

# SPOKANE TRANSIT EMPLOYEE LEAVE REQUEST FORM

FAMILY and MEDICAL LEAVE (FMLA) \_\_\_\_\_

WASHINGTON FAMILY CARE (WFC) \_\_\_\_\_

- All FMLA leave requests will require medical certification completed by a health care provider.
- All WFC leave requests will require a doctor's certification completed the provider, or documentation from your child's school or daycare indicating your child was absent.

Employee's Name \_\_\_\_\_

Phone # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Department \_\_\_\_\_ Mail Box # if applicable \_\_\_\_\_

Date on Which Leave Will/Did Begin \_\_\_\_\_

Date You Expect to Return to Work \_\_\_\_\_

### Reason for Leave:

- \_\_\_\_\_ Prenatal Maternity Leave
- \_\_\_\_\_ Birth of Child
- \_\_\_\_\_ Care of Newborn Infant (within 12 months following birth)
- \_\_\_\_\_ Adoption or Foster Care of Child (within 12 months of placement)
- \_\_\_\_\_ Serious Health Condition of:
  - \_\_\_\_\_ Employee (Only FML)
  - \_\_\_\_\_ Spouse
  - \_\_\_\_\_ Son
  - \_\_\_\_\_ Daughter
  - \_\_\_\_\_ Parent
  - \_\_\_\_\_ Parent-in-law (Only WFC)
  - \_\_\_\_\_ Grandparent (Only WFC)

Please describe the serious health condition that necessitates this leave request.

Check box if this request is because of a work related incident

Type of Leave Requested \_\_\_\_\_ Consecutive Leave \_\_\_\_\_ Intermittent or Reduced Work Schedule

**Paid or Unpaid Leave:** According to STA policy employees are required to use paid leave prior to taking unpaid leave. Please indicate the number of hours, days or weeks of each type of leave you wish to use. You may retain up to forty hours of available paid sick and vacation leave for future use.

I wish to use \_\_\_\_\_ hours earned sick leave. Please retain \_\_\_\_\_ hours of my earned sick leave (40 max).

I wish to use \_\_\_\_\_ hours earned vacation leave. Please retain \_\_\_\_\_ hours of my earned vacation leave (40 max).

I wish to take \_\_\_\_\_ hours unpaid leave (only for approved FML).

I wish to use \_\_\_\_\_ floating holiday(s). I wish to use my birthday holiday. Yes \_\_\_\_\_ No \_\_\_\_\_

I understand the FMLA medical certification form is a federal document and that Section II of the form must be completed by a health care provider or their designated office staff, and signed by the health care provider. By signing this form I affirm that Section II of the FMLA forms and any other documents submitted were completed by a health care provider or their authorized office staff. I attest that the information I provided regarding my request for leave is correct and true.

Employee Signature \_\_\_\_\_

Date \_\_\_\_\_



**Certification for Serious Injury or Illness of a  
Current Servicemember for Military Caregiver Leave  
under the Family and Medical Leave Act**

**U.S. Department of Labor  
Wage Hour Division**



**DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR.  
RETURN TO THE PATIENT.**

OMB Control Number: 1235-0003  
Expires: 6/30/2023

The Family and Medical Leave Act (FMLA) provides that eligible employees may take FMLA leave to care for a covered servicemember with a serious illness or injury. The FMLA allows an employer to require an employee seeking FMLA leave for this purpose to submit a medical certification. 29 U.S.C. §§ 2613, 2614(c)(3). The employer must give the employee **at least 15 calendar days** to provide the certification. If the employee fails to provide complete and sufficient certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found [on the WHD website at www.dol.gov/agencies/whd/fmla](http://www.dol.gov/agencies/whd/fmla).

**SECTION I - EMPLOYER**

Either the employee or the employer may complete Section I. While use of this form is optional, it asks the health care provider for the information necessary for a complete and sufficient medical certification. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. § 825.310. Recertifications are not allowed for FMLA leave to care for a covered servicemember. Where medical certification is requested by an employer, an employee may not be held liable for administrative delays in the issuance of military documents, despite the employee's diligent, good-faith efforts to obtain such documents.** An employer requiring an employee to submit a certification for leave to care for a covered servicemember **must** accept as sufficient certification invitational travel orders (ITOs) or invitational travel authorizations (ITAs) issued to any family member to join an injured or ill servicemember at the servicemember's bedside. An ITO or ITA is sufficient certification for the duration of time specified in the ITO or ITA.

