or mental condition that substantially impairs the covered veteran's ability to secure or follow a substantially gainful occupation by reason of a disability or disabilities related to military service, or would do so absent treatment; or

(iv) an injury, including a psychological injury, on the basis of which the covered veteran has been enrolled in the Department of Veterans' Affairs Program of Comprehensive Assistance for Family Caregivers.

NALC Form 5 Family and Medical Leave Act Form

Employee: Return the completed form to the appropriate FMLA administration HRSSC address or fax (see attached sheet) and keep a copy for your own records.

Certification for Serious Injury or Illness* of a Veteran for Military Caregiver Leave (FMLA)

Section 2: For completion by 1) a United States Department of Defense ("DOD") health care provider or health care provider who is either: 2) a United States Department of Veterans Affairs ("VA") health care provider, 3) a DOD TRICARE network authorized private health care provider, 4) a DOD non-network TRICARE authorized private health care provider, or 5) a health care provider under the FMLA (as defined in 29 CFR 825.125). Please be sure to sign the form in the place provided at the end.

A. Health care provider information

Health care provider's name (please print): _____

Health care provider's business address: _____

Telephone: (____) _____ Fax: _____ Email: _____

Type of practice/medical specialty: _____

Please indicate whether you are: ❒ 1. a DOD health care provider ❒ 2. a VA health care provider
❒ 3. a DOD TRICARE network authorized provider ❒ 4. a DOD non-network TRICARE authorized healthcare provider
❒ 5. a health care provider under the FMLA

B. Medical status

If you are unable to make certain of the military-related determinations contained in Part B below, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator) or an authorized VA representative.

1) The Veteran's medical condition is:

❒ A continuation of a serious injury or illness that was incurred or aggravated when the covered veteran was a member of the Armed Forces and rendered the servicemember unable to perform the duties of the servicemember's office, grade, rank, or rating.
❒ A physical or mental condition for which the covered veteran has received a U.S. Department of Veterans Affairs Service Related Disability Rating (VASRD) of 50% or higher, and such VASRD rating is based, in whole or in part, on the condition precipitating the need for military caregiver leave.
❒ A physical or mental condition that substantially impairs the covered veteran's ability to secure or follow a substantially gainful occupation by reason of a disability or disabilities related to military service, or would do so absent treatment.
❒ An injury, including a psychological injury, on the basis of which the covered veteran is enrolled in the Department of Veterans' Affairs Program of Comprehensive Assistance for Family Caregivers.

2) Is the veteran being treated for a condition which was incurred or aggravated by service in the 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 veteran undergoing medical treatment, recuperation, or therapy for this condition? ❒ Yes ❒ No

If yes, please describe medical treatment, recuperation or therapy:

_____

C. Veteran's need for care by family member

1) Does the patient require assistance for basic medical, hygiene, nutritional needs, safety, transportation? ❒ Yes ❒ No

2) If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery? ❒ Yes ❒ No

3) Will the veteran 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: _____

4) Will the veteran require periodic follow-up treatment appointments? ❒ Yes ❒ No.
If yes, estimate the treatment schedule: _____

5) Is there a medical necessity for the veteran to have periodic care for these follow-up treatment appointments? ❒ Yes ❒ No

6) Is there a medical necessity for the veteran 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 (e.g.: 2 times per week for 8 months lasting 1 day):

Frequency: _____ times per _____ week(s) _____ month(s)
Duration: _____ hour(s) or _____ day(s) per event.

Signature of health care provider: _____ Date: _____

NALC Form 6 - Family and Medical Leave Act

Employee: Return the completed form to the appropriate FMLA administration HRSSC address or fax (see attached sheet) and keep a copy for your own records.

Employee's Notification of New Child in the Family

To take FMLA leave for a new child in the family, an employee must notify management within 30 days (when practicable) of the anticipated date of the birth, placement in foster care or adoption. This form may be used for that purpose. When the leave begins, complete and submit a PS Form 3971, Request for or Notification of Absence, for each pay period in which leave will be taken.

