Dear Employee,

You may be eligible for leave under the Family and Medical Leave Act (FMLA) as described in the attachment, "Employee Rights and Responsibilities Under the Family and Medical Leave Act", and applicable state laws. The enclosed materials describe your rights and obligations under FMLA. The company will comply with any state laws and contractual bargaining agreements. In order to be approved for FMLA, you must complete and submit the enclosed *Family and Medical Leave Act (FMLA) Medical Certification Form.* It is your responsibility to ensure that your completed form is received by our office, via fax or mail, within 25 calendar days of your first day of absence or 25 calendar days from the date the absence was reported.

Note that you may apply for leave on an intermittent basis or reduced schedule. Section B of the form covers this. Please allow for appropriate mail time. We strongly recommend that you retain a copy of the application and proof of mailing/ faxing for your records. Please remember that it is your responsibility to follow-up with your health care provider to ensure the completed form is received by our office. Fees charged by health care provider for completion, copying or faxing of the FMLA Medical Certification Forms are the responsibility of the employee.

If approved:

- Your leave will be counted against your 12 weeks per calendar year FMLA leave entitlement.
- Your FMLA leave may run concurrent with any periods of approved payments under any applicable plan, policy, program, or collective bargaining agreement.
- Recertification may be required if your leave exceeds the period designated by the health care provider. When applying for intermittent leave for a health condition which is chronic or requires periodic treatments or a reduced leave schedule, please be certain that your health care provider indicates the duration and frequency of the leave required on the *Family and Medical Leave Act (FMLA) Medical Certification Form*.
- If you fail to return to work upon the expiration of your FMLA leave, and you have not obtained any other type of approved leave, the company may treat your failure to return as a voluntary resignation, unless your absence has been approved under the provisions of the Sickness and Accident Disability Benefit Plan.

Your FMLA request may be denied, and therefore, the absence may be subject to the provisions of the established attendance plan and practices in your area, if:

- The completed form is not received by our office within 25 calendar days from the first day of absence or 25 calendar days from the date the absence was reported.
- The information provided by your health care provider regarding your health condition does not establish a serious health condition under FMLA regulations.
- Your absence exceeds your remaining FMLA time.

If your absence is approved under the applicable disability plan within 39 days from the date the absence was reported into AMTS, the absence will also be approved under FMLA. However, you will not have another opportunity to apply for FMLA leave for this absence if your short term disability is not approved within this 39 day period.

If you have any questions, please contact the FMLA Administrator at 1-800-638-4228 or visit the Verizon e-web and search for FMLA.

Please complete and return to:

Verizon
The Absence Reporting Center 111 Main Street, 6th Floor White Plains, NY 10601 Fax: 1-877-786-4500 Phone: 1-800-638-4228

Family and Medical Leave Act (FMLA) Medical Certification Form

FMLA is a federal law that guarantees "eligible" employees up to twelve (12) work weeks of job-protected absence for certain family and medical reasons. You are eligible to request an FMLA absence if you have worked for the company for at least one year, worked a minimum of 1250 hours over the previous twelve (12) months, and need to be absent for one of the following reasons:

- A serious health condition that makes you unable to perform any one of the essential functions of your job.
- To care for your immediate family member (spouse, child, or parent) who has a serious health condition.
- To care for your newborn child, or placement of an adopted or foster child.

Family and Medical Leave Act Definitions for Health Care Providers

as defined by the Department of Labor's Regulations

Activities of daily living (ADLs): Examples include adaptive activities such as caring appropriately for one's grooming and hygiene, bathing, dressing and eating.

Health Care Provider (HCP): Authorized health care providers include any of the following who are authorized to practice under State law, and who are practicing within the scope of that practice: doctors of medicine or osteopathy, podiatrists, dentists, clinical psychologists, optometrists and chiropractors, nurse practitioners, nurse-midwives, clinical social workers, and any other person determined by the Secretary of Labor to be capable of providing health care services.

