



NASSAU COUNTY HUMAN RESOURCES

ONE WEST STREET  
MINEOLA, NEW YORK 11501-4895  
TEL. (516)-571-3072 FAX: (516)-571-4384

To: All Nassau County Employees

From: Office of Human Resources

Date: June 2012

Re: Nassau County's Family Medical Leave Act and Family Military Leave Policy (FMLA) (HR-02) and Nassau County's Domestic Partner Leave Policy (HR-04)

Nassau County is committed to providing a Family Medical Leave Policy and Family Military Leave Policy (FMLA) that complies with the Federal Family Medical Leave Act of 1993 (29 U.S.C. §2654 and 29 CFR 825.100 *et. seq.*). Nassau County is also committed to providing a Domestic Partner Leave Policy. A copy of the updated policies is being distributed to you (see attached).

In summary, the FMLA provides employees with up to 12 work weeks of unpaid *job protected leave with health benefits* during a 12 month period, subject to certain restrictions and eligibility requirements, for the birth, adoption or placement in foster care of a child; or for the care of a child, spouse or parent who has a serious health condition; or for a serious health condition that renders the employee unable to perform the functions of his/her position.


In addition, the FMLA provides employees unpaid *job protected leave with health benefits* during a 12 month period, subject to certain restrictions and eligibility requirements, when (i) they are providing care for a spouse, parent, child or next of kin who is a covered service member with a serious injury or illness ("Military Caregiver Leave"); or (ii) they have a "qualifying exigency" arising out of the fact that a "covered military member" who is the spouse, parent or child of the employee is on active duty or has been notified of an impending call or order to active duty in support of a contingency operation ("Qualifying Exigency Leave").

The Domestic Partner Leave Policy extends unpaid *job protected leave with health benefits* to eligible employees with domestic partners similar to those available under the FMLA Policy for employees with spouses.

The intent behind the policies is to allow employees to balance the demands of the workplace with the needs of their families in order to promote the stability and economic security of families. While leave under either policy is unpaid, you will be required to use your accrued leave entitlements while absent on leave. The policies do not replace any collective bargaining agreements, federal or state laws or local ordinances.

We are requiring that you sign an acknowledgement of receipt of the policies for our records.

If you have any questions regarding this policy, please contact your department's Human Resources representative.

<b>POLICY/PROCEDURE TITLE:</b> County-Wide Procedure HR-02 <b>FAMILY MEDICAL LEAVE and Family Military Leave</b>	<b>DATE ISSUED:</b> January 27, 2005 Updated June 2012
<b>DEPARTMENT ISSUING:</b> Office of Human Resources	<b>AUTHORIZED and SIGNED BY:</b> <b>Richard R. Walker</b>  Chief Deputy County Executive

<b>POLICY</b>	<p>The Family Medical Leave Act of 1993 (the “FMLA”) is intended to allow employees to balance the demands of the workplace with the needs of their families in order to promote the stability and economic security of families. The FMLA permits employees to take reasonable periods of unpaid leave for a serious health condition, for the birth, adoption or placement in foster care of a child, or for the care of a child, spouse or parent who has a serious health condition. In addition, the FMLA permits eligible employees to take unpaid leave when: (i) they are providing care for a spouse, parent, child or next of kin who is a covered service member with a serious injury or illness (“Military Caregiver Leave”); or (ii) they have a “qualifying exigency” arising out of the fact that a “covered military member” who is the spouse, parent or child of the employee is on active duty or has been notified of an impending call or order to active duty in support of a contingency operation (“Qualifying Exigency Leave”). Due to their specialized nature, the County’s procedures regarding Military Caregiver Leave and Qualified Exigency Leave are set forth separately in the Appendix to this Policy.</p> <p>The attached policy deals only with employee benefits under the FMLA; it does not include any additional benefits afforded to Nassau County employees under their respective collective bargaining agreements, other federal and state laws, local ordinances and laws, or County policies. Applicable collective bargaining agreements, federal and state laws, local ordinances and laws, and County policies must be consulted in order to coordinate them with an employee’s FMLA leave.</p>
<b>PURPOSE</b>	To establish a policy and guidelines for the use of FMLA leave for employees of Nassau County. The policy and guidelines described below are intended to advise employees of the County’s policies and procedures. It does not represent a complete description of the law or regulations, which can be found in 29 U.S.C. §2654 and 29 CFR 825.100 <i>et. seq.</i> respectively.
<b>SCOPE</b>	All Nassau County Departments and Agencies
<b>FORMS</b>	Form # 1 [intentionally omitted-see Domestic Partner Leave Policy]

	Form # 2	[intentionally omitted-see Domestic Partner Leave Policy]
	Form # 3	Leave Request Form
	Form # 4	Notice of Eligibility and Rights and Responsibilities
	Form # 5	Certification of Health Care Provider
	Form # 6A	Certification of Serious Injury or Illness of Covered Service member for Family Military Leave Act
	Form # 6B	Certification of Qualifying Exigency for Family Military Leave Act
	Form # 7	Notification of Return from Family Medical Leave
	Form # 8	Family Medical Leave Approval/Denial Letter

## I. DEFINITIONS

<b>A. DEFINITIONS</b>	<p>1) <b>CHILD:</b> "Child" means a biological, adopted or foster child, stepchild, legal ward, or child of a person acting as a parent, who is either under the age of eighteen (18); or who is eighteen (18) or older and incapable of self-care because of a mental or physical disability.</p> <p>2) <b>ELIGIBLE EMPLOYEE:</b> An employee* shall be entitled to family leave when he/she meets the following criteria as of the date FMLA Leave is to start:</p> <p>a) The person has been employed by Nassau County for at least twelve (12) months. The twelve (12) months of County employment need not have been consecutive months provided that employment periods prior to a break in service of seven years or more need not be counted. Employment periods preceding a break in service of more than seven years must be counted toward determining FMLA eligibility if the break in service is occasioned by the fulfillment of his or her National Guard or Reserve military service obligation. In determining if an employee has worked for the County for twelve (12) months, if the employee was maintained on the payroll for part of a week, including any periods of paid or unpaid leave (sick, vacation) during which other benefits or compensation are provided, the County will count the entire week; and</p> <p>b) The employee has actually worked for the County for at least 1,250 hours during the twelve (12) months preceding the leave (the total hours worked can include overtime.) Pursuant to USERRA, an employee returning from fulfilling his or her National Guard or Reserve military obligation shall be credited with the hours of service that would have been performed but for</p>
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the military service to determine if the employee performed the 1,250 hours of service.

- 3) **PARENT:** "Parent" means the biological, adoptive, step, or foster parent of an employee or an individual who acted as a parent to an employee when the employee was a child.
- 4) **QUALIFIED HEALTH CARE PROVIDER:** "Qualified health care providers" include
  - a) Doctors of medicine or osteopathy, podiatrists, dentists, clinical psychologists, optometrists, and chiropractors, nurse practitioners and nurse-midwives, clinical social workers and physician assistants who are authorized to practice under state law and who are performing within the scope of their practice under state law and Christian Science practitioners listed with First Church of Christ, Scientist in Boston, Massachusetts.
  - b) *Any health care provider* from whom the employer's group *health plan's* benefits manager will accept certification of the existence of a serious health condition to substantiate a claim for benefits.
  - c) A health care provider listed above who practices in a country other than the United States, who is authorized to practice in accordance with the law of that country, and who is performing within the scope of his or her practice as defined under such law.
- 5) **QUALIFYING LEAVE:** "Qualifying Leave" means leave taken for reasons relating to:
  - a) **The birth and care of a newborn child\*** (the FMLA entitlement will expire twelve (12) months from the date of the birth of the child; however, an expectant mother may take FMLA Leave before the birth if a serious health condition renders her unable to work, or for prenatal care);
  - b) **Placement with the employee of a child for adoption or foster care.\*** This leave may be taken before the actual placement or adoption of a child if an absence from work is required for the placement for adoption or foster care. (The FMLA entitlement expires at the end of the twelve (12) month period beginning on the date of placement of the child );
  - c) **To care for the employee's spouse, child or parent with a serious health condition;** or
  - d) A **serious health condition** that renders **the employee** unable to perform the functions of his/her position.
  - e) Any **qualifying exigency** arising out of the fact that the employee's spouse, child, or parent is a covered military member on active duty (or has been notified of an impending

call or order to active duty) in support of a contingency operation ; or

- f) **To care for a covered service member with a serious injury or illness** if the employee is the spouse, son, daughter, parent or next of kin to the service member.