Employers must generally maintain records and documents relating to medical information, medical certifications, recertifications, or medical histories of employees or employees' family members created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

- (1) Employee name: \_\_\_\_\_  
*First Middle Last*
- (2) Employer name: \_\_\_\_\_ Date: \_\_\_\_\_ (mm/dd/yyyy)  
*(List date certification requested)*
- (3) This certification must be returned by: \_\_\_\_\_ (mm/dd/yyyy)  
*(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee's diligent, good faith efforts.)*

**SECTION II - EMPLOYEE and/or CURRENT SERVICEMEMBER**

Please complete all Parts of Section II before having the servicemember's health care provider complete Section III. The FMLA allows an employer to require that an employee submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a serious injury or illness of a covered servicemember. If requested by your employer, your response is required to obtain or retain the benefit of FMLA-protected leave.

**PART A: EMPLOYEE INFORMATION**

- (1) Name of the current servicemember for whom employee is requesting leave: \_\_\_\_\_

**Employee Name:** \_\_\_\_\_

(2) Select your relationship to the current servicemember. You are the current servicemember's:

- Spouse                       Parent                       Child                       Next of Kin

Spouse means a husband or wife as defined or recognized in the state where the individual was married, including a common law marriage or same-sex marriage. The terms "child" and "parent" include *in loco parentis* relationships in which a person assumes the obligations of a parent to a child. An employee may take FMLA leave to care for a covered servicemember who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave to care for a covered servicemember for whom the employee has assumed the obligations of a parent. No biological or legal relationship is necessary. "Next of kin" is the servicemember's nearest blood relative, other than the spouse, parent, son, or daughter, in the following order of priority: (1) a blood relative as designated in writing by the servicemember for purposes of FMLA leave, (2) blood relatives granted legal custody of the servicemember, (3) brothers and sisters, (4) grandparents, (5) aunts and uncles, and (6) first cousins.

**PART B: SERVICEMEMBER INFORMATION AND CARE TO BE PROVIDED TO THE SERVICEMEMBER**

(3) The servicemember ( is /  is not) a current member of the Regular Armed Forces, the National Guard or Reserves. If yes, provide the servicemember's military branch, rank and unit currently assigned to: \_\_\_\_\_

(4) The servicemember ( is /  is not) assigned to a 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. If yes, provide the name of the medical treatment facility or unit: \_\_\_\_\_

(5) The servicemember ( is /  is not) on the Temporary Disability Retired List (TDRL).

(6) Briefly describe the care you will provide to the servicemember: *(Check all that apply)*

- Assistance with basic medical, hygienic, nutritional, or safety needs  
 Psychological Comfort                       Physical Care  
 Transportation                       Other: \_\_\_\_\_

(7) Give your **best estimate** of the amount of leave needed to provide the care described: \_\_\_\_\_

(8) If a reduced work schedule is necessary to provide the care described, give your **best estimate** of the reduced work schedule you are able to work. From \_\_\_\_\_ (mm/dd/yyyy) to \_\_\_\_\_ (mm/dd/yyyy), I am able to work: \_\_\_\_\_ (hours per day) \_\_\_\_\_ (days per week).

**SECTION III - HEALTH CARE PROVIDER**

Please provide your contact information, complete all Parts of this Section fully and completely, and sign the form below. The employee listed at Section I has requested leave under the FMLA to care for a family member who is a current member of the Regular Armed Forces, the National Guard, or the Reserves who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list for a serious injury or illness. Note: For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty in the Armed Forces or that existed before the beginning of the member's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces that may render the servicemember medically unfit to perform the duties of the servicemember's office, grade, rank, or rating. "Need for care" includes both physical and psychological care. It includes situations where, for example, due to his or her serious injury or illness, the servicemember is not able to care for his or her own basic medical, hygienic, or nutritional needs or safety, or needs transportation to the doctor. It also includes providing psychological comfort and reassurance which would be beneficial to the servicemember who is receiving inpatient or home

**Employee Name:** \_\_\_\_\_

care. A complete and sufficient certification to support a request for FMLA leave due to a current servicemember's serious injury or illness includes written documentation confirming that the servicemember's injury or illness was incurred in the line of duty on active duty or if not, that the current servicemember's injury or illness 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 that the current servicemember is undergoing treatment for such injury or illness by a health care provider listed above.

