



Division 11 Personnel Management

Chapter 18 – Family and Medical Leave Act (FMLA) Leave

March 2009

POLICY

The purpose of this General Order is to advise employees of the Departmental procedures regarding FMLA leave and to outline the process for authorization and compliance. The Department grants such leave in accordance with the County Administrative Procedure and Federal regulations. The Director of the Office of Human Resources Management will render final approval of all requests based on compliance with the most recent policy. Employees, when requesting said leave, must comply with the established requirements for consideration, and all supervisors' approval must be in accordance with these requirements.

child, to any employee eligible to earn annual leave, regardless of the employee's length of service with the County.

FMLA Request and Approval Guidelines

FMLA leave shall not exceed 15 workweeks (600 hours) of any combination of paid leave and LWOP (leave without pay) during any 12-month period. **Compensatory leave is NOT allowed to be used for paid family and medical leave.** Parental leave of 40 hours, granted by the County, is included in the maximum 15 workweeks (600 hours). With the exception of the birth of a child, leave will be granted for the time indicated by the Health Care Provider on the Certification of Health Care Provider Form (attachment #2).

DEFINITIONS

N/A

To be eligible to receive FMLA leave without pay, the employee must first exhaust all paid leave balances as part of his/her 15 workweeks (600 hours) of leave. Use of leave donations, in lieu of leave without pay, must be authorized by the Fire Chief or appointed designee; the intent to use donated leave should be noted on the request form.

PROCEDURES

1. FMLA Leave

Eligibility

- FMLA leave for purposes not related to birth or adoption of a child (see below) shall be granted to employees who are eligible to earn annual leave, who have been employed by the County for at least 12 months, and who have been in a pay status for at least 1,040 hours during the previous 12 months.
- FMLA leave shall be granted for purposes of parental responsibilities associated with the birth, adoption, or foster care placement of a dependent

Eligibility for leave donations is limited to sickness of employee only.

Employees who request FMLA LWOP should contact Pension and Benefits prior to submitting their request to determine the effects upon their pension and health insurance benefits. Leave donation usage is further restricted in accordance with Personnel Law and Administrative Procedure 284. Also refer to applicable policies for correct processing of leave donations. For



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computing purposes, the employee's 12-month period of eligibility shall commence on the first day of approved FMLA leave. If so designated by the Department, FMLA leave will run concurrent with disability leave and workers' compensation.

FMLA leave will be granted to an employee for only one or more of the following reasons:

- Birth of a child of the employee and in order to care for such child;
- The placement of a minor child with the employee for adoption or foster care;
- To care for the spouse, child, parent, or parent-in-law of the employee, if such family member has a serious health condition; or
- A serious health condition that makes the employee unable to perform the function of the position of such employee. NOTE: "Serious Health Condition" (regardless of job or non-job related) means any illness, injury, impairment, or physical or mental condition that involves:
 - Any incapacity or treatment in connection with inpatient care;
 - An incapacity requiring absence of more than three (3) calendar days and continuing treatment by a health care provider; or
 - Continuing treatment by a health care provider of a chronic or long-term condition that is incurable or will likely result in incapacity of more than three (3) days if not treated.

The request for FMLA leave must be submitted on the appropriate FMLA leave request form **at least 30 days prior to expected use**, if the need for leave is

foreseeable (see Attachment #1). The employee must indicate the specific dates desired on the request (estimated birth date for the birth of a child).

There must be a medical need for intermittent leave or leave on a reduced leave schedule. Intermittent leave or reduced leave schedule after a birth or placement of a child for adoption or foster care will be approved on a case-by-case basis.

For administrative purposes, employees on FMLA for any continuous block of time should record it as day work hours using the FMLA Code. The exception would be if they requested intermittent leave. The employee must indicate what type of leave is to be used to cover the period requested. Open-ended requests are not permitted.

The following documents are to be submitted to the employee's immediate supervisor:

- Request for Parental Leave, Family and Medical Leave (FMLA), Leave Without Pay (LWOP) (Attachment #1) (PGC Form #4471)
- Leave Request, PGC Form #305
- Letter of Intent to the Fire Chief stating the dates of intended use; and the justification for usage
- Certification of Health Care Provider (Attachment #2). The employee shall be required to submit certification by the appropriate primary health care provider to support his/her leave request. NOTE: "Health Care Provider" includes: licensed MDs and ODs, podiatrists, dentists, clinical psychologists, optometrists, and chiropractors authorized to practice in the State, nurse practitioners and nurse-midwives authorized under State law, and Christian Science practitioners. For HIPPA compliance,



the Certification of Health Care Provider may be submitted in a sealed envelope only to be opened by the Fire Chief or designee.