\* Special rules apply when both spouses work for the County; see Calculation of Time - "Both Spouses Work for Nassau County" below.

6) **SERIOUS HEALTH CONDITION:** A "serious health condition" is defined in 29 CFR 825.114 to 825.117 as an illness, injury, impairment or physical or mental condition that includes any of the following:

- a) **Inpatient Care:** Inpatient care means 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.

- b) **Continuing Treatment:** 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:

- i) *Treatment two (2) or more times within thirty (30) days of the first day of incapacity 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 the orders of, or on referral by, a health care provider; or*

- ii) *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.*

- iii) *The requirement for treatment by a health care provider means an in person visit to a health care provider. The first (or only) in-person treatment visit must take place within seven days of the first day of incapacity.*

- c) **Chronic Conditions Requiring Treatments:** A chronic condition which:

- (i) *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; and*

- (ii) *Continues over an extended period of time (including recurring episodes of a single underlying condition); and*

- (iii) *May cause episodic rather than continuing periods of incapacity (e.g. asthma, diabetes, epilepsy, etc.)*

- d) **Permanent/Long-Term Conditions Requiring Supervision:** A

	<p>period of incapacity 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 from, a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.</p> <p>e) <b>Multiple Treatments (Non-Chronic Conditions):</b> 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 <i>restorative surgery</i> 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 for treatment, such as cancer (<i>chemotherapy, radiation, etc.</i>), severe arthritis (<i>physical therapy</i>), kidney disease (<i>dialysis</i>).</p> <p>f) <b>Pregnancy or Prenatal Care:</b> The mother is entitled to FMLA Leave for incapacity due to pregnancy, for prenatal care, or for her own serious health condition following the birth of a child. The mother is entitled to leave for incapacity due to pregnancy even though she does not receive treatment from a health care provider during the absence, and even if the absence does not last for more than three consecutive calendar days.</p> <p>g) <b>Non-Qualifying Conditions:</b> Routine physical exams, eye or dental exams, cosmetic treatments, cold, flu and earaches, upset stomach etc. that require only brief treatment and recovery are <i>not "serious health conditions" unless inpatient hospital care is required or complications develop.</i></p> <p>h) <b>Treatment for substance abuse</b> may be a serious health condition and is covered only if the conditions of FMLA are met. Leave may only be taken for treatment of substance abuse by a health care provider or by a provider of health care services on referral by a health care provider. Absence due to an employee's use of the substance, rather than for treatment, does <u>not</u> qualify for FMLA Leave.</p> <p>7) <b>SPOUSE:</b> "Spouse" means a husband or wife as defined or recognized under state law for purposes of marriage in the state where the employee resides.</p>
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## II. INTRODUCTION

As provided by the FMLA, all eligible employees shall be entitled to twelve (12) work weeks of unpaid, job-protected leave with health benefits during a twelve (12)-month period for qualifying leave as defined in clauses (a) through (e) of the above definition of "qualifying

leave.” In addition, “eligible employees” may take job- protected leave for up to a total of twenty-six (26) work weeks in a single twelve (12)-month period for a qualifying leave as defined in section (f) above.

Employees accrue leave benefits only while they remain in a paid status.

### III. REQUESTING FMLA LEAVE

All employees requesting leave under this Policy must complete the Leave Request Form [Form # 3] available from their Department Head, Department Human Resources Representative or from the Nassau County Human Resources (“County Human Resources”).

<p><b>A. WHERE TO FILE A FMLA LEAVE REQUEST</b></p>	<p>The employee shall file the Leave Request Form with the Department Human Resources Representative. If the Department Head approves the FMLA request, the Form should be filed in the employee’s personnel file – medical records section. The Department shall then forward a copy of the request to County Human Resources.</p>
<p><b>B. WHEN TO FILE A LEAVE REQUEST</b></p>	<ol style="list-style-type: none"> <li>1) Where the need to use FMLA Leave <i>is foreseeable</i>, an eligible employee must provide his or her Department Human Resources Representative with <i>at least thirty (30) days advance written notice</i> before the requested leave is to begin.</li> <li>2) If, under the circumstances, thirty (30) days notice is not practicable or if the need for leave is not foreseeable, the employee must notify his or her Department Human Resources Representative <i>as soon as practicable</i>.</li> <li>3) If due to circumstances the employee is unable to provide the Leave Request Form prior to the commencement of the leave, the employee must advise their Department Human Resource Representative that s/he is requesting a FMLA qualifying leave, and the anticipated timing and duration of the leave.</li> <li>4) If the Department is made aware that an employee is taking a qualifying FMLA Leave, the Department may require the employee to fill out any required forms under this Policy.</li> </ol>
<p><b>C. WHEN “MEDICAL CERTIFICATION” IS REQUIRED TO SUPPORT A REQUEST FOR FMLA LEAVE</b></p>	<ol style="list-style-type: none"> <li>1) An eligible employee requesting leave to care for the employee's spouse, child or parent with a <i>serious health condition</i>, or because of the employee's own serious health condition, is required to provide <b>medical certification</b> (on the form provided by the County, Form # 5) of the serious health condition <b>from a qualified health care provider</b>.</li> <li>2) This certification must be provided to the Department Human Resources Representative <i>within fifteen (15) calendar days</i> after</li> </ol>

	<p>the County requests it.</p> <p>3) Upon an employee's explanation of inability to provide such certification within fifteen (15) days, the County may grant a reasonable extension.</p> <p>4) If an employee provides an incomplete and or insufficient certification, the employee must cure the deficiencies within seven (7) calendar days from written notice by the County. The Department is not permitted to contact the employee's health care provider for any purposes. The County Human Resources department may only contact the employee's health care provider to verify the information contained on the certification and or to obtain clarification of a response that was on the certification.</p> <p>5) Failure to provide the required certification, or cure any deficiency in the certification or provide the recertification may result in refusal or discontinuance of the leave, as the case may be. If the leave is refused or discontinued, it ceases to have the protections afforded by the FMLA.</p>
<p><b>D. WHAT A MEDICAL CERTIFICATION MUST CONTAIN</b></p>	<p>1) The certification of a serious medical condition must be from a <i>qualified health provider</i> and must include the following:</p> <p>a) The name, address, telephone number, and fax number of the health care provider and type of medical practice/specialization.</p> <p>b) <i>The date when the condition began, the expected duration and a brief statement or description of appropriate medical facts regarding the patient's health condition. The medical facts should support the certification including a brief statement as to how the medical facts meet the criteria of a "serious health condition."</i> 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.</p> <p>c) If the employee is seeking medical leave for <i>his/her own</i> medical condition, certification should also include a statement that the employee is <i>unable to perform the essential functions</i> of the employee's position, as well as the nature of any other work restrictions, and the likely duration of such inability.</p> <p>d) If the employee is seeking leave to care for a seriously ill spouse, child or parent, the certification should include a statement that the <i>patient requires assistance and that the employee's presence would be beneficial or desirable.</i></p> <p>e) If an employee requests leave on an intermittent or reduced schedule basis, the certification should include information sufficient to establish the medical necessity for such intermittent or reduced schedule leave and an estimate of the</p>



