Employee's Acknowledgment of Receipt and Review of Employer Leave Policies

I, _____, an employee of the Town of Walpole, acknowledge that I have been given a copy of, read, and fully understand the Town's policies and procedures on leaves of absence. I have been offered an opportunity to ask any questions I need to in order to fully understand the Town's policies and my rights and responsibilities under them. I agree that I will conform to these policies and procedures.

_____ _____

Employee Signature Date

FAMILY LEAVE POLICY

Family, Medical and Small Necessities Leaves of Absence

A. **Purpose:** The Family and Medical Leave Act ("FMLA") of 1993 allow eligible employees twelve (12) weeks of unpaid leave ("FMLA Leave") per year under the circumstances outlined below. Employees may take leave for the following reasons:

1. birth of the employee's child or placement of a child with the employee through adoption or foster care;
2. the employee is needed to care for a child, spouse or parent who has a serious health condition; or,
3. the employee is unable to perform the functions of his or her position because of a serious health condition.

"Serious health condition" is defined by law and refers to in-patient care, and in some instances outpatient care, by a medical provider.

B. **Use Paid Leave First:** Employees are required to use certain types of accrued or available paid leave first, as part of the twelve weeks of FMLA leave, before commencing the unpaid portion of the leave. Employees who take leave because of the birth, or placement of a child or to care for an ill spouse, parent or child must first use all accrued vacation and personal time, in that order. Employees who take leave because of their own serious illness must use all accrued sick, personal and vacation time, in that order.

C. **Eligibility:**

1. **1250 hours in previous 12 months:** To be eligible for leave under this policy an employee must have been employed by the Town for at least twelve months, and must have worked at least 1250 hours during the twelve month period preceding the commencement of the leave.

D. **Conditions:**

1. **Twelve Weeks:** Employees may take no more than twelve weeks of leave in a twelve-month period. The twelve-month period is a rolling twelve months beginning twelve months prior to the proposed commencement of requested leaves. If the Town employs both spouses, they are together entitled to a total of twelve weeks of leave for the birth or placement of a child or care of a sick parent.

2. **Notice:** Employees wishing to take FMLA leave must give 30 days notice of foreseeable events. If the event giving rise to the need for leave is not foreseeable, then the employee must give such notice as is practicable under the circumstances. Employees must schedule planned medical treatments with due regard for the Town's operational needs.

E. **Certification:** Employees requesting FMLA must provide medical certification to support a claim for leave for an employee's own serious health condition or to care for a seriously ill child, spouse or parent. The medical certification must set forth: the date on which the serious health condition commenced; the probable duration of the condition; and, the appropriate medical facts within the knowledge of the health care provider regarding the condition. In its discretion, the Town may require a second medical opinion and periodic re-certification at its own expense.

F. **Intermittent or Reduced Schedule Leave:** If medically necessary for a serious health condition of the employee or his or her spouse, child or parent, leave may be taken on an intermittent or reduced leave schedule. If leave is requested on this basis, the Town may require the employee to transfer temporarily to a position, with equivalent compensation, which better accommodates recurring periods of absence or a part-time schedule.

G. **Benefits:**

1. **Health Coverage:** Employees on leave are entitled to the continuance of group health coverage under the same conditions they received coverage prior to the leave. Employees who contribute to their health insurance premiums via payroll deduction must arrange to pay the premium contributions during the period of unpaid absence, if they wish to retain coverage. In the event that an employee elects not to return to work upon completion of an approved unpaid leave of absence, the Town may recover from the employee the cost of any payments made to maintain the employee's coverage, unless the failure to return to work was for reasons beyond the employee's control.

2. **Other Benefits:** Benefits based upon length of service will be calculated as of the last paid workday prior to the start of the unpaid leave of absence. Employees are not entitled to the accrual of any seniority, sick, vacation or personal time while on leave.

