FMLA Fact Sheet

(Family and Medical Leave Act of 1993)

Submit all properly completed forms to:

NiSource
Attn: Cindy Owen – Sr. Leave Compliance Coordinator
801 E. 86th Ave
Merrillville, IN 46410
Scan to: leaveteam@nisource.com
Fax: (844) 229-3822 – Office: (219) 647-4453

** **Please complete page 2. Have your physician complete pages 3-5.** Once completed submit for review. The rest of the pages are for your information, please do not return.

Always contact your supervisor **first** when reporting off work (as soon as possible prior to your scheduled start time).

Completed FMLA packet must be received for review as soon as possible, no later than 30 days from the first day requesting.

Reasons to request FML Paperwork

- The birth of a child, or placement of a child with you for adoption or foster care;
- Your own serious health condition
- Because you are needed to care for your spouse, child, parent due to his/her serious health condition.
- Because of a qualifying exigency arising out of the fact that your spouse, son or daughter, parent is on active duty or call to active duty status in support of a contingency operation as a member of the Nation Guard or Reserves.
- Because you are the spouse, son or daughter, parent, next of kin of a covered service member with a serious injury or illness.

When applying for FMLA for yourself, a completed Sick Leave Claim form is needed along with the completed FMLA paperwork.

While waiting for your FML approval, you must call off as FMLA Pending and code your time sheet as FMLA Pending (if you are absent for the same reason you are applying for FML).

For example: If your FML request is for intermittent caregiver to your spouse, and you are absent to care for your spouse, you should call off and code your time sheet **FMLA Pending**. If you get the flu you will call off and code your time sheet and SICK-UNPAID.

If your FMLA request is approved, any **FMLA Pending** should be changed as per approval notice. See below examples:

- SICK-80-FMLA: Self if the employee has sick leave time and completed a Sick Leave Claim Form
- FMLA-APPROVED-UNP: Caregiver
- SICK-FMLA-UNPAID: Covered for Self but not eligible for sick leave payment

Once your FML has been approved if you exceed your frequency a sick leave claim form or an updated medical certification is needed. If your FMLA request is denied or exhausted, the employee is subject to the Attendance Policy.

If you have any questions please do not hesitate to contact Cindy Owen.

FMLA Request Form

(Family and Medical Leave Act of 1993)

Mail to: NiSource
Attn: Cindy Owen – Sr. Leave Compliance Coordinator
801 E. 86th Ave
Merrillville, IN 46410
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PLEASE COMPLETE AND RETURN THIS FORM TO CINDY OWEN 30 DAYS IN ADVANCE OF LEAVE IF POSSIBLE

EMPLOYEE INFORMATION

Employee Name (First, Last, Middle Initial)		**ID#**	
Home Address	**City**	**State**	**Zip**
Company	**Email**		
Supervisor	**Human Resource Consultant**		
Job Title/ Department	**Telephone Number** ☐ HOME ☐ CELL		
☐ Regular Full-time ☐ Regular Part-time ☐ Temporary	☐ Union ☐ Non-Union		

ABSENCE INFORMATION

☐ New Request	☐ Recertify
Requested Start Date:	Anticipated Return Date:

TYPE OF LEAVE

☐ Continuous Leave of Absence	☐ Intermittent Absence (information required below)

For Intermittent Absences, describe your intermittent or reduced work schedule (**e.g., "up to 2-3 sick days a month per doctor"). This must be medically necessary and documented in a current medical certification form from your health care provider.**

REASON(S) FOR LEAVE

Please indicate the applicable reason(s) for your leave below.

- ☐ The birth of a child, or placement of a child with you for adoption or foster care;
- ☐ Your own serious health condition
- ☐ Because you are needed to care for your ____ spouse; ____ child; ____ parent due to his/her serious health condition.
- ☐ Because of a qualifying exigency arising out of the fact that your ____ spouse; ____ son or daughter; ____ parent is on active duty or call to active duty status in support of a contingency operation as a member of the Nation Guard or Reserves.
- ☐ Because you are the ____ spouse; ____ son or daughter; ____ parent; ____ next of kin of a covered servicemember with a serious injury or illness.