	<p>frequency and duration of any incapacity. If the leave is requested for planned treatments the certification should also include the actual or estimated dates of treatment if known, duration of such treatments and period required for recovery if any.</p> <p>2) All information on the form must relate only to the condition for which the employee is requesting FMLA Leave.</p>
<b>E. THE PROCESS FOR REVIEWING A MEDICAL CERTIFICATION CONTESTED BY THE COUNTY</b>	<p>1) If the County challenges or contests the medical necessity for the leave, the County may ask for a <i>second medical opinion</i>. The County will pay for the employee to get a certification from a second health care provider who will be <i>selected by the County</i>.</p> <p>2) If there is a <i>conflict</i> between the original certification and the second opinion, the County may require the opinion of a third health care provider. The County and the employee will <i>jointly select the third</i> health care provider, and the County will pay for the opinion. The third <i>opinion will be considered final</i>.</p> <p>3) The County shall not select a health care provider who regularly contracts with the County for the second or third opinion.</p>
<b>F. PROOF REQUIRED FOR FMLA LEAVE TO CARE FOR A NEWBORN OR NEWLY ADOPTED CHILD OR A FOSTER CHILD</b>	<p>1) If the leave is for the birth and care of a newborn child; or placement with the employee of a child for adoption or foster care, <i>within fifteen (15) days of the birth or placement</i> of the child, the employee must provide:</p> <ul style="list-style-type: none"> <li>a) <i>A copy of the birth certificate</i>; or</li> <li>b) Proof of the adoption or foster care.</li> </ul>
<b>G. RECERTIFICATION</b>	<p>1) The County can seek medical recertification under the following conditions:</p> <ul style="list-style-type: none"> <li>a) If the medical certification states the employee will be absent for a specific time and the employee has not returned to work at the expiration of that time, the employee must submit a recertification for FMLA Leave.</li> <li>b) If the medical certification does not state the employee will be absent for a specific period of time, then the employee must provide recertification every thirty (30) days.</li> <li>c) If the medical certification indicates the employee will need intermittent or reduced schedule leave in excess of six (6) months, then the employee must provide recertification every six (6) months.</li> </ul>

#### IV. DESIGNATION AND DURATION OF FMLA LEAVE

The decision to designate leave as FMLA Leave rests with the Department. The County will designate all “qualifying leave” as FMLA Leave, even if the employee has not requested

that leave be under the FMLA. The Department will notify employees of the determination to place them on FMLA leave using a Leave Approval/Denial Letter [Form # 8].

<p><b>A. WHEN DOES AN EMPLOYEE'S FMLA LEAVE BEGIN TO RUN?</b></p>	<ol style="list-style-type: none"> <li>1) An employee's FMLA Leave period begins on the date that the qualifying reason renders the employee unable to work.</li> <li>2) The County <i>requires</i> employees to use all accrued leave time including, sick leave, vacation leave, personal leave, floating holidays and earned blood days <i>concurrently with FMLA Leave</i>. The determination of the type of leave that the employee may use may also depend on the terms and provisions of the respective collective bargaining agreements, state and federal and local laws and ordinances, and County policies.</li> <li>3) The balance of the FMLA Leave period remaining after the use of available accrued leave time will then consist of unpaid leave. If paid time is used for a FMLA Leave purpose, it will count toward the <i>twelve (12) weeks of leave</i> entitled under the FMLA. For example, <i>vacation, sick, supplemental sick leave (sick-leave half pay) or donated time or any other leaves will count as part of the twelve (12) weeks</i> when it is taken for a FMLA qualifying leave.</li> <li>4) Compensatory days may be used for a leave, but compensatory time earned pursuant to the FLSA does not run concurrently with FMLA Leave. Compensatory days accrued pursuant to the FLSA do not count towards FMLA entitlements.</li> </ol>
<p><b>B. EXTENSION OF FMLA LEAVE</b></p>	<ol style="list-style-type: none"> <li>1) An employee who has initially requested less than twelve (12) weeks of FMLA Leave and who requests <i>an extension</i> of FMLA Leave due to the continuation, recurrence or onset of her or his own serious health condition, or of the serious health condition of the employee's spouse, child or parent, must submit a request for an extension, in writing, to the employee's Department Human Resources Representative.</li> <li>2) This written request should be made immediately upon the employee's realization that she or he will not be able to return at the expiration of the leave period.</li> <li>3) The employee must provide medical certification of the employee's or the family member's serious health condition within fifteen (15) days from the request for an extension.</li> <li>4) If the request for an extension is due to the employee's serious health condition, the medical certification must also include a statement that the employee is unable to perform the essential functions of the employee's position.</li> <li>5) <i>FMLA Leave may not, however, be extended beyond twelve (12) weeks per year.</i></li> </ol>
<p><b>C. NOTICE OF RETURN</b></p>	<p>At the expiration of the approved FMLA period, the employee is required to report to duty, unless further leave has been granted. If,</p>

	however, the employee is not returning to duty on the date stated in the medical certification (either because the employee will be returning earlier or later than anticipated) or if the medical certification has no date, the employee must give the County reasonable notice (within two (2) business days) of the employee's return to work date.
<b>D. FAILURE TO RETURN TO WORK FOLLOWING END OF FMLA LEAVE</b>	If an employee utilizes all of his or her FMLA Leave time and fails to return to work from that leave, he or she shall be <i>deemed to have resigned unless further leave has been granted pursuant to an applicable collective bargaining agreement, or any other federal, state or local law or ordinance or County policy.</i> The employee will be notified of this, and their right to a hearing regarding this matter, by Human Resources. However, under the Workers' Compensation Law, an employee who is on leave from work due to a <i>work-related</i> injury will not be deemed to have resigned if he remains unable to work after the expiration of the FMLA Leave period.

**V. REINSTATEMENT TO WORK AFTER FMLA LEAVE**

An employee eligible for leave under this Policy - except an employee designated as a "key" employee, as defined under the FMLA whose restoration would cause substantial and grievous economic injury to Nassau County – will be restored to his or her *original position* or to an *equivalent position* with equivalent pay and benefits, and other terms and conditions of employment, except where existing collective bargaining agreements require otherwise. Nassau County cannot guarantee that an employee will be returned to his or her original job. County Human Resources will determine whether a position is an "equivalent position."