H. **Sick Leave, Workers Compensation Leave, or Other Absences:** Employees who are out of work for reasons that would qualify for leave under this policy, irrespective of whether leave has been requested under this policy, are required, upon request, to provide to the Town the information and certifications required by this policy. The Town shall designate all such qualifying leave as Family and Medical Leave, which shall run against the twelve weeks allowed under this policy.

I. **Return to Work:** Employees returning from FMLA Leave in accordance with this policy will be restored to their original positions, or to equivalent positions with equivalent pay and benefits. Employees should contact the personnel department and their supervisors at least two weeks before their return date to make arrangements. Employees may be required to provide a medical opinion from a physician certifying their fitness for duty. The Town reserves the right to send an employee to the Town physician for a second opinion regarding the employees' fitness to return to work.

J. **Procedural Requirements:** Employees requesting an FMLA leave must submit the request in writing to their Department Head (form letter attached). Requests should be made 30 days in advance of the commencement of the leave, but in any event, as soon as practicable. Within fifteen days from the request, the employee must submit a completed Certification of Health Care Provider form (attached) to the Town Administrator or his/her designee.

K. **Small Necessities Leave:**

1. The Small Necessities Act, Massachusetts General Law Chapter 149, Section 52D, became effective on August 4, 1998.

2. An employee shall be entitled to a total of 24 hours of unpaid leave during a 12-month period (the twelve month period is a rolling twelve months beginning twelve months prior to the proposed commencement of requested leave), in addition to leave available under the Family and Medical Leave Act of 1993, for the following purposes:

   (a) To participate in school activities directly related to the educational advancement of a son or daughter.
   (b) To accompany the son or daughter of the employee to routine medical or dental appointments, such as check-ups or vaccinations; and
   (c) To accompany an elderly relative of the employee to routine medical or dental appointments or appointments for other professional services related to the elder's care.

3. Employees who have accumulated sick, personal or vacation time must use such time as part of the 24 hours before becoming eligible for unpaid time. The Town will not provide paid leave in any situation where it would not normally provide such paid leave.

4. At least 7 days in advance, the employee shall submit to the Town a written notice (Employee's Certification form attached) of his/her intent to take small necessities leave and the date and expected duration of the leave. If 7 days notice is not possible, the employee shall give notice as soon as practicable.

Michael E. Boynton 3/18/05
Town Administrator Date

[signature] 3/14/05
Personnel Board Date

Family and Medical Leave Request Form

Employee: _____ Date: _____

Job Title: _____ Department/School: _____

Supervisor: _____

Social Security Number: _____

Eligible employees are entitled under the Family and Medical Leave Act (FMLA) to up to 12 weeks of unpaid, job-protected leave for certain family and medical reasons. Submit this request for to your supervisor at least 30 days before the leave is to commence, when practicable. When submission of the request 30 days in advance is not practicable, submit the request as early as is practicable. The employer reserves the right to deny or postpone leave for failure to give appropriate notice when such denial/postponement would be permitted under federal or state law.

ELIGIBILITY:

1. Counting any periods of time that you worked for the Town (whether they were consecutive or not), have you worked for the Town for a total of 12 months or more? [ ] Yes [ ] No
   (If "yes," continue to next question. If "no" stop here)

2. During the past 12 months, have you worked at least 1,250 hours? [ ] Yes [ ] No
   (If "yes," continue to next question. If "no" stop here)

3. Have you previously received medical or family leave? [ ] Yes [ ] No
   If yes, provide information below:

Dates of leave:

From _____ to _____

Purpose of leave: _____

_____

4. Have you taken any intermittent leave? [ ] Yes [ ] No
   Have you taken time off from scheduled hours? [ ] Yes [ ] No

If "yes," provide details:

_____

_____

REASONS FOR REQUESTING LEAVE:

Leave must be granted for any of the following reasons:

- For a serious health condition that makes it unable for you to perform your job;
- To care for your child, spouse or parent who has a serious health condition; or
- To care for your child after birth, or for placement after adoption or foster care.