Incapacity: The inability to work or perform regular daily activities due to the patient's serious health condition, treatment for that condition, or recovery from that condition.

Instrumental activities of daily living (IADLs): Activities include cooking, cleaning, shopping, paying bills, maintaining a residence, using a post office and telephone.

Regimen of Continuing Treatment: Treatment including, 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.

Serious Health Condition: An illness, injury, impairment, or physical or mental condition that meets one of the following criteria:

1. **Hospital Care**: Inpatient care (e.g. 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 (Acute)**: A period of incapacity of more than three consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:
   A. Treatment two or more times, within 30 days of the first day of incapacity, unless extenuating circumstances exist by an HCP or by a nurse or physician's assistant under direct supervision of an HCP, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, an HCP; or
   B. At least one treatment by an HCP which results in a regimen of continuing treatment under the supervision of the HCP.
3. **Pregnancy**: Any period of incapacity due to pregnancy, or for prenatal care.
4. **Chronic Health Condition Requiring Treatments**: A chronic condition which:
   A. Requires periodic visits (at least twice a year) for treatment by an HCP, or by a nurse or physician's assistant under direct supervision of an HCP;
   B. Continues over an extended period of time; and
   C. May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).
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, e.g. Alzheimer's, a severe stroke. The patient must be under the continuing supervision of, but need not be receiving active treatment by, an HCP.
6. **Scheduled Multiple Treatments**: Any period of absence to receive scheduled multiple treatments (including any period of recovery) by an HCP or by a provider of health care services under orders of, or on referral by, an HCP, 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).

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.

Family and Medical Leave Act (FMLA) Certification Form

Employee's Name: _____First Day of Absence _____ EMPLID _____

INSTRUCTIONS: We estimate that it will take an average of ten (10) minutes to complete this form.
Please note: Incomplete Form Will Be Returned For Completion

1. **Employee** Complete Section **A**
2. **Employee's Treating Health Care Provider** - Complete Sections **B** and **D**
3. **Family Member's Treating Health Care Provider** - Complete Sections **B, C,** and **D**

SECTION A: (TO BE COMPLETED BY THE **EMPLOYEE**. PLEASE BE ADVISED THAT KNOWINGLY PROVIDING FALSE OR INACCURATE INFORMATION IN THIS CERTIFICATION IS A VIOLATION OF THE COMPANY'S CODE OF BUSINESS CONDUCT.)

Type of Leave: (check all that apply)

_____ New Request _____ Extension/Recertification_____ On the Job Injury

Reason for Leave: (check one)

- ☐ A serious health condition that makes you unable to perform any one of the essential functions of your job.
- ☐ A serious health condition affecting your spouse, child or parent for which you are needed to provide care.
- ☐ The birth of your child, or the placement of a child with you for adoption or foster care for the period beginning ___/___/____ through ___/___/___. You must attach documentation supporting the date of your child's birth, or the date of foster placement or adoption.

Requested FMLA: (check all that apply)

- ☐ Full Time Leave - Taken in consecutive, full day increments.
- ☐ Intermittent Leave - Taken periodically over an extended period of time.
- ☐ Reduced Work Schedule - Taken on consecutive days; employee is able to work some of his/her work schedule each day.

SECTION B: (TO BE COMPLETED BY THE **TREATING HCP**. PLEASE NOTE: INCOMPLETE FORMS WILL BE RETURNED FOR COMPLETION AND MAY RESULT IN DENIAL OF FMLA. Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).)

1A. Describe the medical facts, which support your certification, including a brief statement as to how the medical facts meet the criteria for a serious health condition under the FMLA (see page one). The medical facts must be sufficient to support the need for leave. Such medical facts may include information on symptoms, diagnosis, hospitalization, doctor visits, whether medication has been prescribed, any referrals for evaluation or treatment or any other regimen of continuing treatment.

_____

_____

1B. If leave is for the **employee's** own health condition, please provide information sufficient to establish that the employee cannot perform the essential function(s) of the employee's job as well as the nature of any other work restrictions, and the likely duration of such inability.