Employee's Name: _____

EIN: _____ FMLA Case # (if known): _____

To Postal Supervisor:

This serves as notification under the Family and Medical Leave Act of 1993 that I expect to become the parent of a new child, by (check one)

❒ Birth

❒ Adoption

❒ Placement in foster care

on (approximate date)_____.

Following that date I plan to take time off work to care for my new child. I plan to return to work on (approximate date)_____.

Employee Signature_____ Date_____

Family and Medical Leave Act Rules: New Child in the Family

The Family and Medical Leave Act guarantees each letter carrier 12 weeks of time off per postal leave year for a new child in the family—by birth, by placement of a foster child or by adoption. The age of a child adopted or placed in foster care does not affect eligibility for leave (except that the child must be under 18, or older but incapable of self-care). When both parents work for the Postal Service, each parent may take up to 12 weeks of FMLA leave for this purpose.

Before the child arrives. In the case of a birth, the pregnant employee is entitled to FMLA leave before the actual date of birth, for prenatal care or if her condition makes her unable to work. Accrued paid sick leave may be used for these purposes; the employee also may use annual leave or LWOP in accordance with existing rules.

Before or after a foster or adopted child is placed, the employee is entitled to take FMLA leave for making required arrangements for the placement—to attend counseling sessions, appear in court, consult with his or her attorney or doctors representing the birth parent, or submit to a physical examination. A father or mother is entitled to take FMLA leave for these reasons, and may use annual leave or LWOP in accordance with existing rules.

Caring for the child during the first year. Whether the child arrives by birth or by placement, a mother or father is entitled to FMLA leave to care for the child during the first year. No medical justification is needed—the FMLA leave is guaranteed simply to care for the new child. This particular right to FMLA leave terminates on the first anniversary of the child's birth or placement.

LWOP rules. An employee has the right to choose LWOP when taking FMLA leave; he or she need not exhaust sick or annual leave first. Although management generally has discretion in the granting of LWOP (see Section 514 of the *USPS Employee and Labor Relations Manual*), when it comes to FMLA leave management must grant an employee's request to use LWOP rather than sick or annual leave.

