Waterman, Robert - WHD

From: Waterman, Robert - WHD
Sent: Saturday, October 05, 2019 11:22 AM
To: WHDPRAComments
Subject: FW: Additional Comments on Proposed FMLA Forms
Attachments: WH-382 (SDM).docx; FMLA RTW.docx

Importance: Low

From: Schott, Christine M - WHD <Schott.Christine@dol.gov>
Sent: Friday, October 04, 2019 12:51 PM
To: Waterman, Robert - WHD <Waterman.Robert@dol.gov>
Subject: FW: Additional Comments on Proposed FMLA Forms
Importance: Low

From: Scott Macdonald <scott@macdonaldhr.com>
Sent: Friday, October 04, 2019 9:21 AM
To: Schott, Christine M - WHD <Schott.Christine@dol.gov>
Subject: FW: Additional Comments on Proposed FMLA Forms
Importance: Low

Ms. Schott,
I wanted to make sure the Department received my additional recommendations. I was able to find the time to complete a recommended template for WH-382. Please confirm receipt. Have a nice weekend.

Regards,

Scott
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From: Scott Macdonald <scott@macdonaldhr.com>
Sent: Friday, October 4, 2019 9:19 AM
To: 'WHDPRAComments@dol.gov' <WHDPRAComments@dol.gov>
Subject: Additional Comments on Proposed FMLA Forms
Importance: Low

To Whom It May Concern:
Please accept the attached draft of a recommended template for the FMLA Designation Notice (WH-382). This submission is supplemental to my letter and recommended template for WH-381 originally submitted to the Department by email on September 27, 2019 and forwarded to Christine Schott on October 2, 2019.

Please note that the following change is needed to my original letter: On page 7, under recommendation number 2 relating to WH-382, the sentence should read as follows:
"Reason for Recommendation: The added options for the employer to indicate whether it is requesting a Second or Third Opinion is useful for recordkeeping purposes and more aligned with the regulations."

One additional recommendation: Consistent with Section 825.312 or the regulations, it is advisable for employers to provide a form for an employee's health care provider to complete regarding an employee's fitness-for-duty. I have attached an example of such a form I developed that is particularly useful in certain situations such as when there is a question regarding whether medical work restrictions prevent an employee from performing the essential functions of the job. The form also covers the issue of "reasonable safety concerns" addressed in Section 825.312. Accordingly, I recommend the following addition to WH-382 as an option for employers to indicate, as set forth on the last page of the attached recommended template:

- ☐ A "Fitness-for-Duty Certification" form to be used for this purpose is attached. The purpose of the form is to certify that you are able to resume work and address your ability to perform the essential functions of your job.

Thank you for considering my recommendations.

Regards,

Scott

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Designation Notice
(Family and Medical Leave Act)
U.S. Department of Labor
Wage and Hour Division

U.S. Wage and Hour Division

RETURN TO THE EMPLOYEE – DO NOT SEND TO THE DEPARTMENT OF LABOR

OMB Control Number: 1235-0003
Expires: x/xx/20xx

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).

SECTION I - EMPLOYER

Date: _ From: _
(Employer)

To: _
(Employee)

On _ *(date)* we received your most recent information to support your need for leave due to:

- ☐ The birth of a child, or placement of a child with you for adoption or foster care, and to bond with the newborn or newly-placed child
- ☐ Your own serious health condition
- ☐ The serious health condition of your spouse, child, or parent
- ☐ A qualifying exigency arising out of the fact that your spouse, son, daughter or parent is on covered active duty or has been notified of an impending call or order to covered active duty with the Armed Forces
- ☐ A serious injury or illness of a covered servicemember where you are the servicemember's spouse, child, parent, or next of kin *(Military Caregiver Leave)*

☐ **No additional information/documentation was or is required.**
☐ **We have reviewed information related to your need for leave under the FMLA along with any supporting documentation provided and decided:** ***(Select as appropriate)***

☐ Your FMLA leave request is **Approved.** All leave taken for this reason will be designated as FMLA leave.
See Section III below for information.