_____

_____

2. This patient has been under my care for this health condition since: _____/_____/_____.

3. Does the patient's condition qualify as a *serious health condition* under the Family and Medical Leave Act (FMLA)? (See page one for *Family and Medical Leave Act Definitions for Health Care Providers.*)

- ☐ **NO**, the patient's condition does not qualify as a serious health condition under FMLA. (If you check this box, go directly to Section D.)
- ☐ **YES**, the patient's condition qualifies as a serious health condition according to the following category as described by FMLA regulations. (Please check all that apply, and complete the applicable information.)

Employee's Name: _____First Day of Absence _____ EMPLID _____

SECTION B - continued:

Question 3 (cont'd)

a)_____ **Hospital Care** (Inpatient – overnight stay)

Please answer ALL of the following questions:

- First Day incapacitated for this current episode: ____/____/____
- Last Day incapacitated for this current episode: ____/____/____
- Admit Date: ____/____/____ Discharge Date: ____/____/____
- Follow-up Appointment Date(s): _____
  - If employee needs to be absent from work for follow-up appointment(s), please indicate the duration of the follow-up appointment(s): (#)_____(circle one: minutes, hours)

b) _____ **Absence Plus Treatment (Acute)**

Please answer ALL of the following questions:

- First Day incapacitated for this current episode: ____/____/____
- Last Day incapacitated for this current episode: ____/____/____

The patient's period of incapacity exceeded three (3) consecutive calendar days and involved treatment two (2) or more times, within 30 days of the first day of incapacity, absent extenuating circumstances, by the health care provider, or treatment on at least one occasion which resulted in a regimen of continuing treatment. If a regimen of continuing treatment is required under your supervision, provide a general description of the regimen **(e.g., prescribed medication, physical therapy)**:

_____

_____

- Follow-up appointment date(s): _____
- If employee needs to be absent from work for follow-up appointment(s), please indicate the duration of the follow-up appointment(s): (#)_____ (circle one: minutes, hours)

c) _____ **Chronic Condition Requiring Treatment/ Permanent Long Term Condition Requiring Supervision**
The patient requires periodic visits, at least twice a year, to the health care provider for treatment, the condition continues over an extended period of time, and the condition may cause episodic rather than a continuing period of incapacity. The patient requires the following treatment including **prescribed medication,** examinations and/or evaluations of the condition:

_____

_____

Please complete ALL of the following questions that apply:

_____ Current Absence

- Period of incapacity for this absence : From ____/____/____ Through ____/____/____

_____ Future Intermittent Absences (Please complete the following information.)

- How often do you expect this patient to be incapacitated due to their health condition? (indicate range, if applicable) (#)_____ times per (circle one: week, month, year) each lasting (indicate range, if applicable) (#)_____ (circle one: minutes, hours, days, weeks) for a period of (#)_____(circle one: weeks, months)

Employee's Name: _____First Day of Absence _____ EMPLID _____

SECTION B - continued:

Question 3 (cont'd)

d) _____ **Scheduled Multiple Treatments**

Please answer ALL of the following questions:

- First Day incapacitated for this current incident: ____/____/____
- Last Day incapacitated for this current incident: ____/____/____
- The patient will receive the following treatment:

_____

_____

- Treatments will commence on ____/____/____ through ____/____/____.
- The frequency of treatment is (#) ____ times per (circle one: week, month, year)
- The approximate length of the appointment (including travel time) is _____ (circle one: minutes, hours,
- days, weeks, months) (indicate range, if applicable)
- The period required for recovery from treatment is (#) ____ (circle one: minutes, hours, days, weeks).