<b>A. PROCEDURE FOR REINSTATEMENT FOLLOWING A FMLA LEAVE</b>	An employee must notify his or her Department <i>at least two (2) business days prior to the employee's requested return</i> at which point a Notification of Return from Leave [Form # 7] must be completed and filed with Department Human Resources Representative.
<b>B. MEDICAL CERTIFICATIONS FOR REINSTATEMENT FOLLOWING A FMLA LEAVE</b>	<ol style="list-style-type: none"> <li>1) If an employee was on FMLA Leave due to the employee's own illness, the employee must submit a medical certification with regard to the particular health condition that caused the employee's need for FMLA Leave, attesting to the employee's fitness for duty prior to returning to work.</li> <li>2) If the employee fails to provide the medical certification, the employee will not be permitted to return to work and leave will no</li> </ol>

	<p>longer be protected under the FMLA.</p> <p>3) If an employee's medical certification contains restrictions or indicates a need for an accommodation, the employee's request must comply and be reviewed under the request for accommodation provisions contained in the Nassau County EEO policy.</p> <p>4) All return to work notes from health care providers must be reviewed by the Department's Human Resources <u>prior</u> to the employee being permitted to return to work.</p> <p>5) Employees on intermittent leave are not required to furnish a certification of fitness to return to duty.</p>
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## VI. CALCULATION OF LEAVE

Eligible employees can use up to twelve (12) work weeks of FMLA Leave during any twelve (12)-month period. The County will use a *rolling twelve (12)-month period measured backward from the date an employee first uses FMLA Leave*. Each time an employee uses FMLA Leave, the County computes the amount of qualified leave the employee has taken for FMLA Leave, subtracts it from the twelve (12) weeks, and the balance represents the amount of remaining FMLA Leave to which the employee is entitled. For example, if an employee has taken five (5) weeks of FMLA Leave for a qualifying reason the past twelve (12) months, he/she is eligible to take the remainder of seven (7) weeks of FMLA Leave.

<p><b>A. CALCULATION OF LEAVE FOR NEWLY BORN OR NEWLY PLACED CHILD</b></p>	<p>Leave for the birth and care of a newborn child or for placement with the employee of a child for adoption or foster care expires at the end of the twelve (12)-month period beginning on the date of the birth, adoption or placement of the child. <b>FMLA Leave for the birth and care of a newborn child or for the placement with the employee of a child for adoption or foster care must be concluded within this twelve (12)-month period.</b></p>
<p><b>B. ARE HOLIDAYS COUNTED AS PART OF THE FMLA LEAVE PERIOD?</b></p>	<p>Yes. A holiday that occurs during FMLA leave is counted day-for-day as FMLA Leave.</p>
<p><b>C. FMLA LEAVE CALCULATION WHEN BOTH SPOUSES WORK FOR</b></p>	<p>1) If both husband and wife are employed by Nassau County, they will be limited to <i>a total combined amount of leave of twelve (12) weeks for the birth or adoption of a son or daughter or to care for a parent</i> (note: care of a parent-in-law is not covered by the FMLA) with a serious health condition. If the couple uses only a part of the twelve</p>

<p><b>NASSAU COUNTY</b></p>	<p>(12) weeks of leave for either the birth or adoption of a child or to care for a sick parent who has a serious health condition, each could use the remainder of the twelve (12) weeks for another purpose. Each employee is entitled to twelve (12) weeks for his or her own personal medical leave.</p> <p>a) <b>For Example:</b> David and Jane, a married couple, both work for Nassau County. Jane gives birth to a child and takes six (6) weeks of leave subsequent to the birth of the child to care for her newborn. David would be entitled to take six (6) weeks to care for the newborn child. Together, David and Jane would have used the maximum twelve (12) week combined leave time to care for the birth of a child.</p> <p>2) The above limitation <i>does not apply if the leave is requested for either partner's own serious health condition, or for the couple's son or daughter's serious health condition.</i> For example, should an employee request twelve (12) weeks of leave because of his own serious health condition; his partner also could take twelve (12) weeks of leave to care for him. In addition, if the couple's child develops a serious illness, not including their own birth, each parent could take twelve (12) weeks of leave to care for the child.</p>
<p><b>D. CALCULATION OF LEAVE WHEN THE EMPLOYEE WORKS PART TIME OR REDUCED SCHEDULE</b></p>	<p>1) When an employee does not work a full time schedule, the amount of FMLA Leave that an employee uses is determined by the employee's actual work week. FMLA Leave is calculated on a pro rata or proportional basis of the employee's normal workweek.</p> <p>2) Example: The employee normally works twenty (20) hours. If the employee does not work an entire week, the employee has used one week of FMLA Leave.</p>

**VII. INTERMITTENT AND/OR REDUCED LEAVE**

"Intermittent leave" is leave taken in separate blocks of time due to a single qualifying reason. Examples include leave taken for medical appointments on a consistent basis (e.g., every Monday and Wednesday for several weeks), or leave taken several days at a time spread over a six (6)-month period, such as for chemotherapy.

A "reduced leave schedule" is defined as a leave schedule that reduces an employee's usual number of working hours per work week or hours per work day. This would include a situation where an employee is recovering from a serious health condition and has not sufficiently recovered to work a full-time schedule.

<p><b>A. WHEN MAY AN EMPLOYEE TAKE INTERMITTENT LEAVE OR A REDUCED LEAVE SCHEDULE?</b></p>	<p>1) An employee may take intermittent leave or a reduced leave schedule:</p> <ul style="list-style-type: none"> <li>a) For the birth or adoption (or foster care placement) of a son or daughter only if the Department Head consents to such an arrangement. Such a schedule reduction might occur, for example where an employee, with the County's agreement, works part-time after the birth of a child, or takes intermittent leave in several segments;</li> <li>b) When medically necessary for planned and/or unanticipated medical treatment of the employee's serious health condition by or under the supervision of a health care provider, or for recovery from treatment or recovery from a serious health condition; or</li> <li>c) To provide care or psychological comfort to a child, parent or spouse with a serious health condition. The medical certification for the serious health condition must indicate the medical necessity of intermittent leave or leave on a reduced leave schedule; or</li> <li>d) Because of any qualifying exigency arising out of the fact that the employee's spouse, child, or parent is a covered military member on active duty (or has been notified of an impending call or order to active duty) in support of a contingency operation; or</li> <li>e) To care for a covered service member with a serious injury or illness if the employee is the spouse, son, daughter, parent or next of kin of the service member.</li> </ul> <p>2) Intermittent leave or leave on a reduced work schedule can be flexible, based on the medical necessity.</p>
<p><b>B. CALCULATION FOR INTERMITTENT LEAVE OR REDUCED LEAVE SCHEDULE</b></p>	<p>Intermittent leave or leave taken on a reduced schedule will decrease the total amount of FMLA Leave by that amount actually taken. Leave taken intermittently will not affect the exempt status of an employee who is otherwise exempt from the overtime requirements of the Fair Labor Standards Act (FLSA).</p>
<p><b>C. SCHEDULING INTERMITTENT LEAVE OR REDUCED LEAVE SCHEDULES</b></p>	<p>If the need to use leave is foreseeable and based on preplanned and prescheduled medical treatment, then the employee shall, in consultation with the Department Head, attempt to schedule the treatment in a manner that does not unduly disrupt the County's operations, subject to the approval of the health care provider.</p>
<p><b>D. TEMPORARY TRANSFER OF EMPLOYEES</b></p>	<p>In some cases, the County may temporarily transfer an employee using intermittent FMLA or a reduced work week to a different job, with equivalent pay and benefits, if another position would better accommodate the intermittent or reduced schedule.</p>

## VIII. HEALTH INSURANCE

During a period of Family Medical Leave, an employee will be retained under Nassau County's insurance plans based upon the same conditions that applied if the employee had been continuously employed during the entire leave period.

