**Logo, company name

Description automatically generated****FMLA Fact Sheet**(Family and Medical Leave Act of 1993)

**Submit all completed forms to:**

Email to: [Leaveteam@nisource.com](mailto:Leaveteam@nisource.com)

Fax: (844)229-3822

Completed FMLA Packet must be received as soon as possible, within 30 days of the first date requesting/used for consideration of approval.

Reasons to request FMLA 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.

\*\* Please complete pages 2 & 3 (FMLA Request Form & Section 2 of Certification of Health). Have your physician complete pages 4-6 (Certification of Health Care). Once completed submit for review. Pages 7 & 8 are for your information only, please do not return.

No employee is to code/use FMLA unless approved.

**FMLA is an unpaid benefit.** Depending on the circumstances sick leave or vacation may run concurrent with an employee’s approved FMLA.

Always contact your supervisor first when reporting off work (as soon as possible prior to your scheduled start time). If employee’s call off is related to their FMLA request/approval employee must communicate that with their supervisor.

Appointments should be scheduled outside of employee’s work hours when possible. Must notify supervisor when appointment is made if it interferes with work schedule.

Once employees completed FMLA request is received and reviewed, determination will be sent to employee, employee’s supervisor, and employee’s manager via email.

Employees who are out on a continuous approved FMLA during a holiday must code their timesheet as Holiday FML.

Once employee’s FMLA has been approved, an updated medical certification is needed when, circumstances have changed significantly, or employee has exceeded their estimated frequency. Employee is subject to the Attendance Policy if their FMLA is denied, or they exhaust their available FMLA hours.

**Sick leave – for employee’s serious health condition only**

Employee must submit a completed sick leave claim form with their FMLA packet to be reviewed for consideration of approval, to have sick leave (if available) run concurrent with their approved FMLA.

**If you have any questions, please do not hesitate to contact The Leave Team.**

[**Leaveteam@nisource.com**](mailto:Leaveteam@nisource.com)

**FMLA Request Form**(Family and Medical Leave Act of 1993)

Email to: Leaveteam@nisource.com  
Phone: (219)647-4453

Fax: (844) 229-3822

***Please complete and return this Form to the Leave Team 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 | Supervisor | | | |
| 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 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. | | | | |
| **Employee Acknowledgement** | | | | |
| **Employee Signature:** | | **Date:** | | |

**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 to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. 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’ 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.

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| --- | --- |
| Employer name: | NIPSCO Union |

**SECTION II: For Completion by the EMPLOYEE**

**INSTRUCTIONS to the EMPLOYEE:** Please complete Section II before giving this form to your family member or his/her 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 to care for a covered family member with a 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. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

|  |  |  |  |
| --- | --- | --- | --- |
| Your Name: |  |  |  |

First Last Employee ID

|  |  |  |  |
| --- | --- | --- | --- |
| Name of family member for whom you will provide care: |  |  |  |

First Last

Select the relationship of the family member to you: □ Spouse □ Parent □ Child, under age 18

□ Child, age 18 or older and incapable of self-care because of a mental or physical disability

Spouse means a husband or wife as defined or recognized in the state where the individual was married, including in 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 an individual 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 child for whom the employee has assumed the obligations of a parent. No legal or biological relationship is necessary.

Briefly describe the care you will provide to your family member: (Check all that apply)

 Assistance with basic medical, hygienic, nutritional, or safety needs  Transportation

 Physical Care  Psychological Comfort  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

If a reduced work schedule is necessary to provide the care described, give your best estimate of the reduced 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).

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Employee Signature Date

**SECTION III: For Completion by the HEALTH CARE PROVIDER**

**INSTRUCTIONS to the HEALTH CARE PROVIDER:** The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. 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 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). Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

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| --- | --- |
| Provider’s name and business address: |  |

|  |  |
| --- | --- |
| Type of practice / Medical specialty: |  |

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| --- | --- | --- | --- | --- |
| Telephone: | (     ) |  | Fax: | (     ) |

|  |  |
| --- | --- |
| Email : |  |

**PART A: MEDICAL FACTS**

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **1.** Approximate date condition commenced: |  |

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| --- | --- |
| Probable duration of condition: |  |

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

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| --- | --- |
| Date(s) you treated the patient for condition: |  |

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

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| --- | --- | --- |
| Will the patient need to have treatment visits at least twice per year due to the condition?  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: | |
|  |  |

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| --- | --- |
| **2.** Is the medical condition pregnancy?  No  Yes If so, expected delivery date: |  |

|  |  |
| --- | --- |
| **3.** Describe other relevant medical facts, if any, related to the condition for which the patient needs | |
| care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment | |
| such as the use of specialized equipment): |  |
|  | |

**PART B: AMOUNT OF CARE NEEDED:**

When answering these questions, keep in mind that your patient’s need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care.

|  |  |
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| **4.** Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery?  No  Yes | |
| Estimate the beginning and ending dates for the period of incapacity: |  |

|  |  |
| --- | --- |
| During this time, will the patient need care?  No  Yes Explain the care needed by the patient | |
| and why such care is medically necessary: |  |

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| **5.** Will the patient require follow-up treatments, including any time for recovery?  No  Yes. |

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| Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required | |
| for each appointment, including any recovery period: |  |
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| Explain the care needed by the patient, and why such care is medically necessary: |
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| **6.** Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery?  No  Yes |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Estimate the hours the patient needs care on an intermittent basis, if any: | | | | |  | | hour(s) per |
| day; |  | days per week from |  | through | |  | |