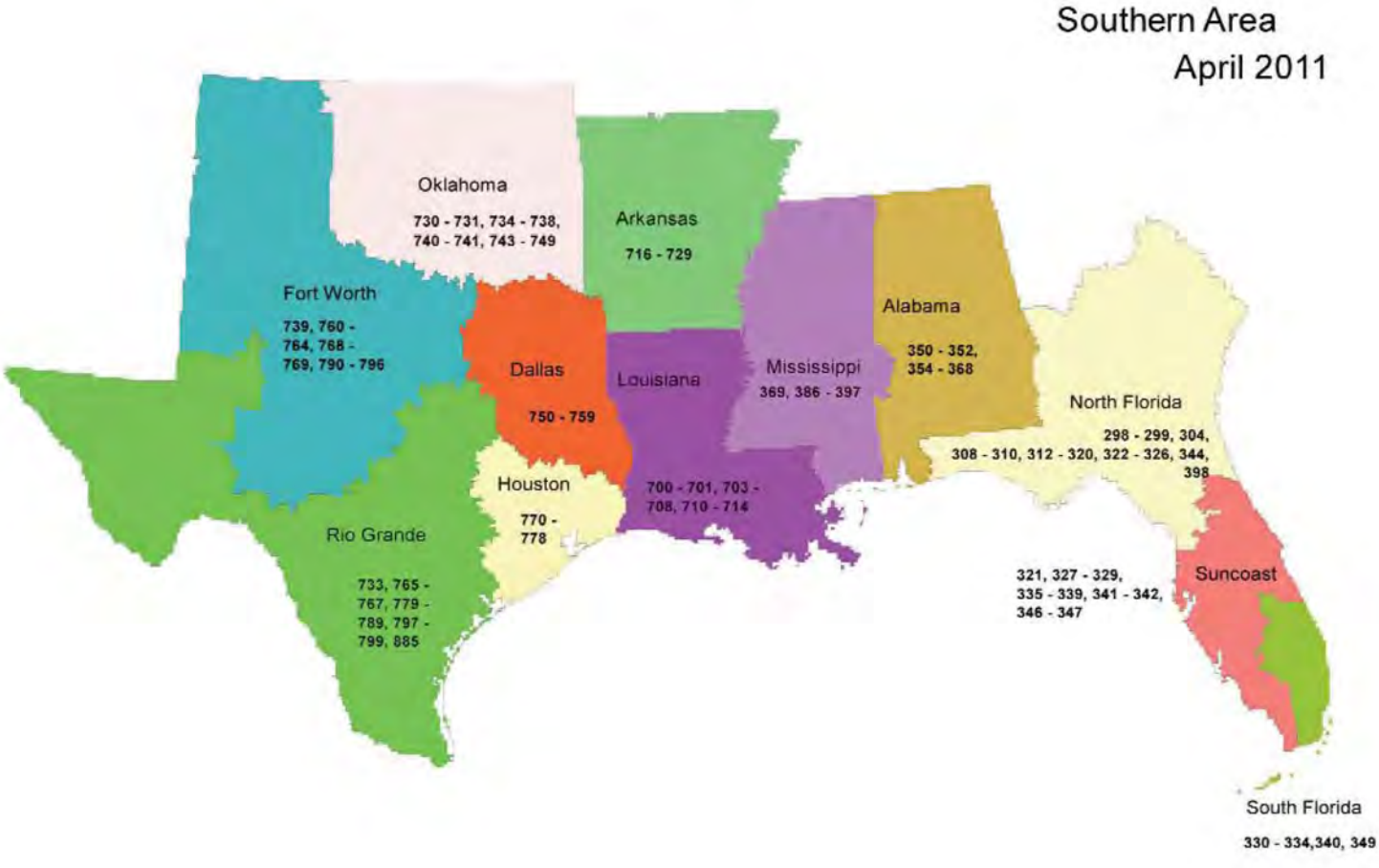
Family and Medical Leave Act (FMLA) Administration
Human Resources Share Service Center (HRSSC)
Contact Information