HR USE ONLY

FMLA Eligible _____Yes; _____No Hours Worked:______________ Pay Group: ________________

Available FMLA: ______ hours System:____________________

Employee Signature (for paper forms):	**Date:**

Certification of Health Care Provider for EMPLOYEE's Serious Health Condition
(FAMILY AND MEDICAL LEAVE ACT)

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division
Revised: May 2015

SECTION I: For Completion by the EMPLOYER
INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertification's, or medical histories of employees 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 CFR § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name: ______________________________

Employee's job title: ______________________________

Employee's essential job functions: ______________________________

Check if job description is attached: ☐

SECTION II: For Completion by the EMPLOYEE
INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your Name: ______________________________
First **Last** **Employee ID**

SECTION III: For Completion by the HEALTH CARE PROVIDER
INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several 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. 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). Please be sure to sign the form on the last page.

Provider's name and business address: ______________________________

Type of practice / Medical specialty: ______________________________

Telephone: (   ) ______________________________

Fax: (   ) ______________________________

PART A: MEDICAL FACTS

1. Approximate date condition commenced: ____________________

Probable duration of condition: ____________________

Mark below as applicable:

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ☐ No ☐ Yes If so, dates of admission: ____________________

Date(s) you treated the patient for condition: ____________________

Will the patient need to have treatment visits at least twice per year due to the condition?
☐ No ☐ Yes

Was medication, other than over-the-counter medication, prescribed? ☐ No ☐ Yes

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? ☐ No ☐ Yes If so, state the nature of such treatments and expected duration of treatment: ____________________

2. Is the medical condition pregnancy? ☐ No ☐ Yes If so, expected delivery date: ____________

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition? ☐ No ☐ Yes

If so, identify the job functions the employee is unable to perform:

____

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

____
____
____

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ☐ No ☐ Yes

If so, estimate the beginning and ending dates for the period of incapacity: ____________

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ☐ No ☐ Yes
If so, are the treatments or the reduced number of hours of work medically necessary? ☐ No ☐ Yes

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period: ______________________

Estimate the part-time or reduced work schedule the employee needs, if any: __________ hour(s) per day; __________ days per week from __________ through __________

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ☐ No ☐ Yes

Is it medically necessary for the employee to be absent from work during the flare-ups?
☐ No ☐ Yes If so, explain: ______________________________________

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: __________ times per __________ week(s) __________ month(s)

Duration: __________ hours or __________ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER:

____

____

____

____

Signature of Health Care Provider **Date**

Return to:

Cindy Owen
Sr. Leave Compliance Coordinator
801 East 86th Ave.
Merrillville, IN 46410
Fax: (844) 229-3822
Office: (219)647-4453

Rights and Responsibilities (FAMILY AND MEDICAL LEAVE ACT)

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division
Revised: February 2013

In general, to be eligible an employee must have worked for an employer for at least 12 months, have worked at least 1,250 hours in the 12 months preceding the leave, and work at a site with at least 50 employees within 75 miles. While use of this form by employers is optional, a fully completed Form WH-381 provides employees with the information required by 29 C.F.R. § 825.300(b), which must be provided within five business days of the employee notifying the employer of the need for FMLA leave. Part B provides employees with information regarding their rights and responsibilities for taking FMLA leave, as required by 29 C.F.R. § 825.300(b), (c).

[Part A – NOTICE OF ELIGIBILITY]

TO: ______________________________

FROM: Cindy Owen Sr. Leave Compliance Coordinator

Date: __________ you informed us that you need leave beginning on __________ for:

☐ The birth of a child, or placement of a child with you for adoption or foster care;
☐ Your own serious health condition;
☐ Because you are needed to care for your ☐ spouse; ☐ child; ☐ parent due to his/her serious health condition.
☐ Because of a qualifying exigency arising out of the fact that your ☐spouse; ☐son or daughter; ☐parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves.
☐ Because you are the ☐ spouse ☐ son or daughter ☐ parent ☐ next of kin of a covered service member with a serious injury or illness.