☐ Your FMLA Leave request is **Not Approved**: ***(Select as appropriate)***
- ☐ The FMLA does not apply to your leave request.
- ☐ As of the date the leave is to start, you do not have any FMLA leave available to use.
- ☐ Other _

☐ **Additional information** is needed to determine if your leave request qualifies as FMLA leave. ***See Section II below for specific information needed.***

Employee Name: _____

SECTION II – ADDITIONAL INFORMATION NEEDED

We are requesting additional information to determine whether your leave request qualifies under the FMLA. Once we obtain the additional information requested, we will inform you **within 5 business days** if your leave will or will not be designated as FMLA leave and count towards the amount of FMLA leave you have available. **Failure to provide the additional information as requested may result in a denial of your FMLA leave request.**

If you have any questions, please contact:

_____ at _____.
(Name of employer FMLA representative) *(Contact information)*

Incomplete or Insufficient Certification

The certification you have provided is incomplete and / or insufficient to determine whether the FMLA applies to your leave request.

☐ The certification provided is incomplete and we are unable to determine whether the FMLA applies to your leave request. *"Incomplete" means one or more of the applicable entries on the certification have not been completed.*

☐ The certification provided is insufficient to determine whether the FMLA applies to your leave request. *"Insufficient" means the information provided is vague, unclear, ambiguous or non-responsive.*

Specify information needed to make the certification complete or sufficient:

_____

_____

_____

You must provide the requested information no later than _____ *(List date due, provide at least seven calendar days)*, unless it is not practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied.

Second and Third Opinions

☐ We request that you obtain a ☐ Second ☐ Third opinion medical certification at our expense, and:
☐ we will provide further details at a later time.
☐ Please contact the following health care provider to make arrangements to obtain the Second or Third Opinion:

_____

A certification form for the Second or Third Opinion ☐ **is** / ☐ **is not** enclosed.

Note: The employee or the employee's family member may be requested to authorize his or her health care provider to release information pertaining only to the serious health condition at issue.

Employee Name: _____

SECTION III – FMLA LEAVE APPROVED

As explained in Section I, your FMLA leave request is approved. All leave taken for this reason will be designated as FMLA leave and will count against the amount of FMLA leave you have available to use in the applicable 12-month period. The FMLA requires that you notify us as soon as practicable if the dates of scheduled leave change, 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 the total **amount of FMLA leave** you have available to use in the applicable 12-month period:

(Select as appropriate)

☐ Provided there is no deviation from your **anticipated FMLA 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)***

☐ (1) **You will not be paid during some or all of your FMLA leave.**
Any unpaid FMLA leave taken will count against the amount of FMLA leave you have available to use.

☐ (2) **Based on your request, you are substituting or using paid leave during your FMLA leave.**
(E.g., sick leave, vacation pay, PTO)
Any paid leave taken for this reason will count against the amount of FMLA leave you have available to use.

☐ (3) **We are requiring you to substitute or use paid leave during your FMLA leave.**
(E.g., sick leave, vacation pay, PTO)
Any paid leave taken for this reason, will count against the amount of FMLA leave you have available to use.

☐ (4) **Your FMLA leave will be used at the same time with other types of paid leaves or benefits.**
(E.g. short or long-term disability, workers' compensation, state medical leave law)
Any paid leave or benefit taken for this reason will count against the amount of FMLA leave you have available to use.

Employee Name: _____

☐ (5) **Return-to-work requirements.**

To be restored to work after taking FMLA leave, you will be required to provide a certification from your health care provider (fitness-for-duty certification) that you are able to resume work. This request for a fitness-for-duty certification is *only* with regard to the particular serious health condition that caused your need for FMLA leave. **If such certification is not timely received, your return to work may be delayed until the certification is provided.**

☐ A "Fitness-for-Duty Certification" form to be used for this purpose is attached. The purpose of the form is to certify that you are able to resume work and address your ability to perform the essential functions of your job.

A list of the essential functions of your position:

☐ **is attached.** If attached, the fitness-for-duty certification must address your ability to perform these functions.

☐ **is not attached.**

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 numb The Department of Labor estimates that it will take an average of 10 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Avenue, N.W., Washington, D.C. 0210.

DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.