1-877-477-3273 Option 5, then Select 6
TTY: 1-866-833-8777

Southern Area

HRSSC FMLA SOUTHEAST
PO Box 970909
Greensboro NC 27497-0909

FAX: 651-456-6067



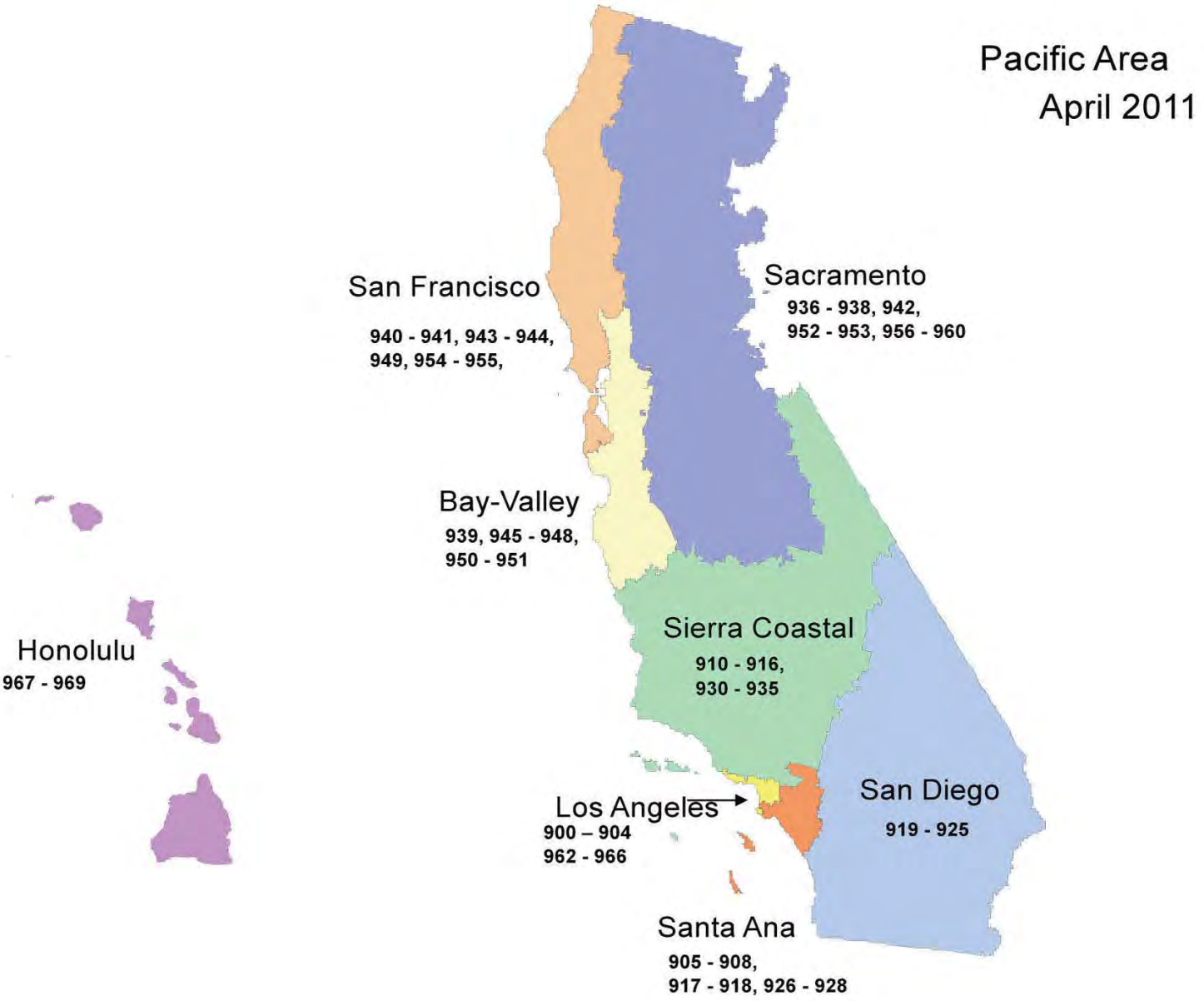
Family and Medical Leave Act (FMLA) Administration
Human Resources Share Service Center (HRSSC)
Contact Information