- Parental Leave and FMLA Request Checklist (Attachment #3).

The supervisor will review/sign and forward the FMLA package to Risk Management within 48 hours of receipt.

Risk Management will examine each request and determine whether the employee's request meets eligibility requirements. Note: Risk Management may designate FMLA to run concurrently with Disability Leave. After Risk Management has obtained the approval signature of the Fire Chief or appointed designee, Risk Management will then forward the FMLA package to the Human Resources Division. The Human Resources Division will then forward the completed package to the Office of Human Resources Management (OHRM) for final approval.

If the need for leave is not foreseeable, the employee must submit the above paperwork as soon as reasonably practical. Requests for family and medical leave for parenting responsibilities must be used within 12 months of the birth of the child or placement of the child with the employee for adoption or foster care. The Office of Human Resources Management (OHRM) will issue an approval form letter covering one (1) year; however, the actual dates utilized must be in accordance with those specified on the request. Any modifications must be processed through Risk Management to obtain authorization from the Fire Chief for approval. A copy of any modifications will be maintained in Risk Management as well as forwarded to Human Resources Division for payroll verification.

All timesheets coded with FMLA leave should be turned in to Risk Management for

verification, authorization, and submission to Fiscal Affairs.

In cases where spouses are determined to be entitled to family and medical leave in the instance of the birth or adoption of a child, and both are employed by this Department, both employees will receive 40 hours of parental leave, but will have to split 14 workweeks (560 hours) within a 12 month period. In instances of the illness of a child, a total of 15 workweeks (600 hours) will have to be split between the two parents.

Where conditions exist that qualify an employee for FMLA leave, the Department may place the employee on FMLA leave status, requiring the employee to submit the appropriate forms and charge their leave under the FMLA leave status.

2. Parental Leave

Eligibility

Parental leave shall be granted by the County to employees who are eligible to earn annual leave for the responsibilities associated with the birth of his/her natural dependent child or the adoption of a child.

Request and Approval Process

An employee will be granted up to 40 hours of paid parental leave after submission of an approved FMLA package.

3. Responsibilities

Employees

Each employee of the Department should review this process. It is the individual employee's responsibility to understand and follow all procedures related to this General Order. Failure of the employee to comply



with this General Order may result in disciplinary action up to and including separation. Employees are also responsible for accurately completing all forms associated with the FMLA package. Each employee must comply with all time frames and the submission process, as outlined in this General Order.

- Maintain an adequate supply of FMLA forms available for Departmental use.

REFERENCES

N/A

FORMS/ATTACHMENTS

Attachment #1 - Request for Parental Leave, Family and Medical Leave (FMLA), Leave Without Pay (LWOP) (PGC Form #4471)

Attachment #2 - Certification of Health Care Provider form

Attachment #3 - Parental Leave and FMLA Request Checklist

Attachment #4 - Leave Request, PGC Form #305

Supervisors

Supervisors shall ensure that employees understand the FMLA procedure and process. Supervisors must comply with all time frames and the submission process, as outlined in this General Order. Supervisors shall monitor their employees leave usage and notify Risk Management if the Department may need to place an employee on FMLA leave.

Risk Management

Risk Management shall:

- Review all FMLA packages.
- Forward all approved FMLA packages to the Human Resources Division.
- Notify the appropriate Command of approved FMLA.
- Verify and approve all timesheets coded with FMLA.
- Maintain an adequate supply of FMLA forms available for Departmental use.

Human Resources Division

The Human Resources Division shall:

- Forward all FMLA packages to the OHRM for final approval.
- Notify Risk Management of FMLA approvals/disapprovals.

PRINCE GEORGE'S COUNTY GOVERNMENT

REQUEST FOR PARENTAL LEAVE, FAMILY AND MEDICAL LEAVE (FMLA), LEAVE WITHOUT PAY (LWOP)

Name SS# Dept.

Date of Hire Full-Time Part-Time

Current Home Address Home Phone

Work Phone

Name/Relationship if request for family member

Type of Leave Requested: (I understand under the County's Family and Medical Leave provisions, I am entitled to a total of 15 weeks of paid and unpaid leave, including 5 days (maximum of 40 hours) paid Parental Leave.)