**PART A: HEALTH CARE PROVIDER INFORMATION**

Health Care Provider's Name: *(Print)* \_\_\_\_\_

Health Care Provider's business address: \_\_\_\_\_

Type of practice/Medical specialty: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ E-mail: \_\_\_\_\_

Please select the type of FMLA health care provider you are:

- DOD health care provider
- VA health care provider
- DOD TRICARE network authorized private health care provider
- DOD non-network TRICARE authorized private health care provider
- Health care provider as defined in 29 C.F.R. § 825.125

**PART B: MEDICAL INFORMATION**

Please provide appropriate medical information of the patient as requested below. Limit your responses to the servicemember's condition for which the employee is seeking leave. If you are unable to make some of the military-related determinations contained below, you are permitted to rely upon determinations from an authorized DOD representative, such as a DOD recovery care coordinator. 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).

(1) Patient's Name: \_\_\_\_\_

(2) List the approximate date condition started or will start: \_\_\_\_\_ *(mm/dd/yyyy)*

(3) Provide your **best estimate** of how long the condition will last: \_\_\_\_\_

(4) The servicemember's injury or illness: *(Select as appropriate)*

- Was incurred in the line of duty on active duty.
- Existed before the beginning of the servicemember's active duty and was aggravated by service in the line of duty on active duty.
- None of the above.

(5) The servicemember ( is /  is not) undergoing medical treatment, recuperation, or therapy for this condition.

If yes, briefly describe the medical treatment, recuperation or therapy: \_\_\_\_\_

Employee Name: \_\_\_\_\_

- (6) The current servicemember's medical condition is classified as: *(Select as appropriate)*
- (VSI) Very Seriously Ill/Injured** Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately. *Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.*
  - (SI) Seriously Ill/Injured** Illness/injury is of such severity that there is cause for immediate concern, but there is no imminent danger to life. Family members are requested at bedside. *Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.*
  - OTHER Ill/Injured** A serious injury or illness that may render the servicemember medically unfit to perform the duties of the member's office, grade, rank, or rating.
  - NONE OF THE ABOVE.** *Note to Employee: If this box is checked, you may still be eligible to take leave to care for a covered family member with a "serious health condition" under 29 C.F.R. § 825.113 of the FMLA. If such leave is requested, you may be required to complete DOL FORM WH-380-F or an employer-provided form seeking the same information.*

**PART C: AMOUNT OF LEAVE NEEDED**

For the medical condition checked in Part B, complete all that apply. Some questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage.

- (7) Due to the condition, the servicemember will need care for a **continuous period of time**, including any time for treatment and recovery. Provide your **best estimate** of the beginning date \_\_\_\_\_ (mm/dd/yyyy) and end date \_\_\_\_\_ (mm/dd/yyyy) for this period of time.
- (8) Due to the condition, it is medically necessary for the servicemember to attend **planned medical treatment** appointments (scheduled medical visits). Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery \_\_\_\_\_ (e.g. 3 days/week)
- (9) Due to the condition, it is medically necessary for the servicemember to receive care on an **intermittent basis** (periodically), such as the care needed because of episodic flare-ups of the condition or assisting with the servicemember's recovery. Provide your **best estimate** of how often (frequency) and how long (the duration) the intermittent episodes will likely last.

Over the next 6 months, intermittent care is estimated to occur \_\_\_\_\_ times per (  day /  week /  month ) and are likely to last approximately \_\_\_\_\_ (  hours /  days ) per episode.

**Signature of Health Care Provider** \_\_\_\_\_ **Date** \_\_\_\_\_ (mm/dd/yyyy)

**PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT**

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years, in accordance with 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 number. The Department of Labor estimates that it will take an average of 15 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. 20210.

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