1-877-477-3273 Option 5, then Select 6
TTY: 1-866-833-8777

Pacific Area

HRSSC FMLA PACIFAC
PO Box 970911
Greensboro NC 27497-0911

FAX: 651-456-6047



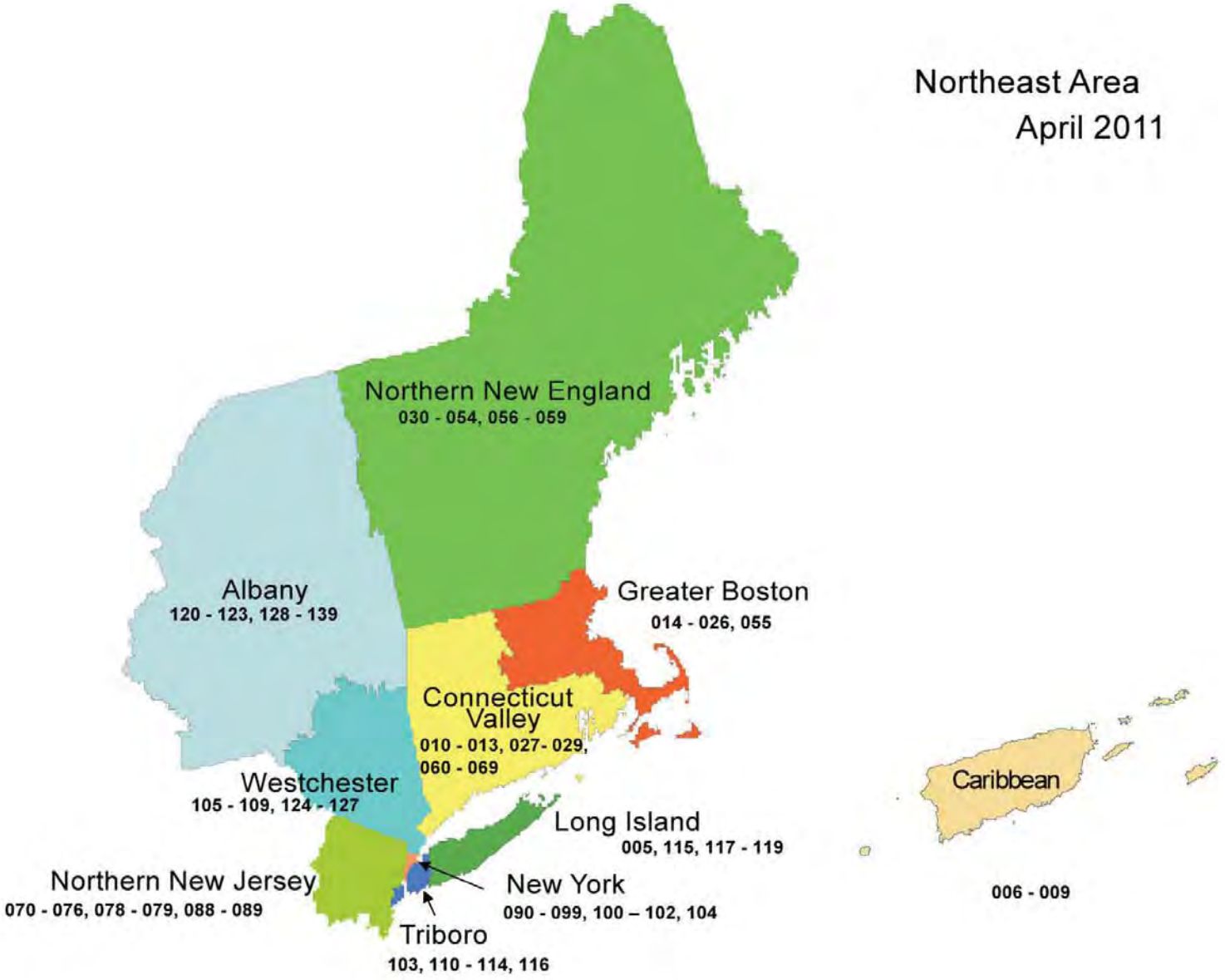
Family and Medical Leave Act (FMLA) Administration
Human Resources Share Service Center (HRSSC)
Contact Information