Return-to-Work / Fitness-for-Duty Certification

I certify that I have examined (See Medical Examination Guidelines, Nos. 1-5)

_____ on _____ with knowledge of his/her essential job functions, working conditions and safety hazards, and I find the following:

- ❒ No work restrictions or reasonable safety concerns. The individual fully able to perform all essential job functions under indicated working conditions and environment. The individual may return to work on _____.
- ❒ The patient is able to return to work on a reduced schedule. The patient may return to work with the following number of hours per ___ day ___ week: _____
- ❒ The individual has the following work restriction(s) and duration set forth below (See Guidelines No. 5):

A. Physical Requirements

	Continual (>66%)	Frequent (<66%)	Occasional (<33%)	Rarely or Not At All (<5%)
1. Lifting: Up to lbs.				
2. Carrying: Up to lbs.				
3. Pushing/Pulling: Up to lbs.				
4. Use of Equipment (e.g., machines, tools)				
5. Sitting				
6. Standing				
7. Walking				
8. Bending				
9. Stooping				
10. Crawling				
11. Climbing				
12. Reaching Above Head				
13. Grasping: a. One Hand				
b. Both Hands				
14. Fine Manipulating a. One Hand				
b. Two Hands				
15. Keyboarding				
16. Repetitive motion with hands, arms				

B. Environmental Requirements

	Continuous	Frequent	Occasional	Rarely or Not At All
1. Exposure to Marked Changes in Temperature				
2. Outside Work				
3. Exposure to dust, fumes, odors, water				
4. Exposure to biological, mechanical, electrical, and/or chemical hazards				
5. Normal (inside) environment				
6. Exposure to bloodborne pathogens				
7. Exposure to loud noise				
8. Ongoing exposure to vibrations				

Additional Medical Work Restrictions, Information or Comments (e.g., close eye work, ability to see computer screen, sensitivity to light, ability to hear normal or soft tones, need for hearing aid, mental limitations):

_____

_____

_____

The restrictions set forth above are in effect until _____.
The individual will be reexamined on _____.

❒ Reasonable safety concerns exit regarding the employee's ability to perform the functions of his or her job position based upon the serious health condition for which the employee took leave (See Guidelines Nos. 6 and 7).

Specify (a) the nature and severity of the potential harm, (b) the likelihood that the potential harm will occur; and (c) the duration of risk:

(a) _____

(b) _____

(c) _____

_____
Name of Examining Physician (Please type or print legibly)

_____
Signature Date

_____
Address

_____
E-mail Address

_____
Telephone Number

Return completed form to:

FITNESS-FOR-DUTY MEDICAL EXAMINATION
Guidelines for Performing, Recording, and Reporting Results of Medical Examinations

1. The examining physician should review these guidelines before performing the medical examination.
2. The purpose of the medical examination is to determine the individual's current ability to perform the essential functions of the job being held or sought.
3. The examining physician must have knowledge of the job functions of the position held or sought, the job demands, working environment and conditions, and conduct the examination in relation to the specific job.
4. All medical judgments must be made on an individual basis and not on generalized assumptions. Specified work restrictions must be specific to the individual's function limitation, rather than based on general medical diagnosis or the patient's wishes.
5. Work restrictions should be specified in terms of degree, direction, weight, frequency, repetitiveness or duration. Consideration should be given (but not limited to) the following categories. Specific restrictions on:

    - Standing, walking, climbing, lifting, pushing, pulling, carrying, bending, squatting, stopping.
    - Head, neck, shoulder, arm, leg, wrist, hand or foot use, motion or positions.
    - Sustained vision, fine vision, depth perception, peripheral vision, color discrimination, microscopic work. Safety lenses/side shields required.
    - Work where hearing loss would create hazard, other hearing related restrictions.
    - Machinery, heights, remoteness, vehicles.
    - Skin exposures, environmental exposures (including radiation).
    - Mental or emotional demands, exertion, tension.
    - Work schedules.
    - Travel restrictions.
    - Special eating privileges required.

    Explain restrictions with as much specificity as possible, and make sure to include the duration of any such restrictions.

6. The existence of reasonable safety concerns regarding the employee's ability to perform the functions of his or her job position based upon the serious health condition for which the employee took leave means there is a reasonable belief of significant risk of harm to the individual employee or others. In determining whether reasonable safety concerns exist, an employer should consider the nature and severity of the potential harm and the likelihood that potential harm will occur.
7. The physician should identify the specific risk posed by the individual. For individuals with physical health conditions, the physician must identify the aspect of the condition that would pose a reasonable safety concern. The physician should then consider the four factors listed above. For individuals with mental or emotional health conditions, the physician must identify the specific behavior on the part of the individual that would pose a reasonable safety concern.
8. Upon completion of the examination, the examining physician should complete and sign the Medical Examiner's Certification form, furnish one copy to the person examined, one copy to the employer and retain one copy.