<b>A. OBLIGATION TO PAY PREMIUMS DURING LEAVE</b>	Employees who are required to make contributions towards the cost of their insurance must continue to pay their portion of the premium in order to retain their coverage. An employee who fails to make his/her premium payments may be subject to notification and "grace" periods provided pursuant to the FMLA, lose the coverage, and may not be covered for any claims that may have occurred while on FMLA Leave.
<b>B. HEALTH INSURANCE FOLLOWING LEAVE</b>	<ol style="list-style-type: none"><li>1) Should the employee fail to return to work after the FMLA Leave expires, and the employee has exhausted all of their time and leave benefits, the employee must reimburse Nassau County for payment of health insurance premiums during the FMLA Leave, unless the failure to return is due to the presence of a serious health condition of the employee or the employee's family member which precludes the employee from performing his or her job or to circumstances beyond the employee's control.</li><li>2) Upon the expiration of FMLA Leave, the continuation of insurance coverage and the terms of said coverage will be determined by respective collective bargaining agreements, state and federal laws (including COBRA), local ordinances, and County policies.</li></ol>

## IX. CONFIDENTIALITY

Documents and records which relate to medical certifications, recertifications or medical histories of employee or employee's family members shall be treated as confidential medical records and shall be maintained in accordance with all applicable laws, rules, and regulations governing such records.

**X. AVAILABILITY AND DISTRIBUTION**

<p><b>A. AVAILABILITY AND DISTRIBUTION</b></p>	<ol style="list-style-type: none"><li>1) This Policy will be available to employees at the Human Resources units of Agencies and Departments throughout the County. This Policy is posted on the Nassau County Intranet.</li><li>2) New employees shall receive a copy of this Policy and contact Human Resources for further information. New employees are required to read the Policy and sign an acknowledgement and receipt that s/he has received the FMLA Policy.</li><li>3) FMLA request forms may be obtained by contacting the Human Resources Representative within your Department and/or the Nassau County Intranet.</li><li>4) If there is an accompanying Frequently Asked Questions (FAQ), and there is a conflict between the FAQ and the policy rules, the Policy will control.</li></ol>
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**XI. COMPLAINTS**

<p><b>A. PLACES TO FILE A COMPLAINT</b></p>	<p>Any person who believes that s/he has experienced a violation of this Policy has a right to file a formal complaint with the United States Department of Labor.</p> <p><b>a) United States Department of Labor</b> 1400 Old Country Road Westbury, New York Phone: (516) 338-1890</p>
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## MILITARY FMLA LEAVE APPENDIX

### XII. DEFINITIONS

#### A. DEFINITIONS

**1) AUTHORIZED HEALTH CARE PROVIDER:** For purposes of Military Caregiver Leave, an “Authorized Health Care Provider” means either: (i) a United States Department of Defense (“DOD”) health care provider; (ii) a United States Department of Veterans Affairs (“VA”) health care provider; (iii) a DOD TRICARE network authorized private health care provider; or (iv) a DOD non-network TRICARE authorized health care provider.

**2) COVERED SERVICEMEMBER:** “Covered servicemember” means:

(a) a current member of the Armed Forces (including a member of the National Guard or Reserves), who is undergoing medical treatment, recuperation, or therapy, or is otherwise in outpatient status, or on the temporary disability retired list, for a serious injury or illness; or

(b) a veteran who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness. The veteran must have been a member of the Armed Forces (including a member of the National Guard or Reserves) at any time during the *five (5) years prior* to that medical treatment.

**3) CHILD OF A COVERED SERVICEMEMBER:** A “child of a covered servicemember” is an individual of any age whose “parent” is a “covered servicemember.”

**4) NEXT OF KIN OF A COVERED SERVICEMEMBER:** “Next of kin of a covered servicemember” means the nearest blood relative other than the covered servicemember’s spouse, parent or child, in the following order of priority: Blood relatives who have been granted legal custody of the covered servicemember by court decree or statutory provisions; brothers and sisters; grandparents; aunts and uncles; and first cousins, unless the covered servicemember has specifically designated in writing another blood relative as his or her nearest blood relative for military caregiver leave under the FMLA.

**5) OUTPATIENT STATUS:** “Outpatient status” with respect to a covered servicemember, means the status of a member of the Armed Forces assigned to either a military medical treatment facility as an outpatient or a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients.

	<p><b>6) SERIOUS INJURY OR ILLNESS:</b> “Serious injury or illness” means:</p> <p>(a) for a <i>current member</i> of the Armed Forces, an injury incurred in the line of duty on active duty, or an injury that existed prior to active duty and was aggravated by service in the line of duty on active duty, that may render the member medically unfit to perform the duties of the member’s office, grade, rank, or rating.</p> <p>(b) for a <i>veteran</i> (where eligible as a covered servicemember, above), a qualifying injury or illness that was incurred by the member in the line of duty on active duty, or an injury that existed prior to active duty and was aggravated by service in the line of duty on active duty. The injury may manifest itself either before or after the member becomes a veteran.</p> <p>* Note: “Qualifying” injuries and illnesses are to be defined by the Secretary of Labor, but no definitions have yet been released.</p> <p><b>7) VETERAN:</b> “Veteran” means a person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions <i>other than dishonorable</i>.</p>
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### MILITARY CAREGIVER LEAVE

#### XIII. REQUESTING MILITARY CAREGIVER LEAVE

Like other types of FMLA Leave, employees should submit requests for Military Caregiver Leave on Form #3 to their Department Head. All other procedures in the main Policy for requesting FMLA Leave to care for an immediate family member with a Serious Health Condition also apply to Military Caregiver Leave, except as provided below.

<p><b>A. WHEN “CERTIFICATION” IS REQUIRED TO SUPPORT A REQUEST FOR MILITARY CAREGIVER LEAVE</b></p>	<p>1) In general, an eligible employee requesting leave to care for the employee's spouse, child, parent or next-of-kin who is a <i>covered servicemember with a serious injury or illness incurred in or aggravated by service in the line of duty on active military duty</i>, is required to provide <b>certification</b> (on the form provided by the County, Form # 6A) of the serious injury or illness <b>from an Authorized Health Care Provider</b>.</p> <p>a) In lieu of a Certification, an eligible employee may submit Invitational Travel Orders (“ITOs”) or Invitational Travel Authorizations (“ITAs”) issued by a branch of the Armed Forces to any family member (regardless of whether or not this family member is the employee) to join an injured or ill servicemember at his or her bedside. The ITO or ITA is sufficient certification for the time period specified in the ITO or ITA, but if the individual named in the ITO or ITA is not the employee, the</p>
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	<p>County may require the employee to submit documentation that the injured or ill covered servicemember is the employee's spouse, child, parent or next-of-kin.</p> <p>b) This certification must be provided to the Department Human Resources Representative <i>within fifteen (15) calendar days</i> after the County requests it.</p> <p>2) Upon an employee's explanation of inability to provide such certification within fifteen (15) days, the County may grant a reasonable extension.</p> <p>3) If an employee provides an incomplete and/or insufficient certification, the employee must cure the deficiencies within seven (7) calendar days from written notice by the County. The employee's Department is not permitted to contact the employee's health care provider for any purposes. County HR may contact the employee's health care provider only to verify the information contained on the certification and/or to obtain clarification of a response that was on the certification.</p> <p>4) The County may <i>not</i> require the employee to provide <i>recertification</i> of a serious illness or injury of a covered servicemember, nor may the County require second or third medical opinions to confirm a medical certification provided by an Authorized Health Care Provider.</p> <p>5) An employee's failure to provide the required certification, or cure any deficiency in the certification may result in refusal or discontinuance of the leave, as the case may be. If the leave is refused or discontinued, it ceases to have the protections afforded by the FMLA.</p>
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**B. WHAT A CERTIFICATION MUST CONTAIN**

The certification of a serious illness or injury of a covered servicemember must include all the information required by Form 6A attached to this Policy.