I am requesting leave for the following reason:

Personal serious health condition

Serious health condition of:

Spouse Name: _____
Child Name: _____
Parent Name: _____

Birth of a child Expected delivery date is: _____

Adoption or placement of a child for foster care

Child's name: _____
Scheduled date of adoption or placement: _____

Dates of Leave requested:

I request leave from _____ to _____

I request intermittent leave according to the following schedule: _____

_____

I request a reduced schedule leave according to the following schedule: _____

_____

The total number of days of leave that I request is _____

EMPLOYEE STATEMENT:

I agree to return to work on _____. If circumstances change such that I will not be able to return to work on that date, I agree to inform my supervisor by submitting a **NOTICE TO EMPLOYER OF CHANGES IN APPROVED MEDICAL OR FAMILY LEAVE** form. I understand that my benefits will continue during my leave and that I will arrange to pay my share of applicable premiums.

Signature: _____ Date: _____

Certification of Health Care Provider
(Family and Medical Leave Act of 1993)

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

*(When completed, this form goes to the employee, **Not to the Department of Labor**.)*

OMB No.: 1215-0181
Expires: 07/31/04

1. Employee's Name

2. Patient's Name *(If different from employee)*

3. Page 4 describes what is meant by a **"serious health condition"** under the Family and Medical Leave Act. Does the patient's condition[1] qualify under any of the categories described? If so, please check the applicable category.

(1) _____ (2) _____ (3) _____ (4) _____ (5) _____ (6) _____ , or None of the above _____

4. Describe the **medical facts** which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories:

5. a. State the approximate **date** the condition commenced, and the probable duration of the condition (and also the probable duration of the patient's present **incapacity**[2] if different):

b. Will it be necessary for the employee to take work only **intermittently or to work on a less than full schedule** as a result of the condition (including for treatment described in Item 6 below)?

If yes, give the probable duration:

c. If the condition is a **chronic condition** (condition #4) or **pregnancy**, state whether the patient is presently incapacitated[2] and the likely duration and frequency of **episodes of incapacity**[2]:

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

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

6. a. If additional **treatments** will be required for the condition, provide an estimate of the probable number of such treatments.

If the patient will be absent from work or other daily activities because of **treatment** on an **intermittent** or **part-time** basis, also provide an estimate of the probable number of and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any:

b. If any of these treatments will be provided by **another provider of health services** (e.g., physical therapist), please state the nature of the treatments:

c. **If a regimen of continuing treatment** by the patient is required under your supervision, provide a general description of such regimen (*e.g.*, prescription drugs, physical therapy requiring special equipment):

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7. a. If medical leave is required for the employee's **absence from work** because of the **employee's own condition** (including absences due to pregnancy or a chronic condition), is the employee **unable to perform work** of any kind?

b. If able to perform some work, is the employee **unable to perform any one or more of the essential functions of the employee's job** (the employee or the employer should supply you with information about the essential job functions)? If yes, please list the essential functions the employee is unable to perform:

c. If neither a. nor b. applies, is it necessary for the employee to be **absent from work for treatment**?

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8. a. If leave is required to **care for a family member** of the employee with a serious health condition, **does the patient require assistance** for basic medical or personal needs or safety, or for transportation?

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

c. If the patient will need care only **intermittently** or on a part-time basis, please indicate the probable **duration** of this need:

Signature of Health Care Provider

Type of Practice

Address

Telephone Number

Date

To be completed by the employee needing family leave to care for a family member:

State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule:

Employee Signature

Date

Fitness for Duty Certification

Employee: _____

Department/Location: _____

Status: Full time Part time On leave since: _____
(Date)

You have my permission to contact the health care provider indicated on this certification for purposes of certification and authentication.

Signed _____ Date: _____

(Information below to be completed by health care provider)

Effective as of _____, the above-mentioned employee is hereby certified as fit to resume work duties as follows:

[ ] Full-time duties, no restrictions

[ ] Part-time duties, no restrictions

[ ] Unable to return to work until: _____

Additional comments, if any:

Name of Health care provider: _____

Address: _____Telephone _____

Type of practice/specialty: _____

Signature: _____ Date: _____