1-877-477-3273 Option 5, then Select 6
TTY: 1-866-833-8777

Northeast Area

HRSSC FMLA NORTHEAST
PO Box 970901
Greensboro NC 27497-0901

FAX: 651-456-6062



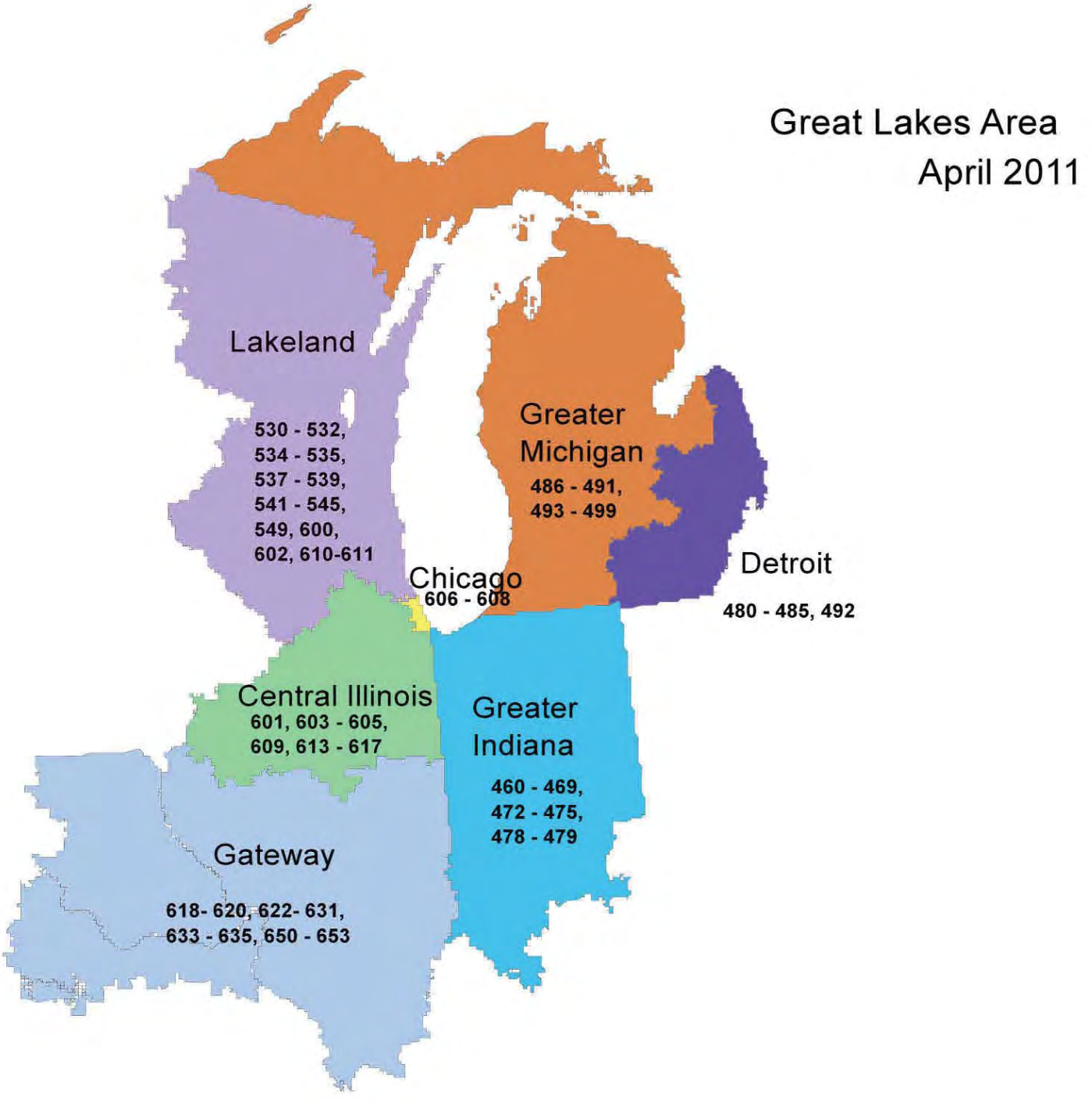
Family and Medical Leave Act (FMLA) Administration
Human Resources Share Service Center (HRSSC)
Contact Information