This Notice is to inform you that you:

☐ Are eligible for FMLA leave (See Part B below for Rights and Responsibilities)
☐ Are **not** eligible for FMLA leave, because (only one reason need be checked, although you may not be eligible for other reasons)
 ☐ You have not met the FMLA's 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately ______ months towards this requirement.
 ☐ You have not met the FMLA's 1,250-hours-worked requirement.

[PART B-RIGHTS AND RESPONSIBILITIES FOR TAKING FMLA LEAVE]

As explained in Part A, you meet the eligibility requirements for taking FMLA leave and still have FMLA leave available in the applicable 12-month period. **However, in order for us to determine whether your absence qualifies as FMLA leave, you must return the following information to us within 15 calendar days from receipt of this notice.** If sufficient information is not provided in a timely manner, your leave may be denied.

☒ Sufficient certification to support your request for FMLA leave. A certification form that sets forth the information necessary to support your request is enclosed.
☐ Other information needed:
☐ No additional information requested

If your leave does qualify as FMLA leave you will have the following **responsibilities** while on FMLA leave (check applicable):

☒ Make arrangements to continue to make your share of the premium payments on your health insurance to maintain health benefits while you are on leave. You have a minimum 30-day grace period in which to make premium payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse, or, at our option, we may pay your share of the premiums during FMLA leave, and recover these payments from you upon your return to work.

☐ Due to your status within the company, you are considered a "key employee" as defined in the FMLA. As a "key employee," restoration to employment may be denied following FMLA leave on the grounds that such restoration will cause substantial and grievous economic injury to us. We ☐**have** ☐**have not** determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic harm to us.

☐ While on leave you will be required to furnish us with periodic reports of your status and intent to return to work every _____.

If the circumstances of your leave change and you are able to return to work earlier than the date indicated on the reverse side of this form, **you will be required to notify us at least two workdays prior to the date you intend to report for work.**

Rights and Responsibilities (FAMILY AND MEDICAL LEAVE ACT)

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division
Revised: February 2013

If your leave does qualify as FMLA leave you will have the following **rights** while on FMLA leave:

- You have a right under the FMLA for up to 12 weeks of unpaid leave in a 12-month period calculated as a "rolling" 12-month period measured backward from the date of any FMLA leave usage.
- You have a right under the FMLA for up to 26 weeks of unpaid leave in a single 12-month period to care for a covered service-member with a serious injury or illness.
- Your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work.
- You must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA-protected leave. (If your leave extends beyond the end of your FMLA entitlement, you do not have return rights under FMLA.)
- If you do not return to work following FMLA leave for a reason other than: 1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; 2) the continuation, recurrence, or onset of a covered service-member's serious injury or illness which would entitle you to FMLA leave; or 3) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave.
- You have the right to have **sick, vacation,** and/or **other leave** run concurrently with your unpaid leave entitlement, provided you meet any applicable requirements of the leave policy. Applicable conditions related to the substitution of paid leave are referenced or set forth below. If you do not meet the requirements for taking paid leave, you remain entitled to take unpaid FMLA leave.

*For a copy of conditions applicable to sick/vacation/other leave usage please refer to FMLA Policy available on MySource (Employee Info>HR Information>HR Policies & Procedures).

☐ Applicable conditions for use of paid leave

____
____
____

Return to: Cindy Owen

Sr. Payroll & Leave Coordinator

801 East 86th Ave.	Merrillville	IN	46410
Address	City	State	Zip

Once we obtain the information from you as specified above, we will inform you, within 5 business days, whether your leave will be designated as FMLA leave and count towards your FMLA leave entitlement. If you have any questions, please do not hesitate to contact Cindy Owen at 219/647-4453.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

It is mandatory for employers to provide employees with notice of their eligibility for FMLA protection and their rights and responsibilities. 29 U.S.C. § 2617; 29 C.F.R. § 825.300(b), (c). 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 number. 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 Ave., NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.**