e) _____ **Pregnancy**

- The patient's pregnancy was confirmed on ___/___/____ with an estimated delivery date (EDC) of ___/___/____
- The patient is scheduled for approximately (#) ____ prenatal appointments.
- The approximate length of the prenatal appointment is (#) ____ (circle one: minutes, hours)
- Do you presently anticipate a need for the patient to be absent from work during her pregnancy?
  ____ Yes ____ No
  - If yes, please describe the medical facts that support this need: _____
    _____
  - How often do you expect this patient to be incapacitated due to this medical condition? (indicate range, if applicable)
    (#) ____ times per (circle one: week, month, year) each lasting (indicate range, if applicable)
    (#) ____ (circle one: minutes, hours, days, weeks) for a period of (#) ____ (circle one: weeks, months)

4. If a ***Reduced Work Schedule*** is necessary upon an employee's return to duty, please provide a description of the required work schedule.(i.e. number of hours per day) (#) _____ from ___/___/___ through ___/___/___.

SECTION C: (TO BE COMPLETED BY THE **TREATING HCP** IF THE LEAVE REQUEST IS **TO CARE FOR A FAMILY MEMBER**. PLEASE NOTE: INCOMPLETE FORMS WILL BE RETURNED FOR COMPLETION AND MAY RESULT IN DENIAL OF FMLA.) (Limit your responses to the condition for which the patient needs leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e).)

Patient's Name _____ Relationship to Employee _____ Date of Birth ___/___/___

5. It is necessary for the employee to be absent from work from ___/___/___ through ___/___/___ to care for this family member. (Please check any of the following and complete the applicable information.)

- ☐ **Full Time Leave** - Taken in consecutive, full day increments
- ☐ **Follow-up appointment to Full Time Leave: _____**

Duration of the follow-up appointment, that employee needs to be away from work: (#) ____ (circle one: minutes, hours)

- ☐ **Intermittent Leave -** Taken periodically over an extended period of time, with a likely frequency of (#)___ to (#)____ times per (circle one: week, month, year) with a probable duration of (#)____ (circle one: minutes, hours, days, weeks) for a period of (#) ____ (circle one: weeks, months)
- ☐ **Reduced Work Schedule** -Taken on consecutive days; the employee is able to work some of his/her work schedule each day. The employee is able to work (#)____ hours per day.

Employee's Name: _____First Day of Absence _____ EMPLID _____

SECTION C - continued:

6. Does the patient require assistance for:

Basic Medical or Personal Needs	☐ Yes	☐ No	Transportation	☐ Yes	☐ No
Psychological Comfort	☐ Yes	☐ No	Safety	☐ Yes	☐ No

7. If leave is required to care for a child age 18 or older, the child must be incapable of self-care. The individual must require active assistance or supervision to provide daily self-care in three or more of the activities of daily living (ADLs) or instrumental activities of daily living (IADLs). If the employee has requested FMLA leave to care for a child age 18 or older, please provide at least three ADLs/IADLs that the patient requires active assistance or supervision with. (See page one for the definition of ADLs and IADLs.)

_____

_____

SECTION D: (TO BE COMPLETED BY THE **TREATING HEALTH CARE PROVIDER**)

We strongly recommend that you retain a copy of this form in the event clarification of its content is needed. Incomplete forms will be returned to the employee to be completed. This may result in a delay or denial of the employee's FMLA approval.

I certify that the above information is true and correct:

Treating Health Care Provider's Printed Name	Signature	Date

Type of Practice	Address	Phone#	Fax#

Fax Cover Sheet

Employees please ensure to send the FMLA forms to:

Verizon

Absence Reporting Center

111 Main Street, 6th Floor

White Plains, NY 10601

FAX 1-877-786-4500

Employee Name: _____

EMPLID: _____

First Day of Absence: _____

Date: _____

Fax#:_____

From: _____

Pages including cover sheet: _____

CONFIDENTIAL AND PRIVATE

EMPLOYEE RIGHTS
UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION

LEAVE ENTITLEMENTS

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

BENEFITS & PROTECTIONS

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

ELIGIBILITY REQUIREMENTS

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

REQUESTING LEAVE

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

EMPLOYER RESPONSIBILITIES

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

ENFORCEMENT

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division

WH1420 REV 04/16