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| Explain the care needed by the patient, and why such care is medically necessary: |
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| **7.** Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities?  No  Yes |

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| --- |
| 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: \_\_\_\_\_\_\_Hour(s) or \_\_\_\_\_\_\_ day(s) per episode |

|  |
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| Does the patient need care during these flare-ups?  No  Yes |
| Explain the care needed by the patient, and why such care is medically necessary: | |
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**ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.**

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**Signature of Health Care Provider Date**

**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. 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 20 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 COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**

**Return to: Leave Team**

**Email: LeaveTeam@NiSource.com**

**Fax: (844) 229-3822**

**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).**

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TO:

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| --- | --- |
| NiSource Leave Team |  |

FROM:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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;

You are needed to care for your  spouse;  child under age 18;  child 18 or older incapable of self-care for mental or physical disability  parent

A qualifying exigency arising out of the fact that your spouse; child of any age; 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.

You are the  spouse  Child  parent  next of kin of a covered service member with a serious injury or illness.

**Section I – NOTICE OF ELIGIBILITY**

Eligible for FMLA leave (See Section II for any Additional Information Needed and Section III for Rights and Responsibilities)

**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.

**SECTION II – ADDITIONAL INFORMATION NEEDED**

As explained in Section I, 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.** Once we obtain any additional information specified below we will inform you, **within 5 business days**, whether your leave will be designated as FMLA leave and count towards the FMLA leave you have available. 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 isenclosed.

**SECTION III – NOTICE OF EMPLOYEE’S RIGHTS AND RESPONSIBLITES**

**Part A: FMLA Leave Entitlement** You have a right under the FMLA to take unpaid, job-protected FMLA leave in a 12-month period for certain family and medical reasons, including up to **12 weeks** of unpaid leave in a 12-month period for the birth of a child or placement of a child for adoption or foster care, for leave related to your own or a family member’s serious health condition, or for certain qualifying exigencies related to the deployment of a military member to covered active duty. You also have a right under the FMLA to take up to **26 weeks** of unpaid, job-protected FMLA leave in a single 12-month period to care for a covered service member with a serious injury or illness (*Military Caregiver Leave*).The 12-month period for FMLA leave is calculated as:

A “rolling” 12-month period measured backward from the date of any FMLA leave usage. *(Each time an employee takes FMLA leave, the remaining leave is the balance of the 12 weeks not used during the 12 months immediately before the FMLA leave is to start.)*

**Part B: Substitution of Paid Leave – When Paid Leave is Used at the Same Time as FMLA Leave**

You have a right under the FMLA to request that your accrued paid leave be substituted for your FMLA leave. This means that you can request that your accrued paid leave run concurrently with some or all of your unpaid FMLA leave, provided you meet any applicable requirements of our leave policy. Concurrent leave use means the absence will count against both the designated paid leave and unpaid FMLA leave at the same time. If you do not meet the requirements for taking paid leave, you remain entitled to take available unpaid FMLA leave in the applicable 12-month period. Even if you do not request it, the FMLA allows us to require you to use your available sick, vacation, or other paid leave during your FMLA absence.

□**Some or all of your FMLA leave will not be paid.** Any unpaid FMLA leave taken will be designated as FMLA leave and counted against the amount of FMLA leave you have available to use in the applicable 12-month period.

**SECTION III – NOTICE OF EMPLOYEE’S RIGHTS AND RESPONSIBLITES** (Cont.)

□**You have requested to use some or all of your available paid leave** *(e.g., sick, vacation, PTO)* during your FMLA leave. Any paid leave taken for this reason will also be designated as FMLA leave and counted against the amount of FMLA leave you have available to use in the applicable 12-month period.

□**We are requiring you to use some or all of your available paid leave** *(e.g., sick, vacation, PTO)* during your FMLA leave*.* Any paid leave taken for this reason will also be designated as FMLA leave and counted against the amount of FMLA leave you have available to use in the applicable 12-month period.

**Part C: Maintain Health Benefits** Your health benefits must be maintained during any period of FMLA leave under the same conditions as if you continued to work. During any paid portion of FMLA leave, your share of any premiums will be paid by the method normally used during any paid leave. During any unpaid portion of FMLA leave, you must continue to make any normal contributions to the cost of the health insurance premiums. To make arrangements to continue to make your share of the premium payments on your health insurance while you are on any unpaid FMLA leave, contact **Benefits Center at** **888-640-3320.**

**Part D: Other Employee Benefits** Upon your return from FMLA leave, your other employee benefits, such as pensions or life insurance*,* must be resumed in the same manner and at the same levels as provided when your FMLA leave began. To make arrangements to continue your employee benefits while you are on FMLA leave, contact **Benefits Center at 888-640-3320.**

**Part E: Return-to-Work Requirements** 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. An equivalent position is one that is virtually identical to your former position in terms of pay, benefits, and working conditions. At the end of your FMLA leave, all benefits must also be resumed in the same manner and at the same level provided when the leave began. You do not have return-to-work rights under the FMLA if you need leave beyond the amount of FMLA leave you have available to use.   
 **Part F: Other Requirements While on FMLA Leave** While on leave you will not be required to furnish us with periodic reports of your status and intent to return to work based on your current approval period.

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

**Return pages 2-6 to:**

**Leave Team –** [**leaveteam@nisource.com**](mailto:leaveteam@nisource.com)

**Fax: 844-229-3822**

**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.**

**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.**