1-877-477-3273 Option 5, then Select 6
TTY: 1-866-833-8777

Great Lakes Area

HRSSC FMLA GREAT LAKES
PO Box 970908
Greensboro NC 27497-0908

FAX: 651-456-6055



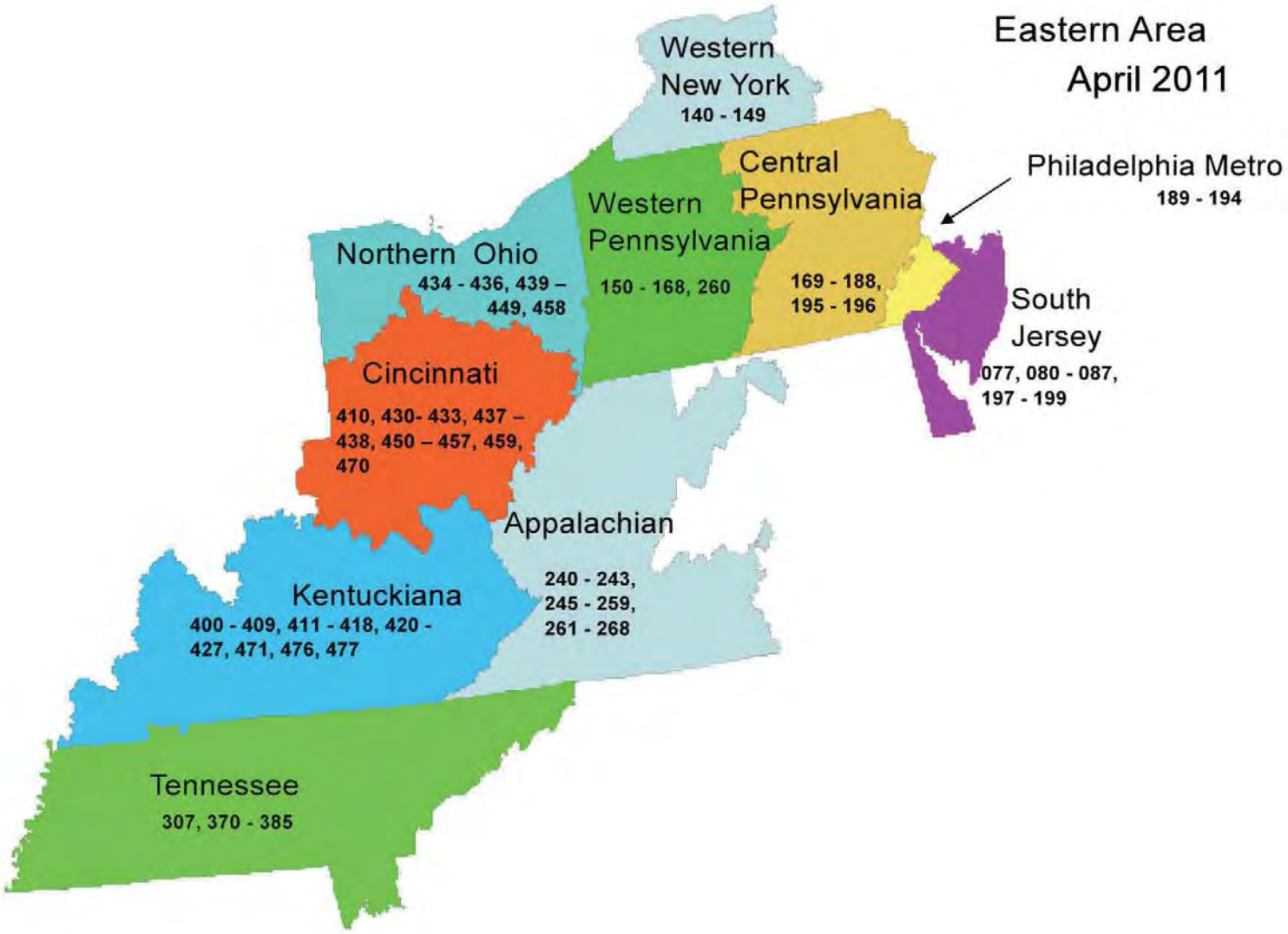
Family and Medical Leave Act (FMLA) Administration
Human Resources Share Service Center (HRSSC)
Contact Information