1) *The Authorized Health Care Provider must provide the following information:*

- a) The name, address, telephone number, and fax number of the health care provider, the type of medical practice/specialization, and to which of the four categories of "authorized" providers the health care provider belongs;
- b) Whether the covered servicemember's injury or illness was incurred or aggravated by service in the line of duty while on active duty;
- c) The approximate date on which the serious illness or injury commenced and its probable duration;
- d) A statement or description of appropriate medical facts regarding the covered servicemember's health condition for which FMLA Leave is requested. The medical facts must be sufficient to support the need for leave. Such medical facts must include information on whether the injury or illness may render the covered servicemember medically unfit to perform the duties of the servicemember's office, grade, rank, or rating and whether the member is receiving medical treatment, recuperation or therapy;
- e) Information sufficient to establish whether the covered

servicemember is in need of care, and whether the covered servicemember will need care for a single continuous period of time, including any time for treatment and recovery, and an estimate as to the beginning and ending dates for this period of time;

- f) If an employee requests leave on an intermittent or reduced schedule basis for planned medical treatment appointments for the covered servicemember; whether there is a medical necessity for the covered servicemember to have such periodic care and an estimate of the treatment schedule of such appointments; and
  - g) If an employee requests leave on an intermittent or reduced schedule basis to care for a covered servicemember other than for planned medical treatment (e.g., episodic flare-ups of a medical condition), whether there is a medical necessity for the covered servicemember to have such periodic care, which can include assisting in the covered servicemember's recovery, and an estimate of the frequency and duration of the periodic care.
- 2) *The employee and/or covered servicemember must provide the following information:*
- a) The names of the employee and covered servicemember and their relationship;
  - b) Whether the covered servicemember is a current member of the Armed Forces, the National Guard or Reserves and their military branch, rank and current unit assignment, or whether the covered servicemember is a veteran;
  - c) Whether the covered servicemember is assigned to a military medical 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) and the name of the medical treatment facility or unit;
  - d) Whether the covered servicemember is on the temporary disability retired list; and
  - e) A description of the care to be provided to the covered servicemember by the employee and an estimate of the leave needed to provide the care.

#### **XIV. DESIGNATION, DURATION AND CALCULATION OF MILITARY CAREGIVER LEAVE**

Military Caregiver Leave may be taken for up to twenty six (26) weeks in any "single twelve month period." Like other types of FMLA Leave which are calculated on a "rolling 12 month period", the single twelve (12)-month period for calculating Military Caregiver Leave begins the first day that an employee takes leave to care for a covered servicemember and ends twelve (12) months after that day.

The leave entitlement is to be applied on a per-covered servicemember, per injury basis, so that an employee can take more than one twenty six (26)-week period of leave to care for a different service member or for the same servicemember with a different injury, but cannot take more than twenty six (26) weeks of leave in total during any single twelve (12)-month period. Spouses who are both employed by Nassau County are limited to a combined twenty six (26) weeks of Military Caregiver Leave in any single twelve (12)-month period. Military Caregiver Leave for employees working on a part-time or reduced schedule is calculated on a pro rata basis, like general FMLA Leave. Military Caregiver Leave may be taken on an intermittent or reduced leave schedule subject to the policies and procedures described in Section VII of the main FMLA Policy.

The general procedures for designating FMLA Leave and notifying employees of this designation apply equally to Military Caregiver Leave. When requested leave qualifies as both Military Caregiver leave and as leave to care for a family member with a “serious health condition”, the leave should be designated in the first instance as Military Caregiver Leave and counted solely against the employee’s entitlement to Military Caregiver Leave. Thus, for example, an eligible employee would not be precluded from taking twenty (20) straight weeks of Military Caregiver Leave, even though this leave could also qualify as leave to care for a family member with a serious health condition, which would be limited to twelve (12) weeks in any twelve (12)-month period. In addition, even after taking twenty (20) weeks of Military Caregiver Leave, an employee could immediately then take up to six (6) weeks of leave that would not qualify as Military Caregiver Leave, but would qualify as leave to care for a family member with a serious health condition. However, since the employee would be limited to *twenty six (26) weeks of combined Military Caregiver Leave and non-military caregiver FMLA Leave* in the single twelve (12)-month period, the employee could not take more than six (6) weeks of leave to care for a family member with a serious health condition.

## **XV. REINSTATEMENT TO WORK, INTERMITTENT LEAVE, HEALTH INSURANCE AND CONFIDENTIALITY**

The same rules and procedures as apply generally under the main FMLA Policy to employees who take FMLA Leave to care for a family member with a serious health condition apply to Military Caregiver Leave.

## XVI. QUALIFYING EXIGENCY LEAVE

All relevant definitions, procedures, and policies contained in the main FMLA Policy apply to Qualifying Exigency Leave, except as outlined below.

<b>A. DEFINITIONS</b>	<p><b>1) COVERED ACTIVE DUTY OR CALL TO COVERED ACTIVE DUTY STATUS:</b> Covered active duty is defined by Section 2611 of Title 29 of the United States Code, and, for regular members of the Armed Forces, includes duty during deployment with the Armed Forces <i>to a foreign country</i>, or notification of an impending call or order to that duty. For members of a <i>reserve component</i> of the Armed Forces, it refers to duty during deployment <i>to a foreign country under a call or order to active duty</i> under certain provisions of law, or notification of an impending call or order to that duty.</p> <p><b>2) COVERED MILITARY MEMBER</b> – “Covered military member” means the employee’s spouse, son, daughter, or parent who is on covered active duty or call to covered active duty status.</p> <p>For purposes of the definition of covered military member <i>only</i>, son or daughter includes the employee's biological, adopted, or foster child, stepchild, legal ward, or a child to whom the employee acted as a parent. This child must be on covered active duty or call to covered active duty status, and may be <i>of any age</i>.</p>
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## XVII. ELIGIBILITY FOR QUALIFYING EXIGENCY LEAVE

Employees are eligible for Qualifying Exigency Leave if they meet the definition of “eligible employee” set forth in the main Policy, and if they meet the conditions described below.

<b>A. WHAT CONSTITUTES A QUALIFYING EXIGENCY?</b>	<p>Qualifying Exigency Leave may be taken in the following situations:</p> <p><b>1) Short Notice Deployment:</b> Leave to address issues that arise from the fact that a covered military member is deployed to covered active duty with seven (7) or fewer days notice. This leave may only be taken <i>for seven (7) days beginning on the date the covered military member is notified</i>.</p> <p><b>2) Military Events and Related Activities:</b></p> <ul style="list-style-type: none"><li>a) Leave to attend official ceremonies, programs or events sponsored by the military; or</li><li>b) Leave to attend family support or assistance programs and informational briefings sponsored or promoted by the military, military service organizations, or the American Red Cross.</li><li>c) All activities must be related to the <i>covered active duty or call to covered active duty status</i> of a covered</li></ul>
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military member.

**3) Childcare and School Activities:**

- a) Leave may be taken to
  - i) *Arrange for alternative childcare;*
  - ii) *Provide childcare on an urgent, immediate basis.* The childcare may not be on a routine, regular, or everyday basis;
  - iii) *Enroll in or transfer to a new school or day care facility;*
  - iv) *Attend meetings with staff at a school or daycare facility,* such as meetings with school officials regarding disciplinary measures, parent-teacher conferences, or meetings with school counselors.
- b) Leave may be taken under this Section only where the need for the childcare or other activities arises from a covered military member's *covered active duty or call to covered active duty status.*
- c) Leave may be taken only for the care or school activities of a child who is
  - i) a biological, adopted, or foster child, a stepchild, or a legal ward of a covered military member, or a child to whom a covered military member acted as a parent; and
  - ii) Either under age eighteen (18), or age eighteen (18) or older and incapable of self-care because of a mental or physical disability at the time that FMLA Leave is to commence.