Parental FMLA Sick FMLA Annual Begin Date End Date

Personal Days FMLA LWOP County LWOP Begin Date End Date

Reason for Leave (Explain)

NOTE: A leave request based on an employee's serious health condition or the serious health condition of an employee's spouse, child, parent or parent-in-law must be accompanied by a verifying medical certification from a physician (see Administrative Procedure 284, Attachment 11).

I hereby authorize Prince George's County Government, Office of Personnel & Labor Relations, to contact my physician to verify the reason for my requested leave or for any other information concerning my family and medical leave.

I understand that failure to return to work at the end of my leave period may be treated as a resignation unless an extension has been agreed upon and approved in writing by the Prince George's County Government.

Signature Date

APPROVED BY:

Appointing Authority Date Personnel Officer Date

Distribution: Employee Services - White Payroll - Green Appointing Authority - Pink Employee - Goldenrod Pensions and Benefits - Canary

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

1. Employee's Name:

2. Patient's Name (if different from employee):

3. The attached sheet describes what is meant by a "serious health condition" under the Family and Medical Leave Act. Does the patient's condition¹ 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:

5a. State the approximate date the condition commenced, and the probable duration of the condition (and also the probable duration of the patient's present incapacity² 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 incapacitated² and the likely duration and frequency of episodes of incapacity²:

6a. 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 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.

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 therefore, or recovery therefrom.

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):

7a. 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? _____

8a. 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)

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

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

(Employee Signature)

(Date)

A "Serious Health Condition" means an illness, injury, impairment, or physical or mental condition that involves one of the following:

1. Hospital Care

Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical facility, including any period of incapacity² or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

(a) A period of incapacity² of more than three consecutive calendar days (including any subsequent treatment or period of incapacity² relating to the same condition), that also involves:

- (1) Treatment³ two or more times by a health care provider, by a nurse or physician's assistant 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*
- (2) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment 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 for treatment by a health care provider, or by a nurse or physician's assistant 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 incapacity² (e.g., asthma, diabetes, epilepsy, etc.)

5. Permanent/Long-term Conditions Requiring Supervision

A period of incapacity² 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 incapacity² or 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 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.

PRINCE GEORGE'S COUNTY FIRE/EMS DEPARTMENT

Parental Leave & FMLA Request Checklist

The following documents are to be submitted to the employee's immediate supervisor, and forwarded within 48 hours to the Occupational Safety and Health Office (OSH). The request must be submitted **at least 30 days prior** to the expected use, if the need for leave is foreseeable.

- Request for Parental Leave, Family and Medical Leave (FMLA), Leave Without Pay (LWOP), 5-part form
 - Completed & signed by employee
 - Ensure dates, types, and amount of leave requested match Leave Request Form and Letter of Request to Fire Chief or appointed designee.
 - Reviewed and signed by Immediate Supervisor.

- Leave Request, PGC Form #305
 - Completed & signed by employee
 - At least one leave slip for each type of leave (Parental, FMLA Sick, FMLA Annual, FMLA LWOP) to be used. Depending upon the amount and types of leave to be used, two or more leave slips may be needed for one particular type of leave.
 - Ensure dates, types, and amount of leave requested match the Request for Parental Leave, Family and Medical Leave (FMLA), Leave Without Pay (LWOP) Form and Letter of Request to Fire Chief or appointed designee.
 - Signed by immediate supervisor and/or Battalion Chief.

- Letter of Intent to the Fire Chief or appointed designee
 - Prepared and initialed by employee.
 - Letter must state the dates of intended use and the justification for usage.
 - Ensure dates, types, and amount of leave requested match the Request for Parental Leave, Family and Medical Leave (FMLA), Leave Without Pay (LWOP) Form and Leave Request Forms.
 - Reviewed and initialed by immediate supervisor.

- Certification of Health Care Provider
 - Completed and signed by health care provider.

- Application for Acting Pay
 - If the FMLA leave request will result in the need for Acting Pay, the Battalion Chief should submit an Application for Acting Pay.

Immediate Supervisor _____ Date _____

Fire Chief or Appointed Designee _____ Date _____

Human Resources Division _____ Date _____

Office of Human Resources Management _____ Date _____