1-877-477-3273 Option 5, then Select 6
TTY: 1-866-833-8777

Eastern Area

HRSSC FMLA EASTERN
PO Box 970905
Greensboro NC 27497-0905

FAX: 651-456-6041



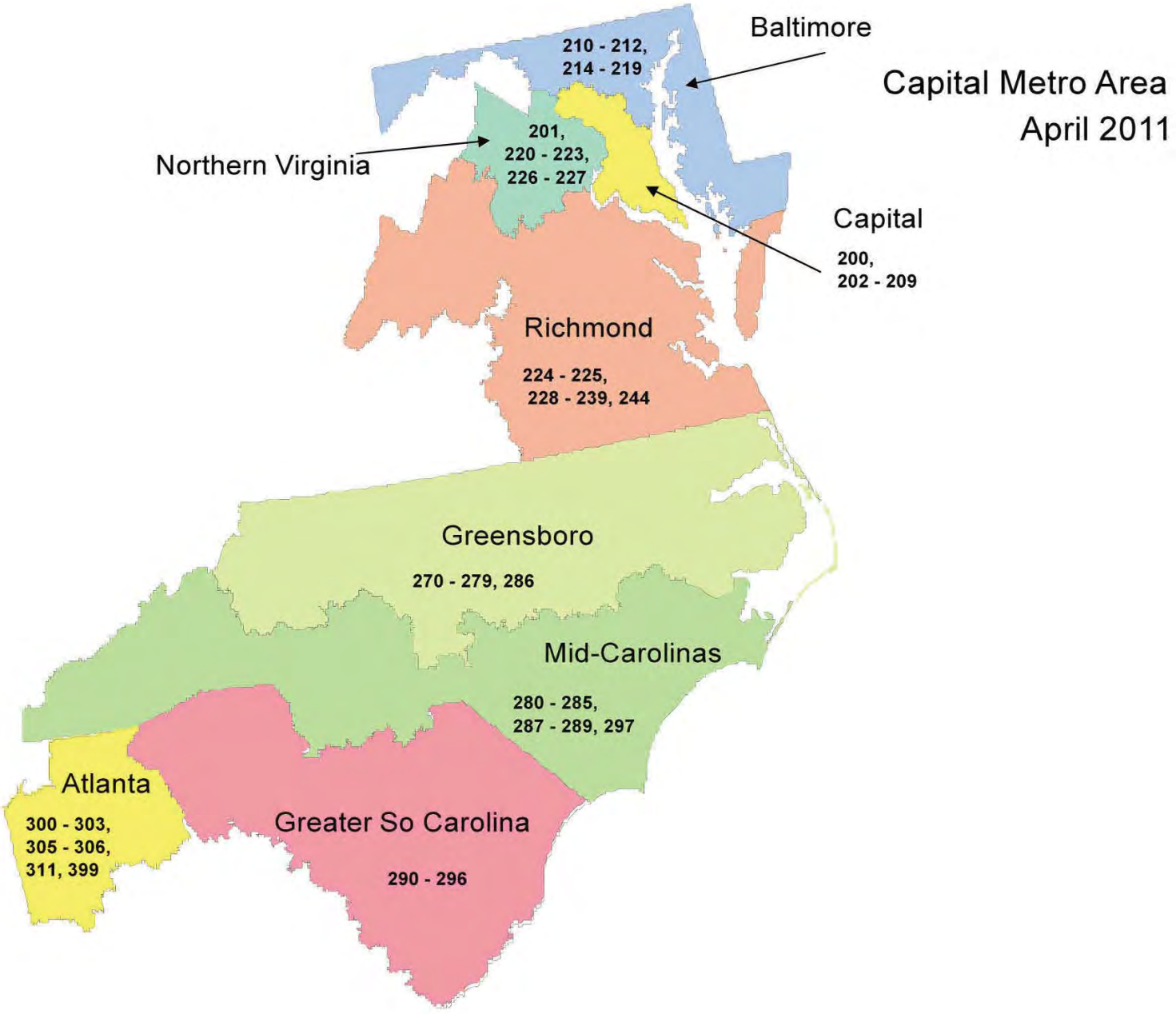
Family and Medical Leave Act (FMLA) Administration
Human Resources Share Service Center (HRSSC)
Contact Information

1-877-477-3273 Option 5, then Select 6
TTY: 1-866-833-8777

Capital Area

HRSSC FMLA CAPITAL METRO
PO Box 970903
Greensboro NC 27497-0903

FAX: 651-456-6036



Family and Medical Leave Act (FMLA) Administration
Human Resources Share Service Center (HRSSC)
Contact Information

1-877-477-3273 Option 5, then Select 6
TTY: 1-866-833-8777

Western Area

HRSSC FMLA WESTERN
PO Box 970910
Greensboro NC 27497-0910

FAX: 651-456-6071