**4) Financial and Legal Arrangements:**

- a) Leave to *make or update financial or legal arrangements to address the covered military member's absence* while on covered active duty or call to covered active duty status, such as:
  - i) Preparing and executing financial and healthcare powers of attorney;
  - ii) Transferring bank account signature authority;
  - iii) Enrolling in the Defense Enrollment Eligibility Reporting System (DEERS);
  - iv) Obtaining military identification cards; or
  - v) Preparing or updating a will or living trust.
- b) Leave to *act as the covered military member's representative before a government agency in order to obtain, arrange, or appeal military service benefits.* Leave may be taken for this purpose while the covered military member is on covered active duty or call to covered active duty status, and for ninety (90) days after covered active duty status is terminated.

**5) Counseling:**

- a) Leave may be taken to attend counseling provided by someone *other than a health care provider.* The counseling may be for
  - i) The employee;

	<ul style="list-style-type: none"> <li>ii) The covered military member; or</li> <li>iii) A child who is <ul style="list-style-type: none"> <li>(1) the biological, adopted, or foster child, a stepchild, or a legal ward of the covered military member, or a child to whom the covered military member acted as a parent; <b>and</b></li> <li>(2) Either under age eighteen (18), or age eighteen (18) or older and incapable of self-care because of a physical or mental disability at the time that FMLA Leave is to commence.</li> </ul> </li> <li>b) To be eligible for leave under this category, the <i>need for counseling must arise from the covered active duty or call to covered active duty status</i> of a covered military member.</li> <li>6) <b>Rest and Recuperation:</b> Leave to spend time with a covered military member who is on short-term, temporary, rest and recuperation leave during the period of deployment. Leave is limited to <u>five (5) days</u> for each instance of rest and recuperation.</li> <li>7) <b>Post Deployment Activities:</b> <ul style="list-style-type: none"> <li>a) Leave to attend <i>arrival ceremonies, reintegration briefings and events</i>, and any other official ceremony or program sponsored by the military. This leave may be taken for a period of ninety (90) days following the termination of the covered military member's covered active duty status.</li> <li>b) Leave to address issues that arise from the <i>death of a covered military member</i> while on covered active duty status, such as meeting and recovering the body of the covered military member and making funeral arrangements.</li> </ul> </li> <li>8) <b>Additional Activities:</b> Leave may be taken to address other events which arise out of the covered military member's covered active duty or call to covered active duty status <i>only where the County and employee agree that the leave shall qualify as an exigency</i>. The employer and employee must also agree to both the timing and the duration of this leave.</li> </ul>
<p><b>B. WHICH SERVICEMEMBER'S FAMILIES ARE ELIGIBLE FOR THIS LEAVE?</b></p>	<p>Qualifying Exigency Leave is available to the families of covered military members where the covered military member is on covered active duty or call to covered active duty status. This includes members of the <i>Regular Armed Forces or members of the reserve components</i> (Army National Guard of the United States, Army Reserve, Navy Reserve, Marine Corps Reserve, Air National Guard of the United States, Air Force Reserve and Coast Guard Reserve), and <i>retired members of the Regular Armed Forces or Reserve</i>.</p>



**XVIII. REQUESTING QUALIFYING EXIGENCY LEAVE**

Employees should submit requests for Qualifying Exigency Leave on Form # 6B to their Department Head, as they would for other types of FMLA Leave. All other relevant procedures for requesting FMLA Leave as set forth in the main Policy should be followed for a request for Qualifying Exigency Leave, except as provided below.

<p><b>A. WHEN TO FILE A QUALIFYING EXIGENCY LEAVE REQUEST</b></p>	<ol style="list-style-type: none"> <li>1) Where the need for Qualifying Exigency Leave is <i>foreseeable</i>, the employee must provide his or her Department Head and Department Human Resources Representative with written notice <i>as soon as practicable</i>, regardless of how far in advance such leave is foreseeable.</li> <li>2) Where the need for Qualifying Exigency Leave is not foreseeable, the employee must also provide notice <i>as soon as practicable</i>.</li> <li>3) The notice must state that a covered military member is on covered active duty or call to covered active duty status, and that the requested leave is for one of the reasons listed in "What Constitutes a Qualifying Exigency," above.</li> </ol>
<p><b>B. CERTIFICATION REQUIRED TO SUPPORT A REQUEST FOR QUALIFYING EXIGENCY LEAVE; WHEN TO PROVIDE CERTIFICATION</b></p>	<ol style="list-style-type: none"> <li>1) An eligible employee requesting Qualifying Exigency Leave is required to provide <b>certification</b> (in the form provided by the County, Form # 6B).</li> <li>2) This certification must be provided to the Department Human Resources Representative <i>within fifteen (15) calendar days</i> after the County requests it.</li> <li>3) Upon an employee's explanation of inability to provide such certification within fifteen (15) days, the County may grant a reasonable extension.</li> <li>4) If an employee provides an incomplete and/or insufficient certification, the employee must cure the deficiencies within seven (7) calendar days from written notice by the County.</li> <li>5) An employee's failure to provide the required certification, or cure any deficiency in the certification may result in refusal or discontinuance of the leave, as the case may be. If the leave is refused or discontinued, it ceases to have the protections afforded by the FMLA.</li> </ol>
<p><b>C. WHAT A CERTIFICATION FOR MILITARY EXIGENCY MUST CONTAIN</b></p>	<ol style="list-style-type: none"> <li>1) The certification supporting a request for Qualifying Exigency must include all the information required by Form #6B attached to this Policy. The following must be provided:             <ol style="list-style-type: none"> <li>a) A copy of the covered military member's <i>active duty orders</i> or other documentation issued by the military which indicates that the covered military member is on covered active duty or call to covered active duty status, and <i>the dates</i> of the active duty service.                 <ol style="list-style-type: none"> <li>i) This information need only be provided once. However, a copy of new active duty orders or</li> </ol> </li> </ol> </li> </ol>

	<p>other documentation shall be provided where a request for Qualifying Exigency Leave arises out of a <i>different</i> covered active duty or call to covered active duty status of the same or a different covered military member.</p> <p>b) A statement or description of the reason(s) the employee is requesting leave, including facts sufficient to support the need for leave. This should include:</p> <ul style="list-style-type: none"> <li>i) The type of Qualifying Exigency for which leave is requested; and</li> <li>ii) Any available written documentation supporting the request. For example, this may include a copy of a meeting announcement for informational briefings sponsored by the military, a document confirming an appointment with a counselor or school official, or a copy of a bill for services for the handling of legal or financial affairs.</li> <li>iii) This statement must be <i>signed by the employee</i>.</li> </ul> <p>2) The amount of leave needed, including:</p> <ul style="list-style-type: none"> <li>a) The approximate date on which the exigency commenced or will commence; and</li> <li>b) Where the employee requests leave for a <i>single, continuous</i> period of time: the beginning and end dates of absence.</li> <li>c) Where the employee requests leave on an <i>intermittent or reduced schedule</i> basis: an estimate of the frequency and duration of the exigency; the estimated schedule of leave.</li> </ul> <p>3) If the exigency involves meeting with a third party, the employee must provide:</p> <ul style="list-style-type: none"> <li>a) Appropriate contact information for the individual or entity with whom the employee is meeting (such as the name, title, organization, address, telephone number, fax number, and email address); and</li> <li>b) A brief description of the purpose of the meeting.</li> </ul>
<p><b>D. WHAT VERIFICATION THE COUNTY MAY OBTAIN</b></p>	<ul style="list-style-type: none"> <li>1) If an employee submits a complete and sufficient certification supporting his or her request for Qualifying Exigency Leave, the County may not request additional information from the employee.</li> <li>2) However, if the exigency involves meeting with a third party, the County may contact the third party in order to verify a meeting or appointment schedule and the nature of the meeting.</li> <li>3) The County also may contact an appropriate unit of the Department of Defense to request verification that a covered military member is on covered active duty or call to covered active duty status.</li> <li>4) The employee's permission is not required for these</li> </ul>

	verifications, but the County may not request any additional information.
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## **XIX. DURATION AND TIMING OF QUALIFYING EXIGENCY LEAVE**

Eligible employees can use up to twelve (12) work weeks of non-military FMLA leave *and* Qualifying Exigency Leave **combined** during any twelve (12)-month period; the *total* FMLA leave for non-military FMLA leave *and* Qualified Exigency Leave may not exceed twelve (12) weeks during a twelve (12)-month period. As stated in the main policy, *the County uses a rolling twelve (12)-month period measured backward from the date an employee first uses FMLA Leave*. Separate rules apply for Military Caregiver Leave, as described above.



# LEAVE REQUEST FORM

EMPLOYEE NAME: \_\_\_\_\_

DOH: \_\_\_\_\_

DEPARTMENT: \_\_\_\_\_

CC: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_

### TYPE OF LEAVE

- Family Medical Leave for:
  - The birth of a child or placement of a child with you for adoption or foster care; or
  - A serious health condition that makes you unable to perform the essential functions for your job; or
  - A serious health condition affecting your
    - spouse/domestic partner,
    - child, or
    - parent for which you are needed to provide care
  - Military Family Medical Leave
    - Military Caregiver Leave
    - Qualifying Exigency Leave
- Child Care (if selecting birth of a child or placement of a child with you for adoption or foster care, this leave must be selected)
- Donated
- Military – Active Military Duty Leave
- Sick Leave Half Pay
- Suspension
- Other Paid Leave \_\_\_\_\_
- Absent Status
- Civil Service Leave From Title

Effective Leave Date: \_\_\_\_\_

Expected Return Date: \_\_\_\_\_

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

Date: \_\_\_\_\_

Supervisor:  Approved  Denied

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Department Head:  Approved  Denied

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Human Resources:  Approved  Denied

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Reason for Denial: \_\_\_\_\_

- Note: If leave request is denied, please indicate why in the space provided.
- Note: If "Family Medical Leave" is selected, you must complete form on the 2<sup>nd</sup> page.
- Note: If FMLA Leave is being taken on intermittent basis, the 2<sup>nd</sup> page must be completed on a bi-weekly basis until leave entitlement is exhausted.
- Note: Medical Certification for Illness and/or Birth/Adoption Certificate must accompany application

**FMLA LEAVE CALCULATIONS**

(1) Units of Days Used for Leave

(2) # of Work Days

(3) Total Units for Leave (1 x 2)

AMOUNT OF PAID LEAVE TO BE CHARGED (Use same units as above)

Sick Leave	_____
Vacation Leave	_____
Personal Leave	_____
Floating Holiday	_____
Blood Day	_____
Non-FLSA Compensatory Leave	_____
Other: _____	_____

(4) TOTAL PAID LEAVE TO BE USED FOR FAMILY LEAVE

UNPAID UNITS OF FAMILY LEAVE – See above: (3) minus (4)

**Leave Dates Requested**

Enter the leave dates the employee is requesting. Mark all paid leave dates with the appropriate code (see below) and all unpaid leave dates with the code “U”.

	Sick – S	Vacation – V	Personal – P	Floating – F	Blood Day – B	Comp – C
1	_____		21	_____	41	_____
2	_____		22	_____	42	_____
3	_____		23	_____	43	_____
4	_____		24	_____	44	_____
5	_____		25	_____	45	_____
6	_____		26	_____	46	_____
7	_____		27	_____	47	_____
8	_____		28	_____	48	_____
9	_____		29	_____	49	_____
10	_____		30	_____	50	_____
11	_____		31	_____	51	_____
12	_____		32	_____	52	_____
13	_____		33	_____	53	_____
14	_____		34	_____	54	_____
15	_____		35	_____	55	_____
16	_____		36	_____	56	_____
17	_____		37	_____	57	_____
18	_____		38	_____	58	_____
19	_____		39	_____	59	_____
20	_____		40	_____	60	_____

Note: Compensatory days may be used for a leave, but compensatory time earned pursuant to the Fair Labor Standards Act (FLSA) does not run concurrently with FMLA leave. Compensatory days accrued pursuant to the FLSA do not count towards FMLA entitlements.



Form #4

Notice of Eligibility and Rights & Responsibilities (Family and Medical Leave Act)

**[PART A - NOTICE OF ELIGIBILITY]**

TO: \_\_\_\_\_  
Employee

FROM: \_\_\_\_\_  
Employer Representative

DATE: \_\_\_\_\_

On \_\_\_\_\_, you informed us that you needed 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; \_\_\_ or 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.

If you have any questions, contact \_\_\_\_\_ or view the FMLA poster located in \_\_\_\_\_.

**[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 by \_\_\_\_\_. (If a certification is requested, employers must allow at least 15 calendar days from receipt of this notice; additional time may be required in some circumstances.) If sufficient information is not provided in a timely manner, your leave may be denied.

- \_\_\_\_\_ Sufficient certification to support your request for FMLA leave is still needed. 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:

1. If you are required to pay your share of the health insurance premium and are at no-pay status please contact \_\_\_\_\_ at \_\_\_\_\_ to 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 (or, indicate longer period, if applicable) 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.
2. You will be required to use your available leave entitlements \_\_\_ sick, \_\_\_ vacation, and/or \_\_\_ other leave during your FMLA absence. This means that you will receive your paid leave and the leave will also be considered protected FMLA leave and counted against your FMLA leave entitlement.
3. If you qualify for intermittent FMLA leave, you must inform your supervisor of your expected absence schedule or you must follow departmental call-in procedures.
4. While on leave you will be required to furnish us with periodic reports of your status and intent to return to work every \_\_\_\_\_.  
(Indicate interval of periodic reports, and type of reports, as appropriate for the particular leave situations, i.e. medical reports every 60 days).
5. 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.

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

1. 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.
2. 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. This single 12-month period commenced on \_\_\_\_\_.
3. Your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work.
4. 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.)
5. 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 Nassau County for our share of health insurance premiums paid on your behalf during your FMLA leave.
6. For a copy of conditions applicable to sick/vacation/other leave usage please refer to \_\_\_\_\_ available at: \_\_\_\_\_

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 entitlements.

If you have any questions, please do not hesitate to contact: \_\_\_\_\_ at: \_\_\_\_\_.



### Certification of Health Care Provider

1) Employees Name: \_\_\_\_\_

Department: \_\_\_\_\_

Employee ID number: \_\_\_\_\_

2) Patient's Name (If different from employee): \_\_\_\_\_

3) Serious Health Condition.

i) Page 4 describes what is meant by a "serious health condition" under the Family and Medical Leave Act. Does the patient's condition qualify under any of the categories described? (Please check the appropriate line below.)

- (a) Inpatient Care \_\_\_\_\_
- (b) Continuing Treatment \_\_\_\_\_
- (c) Chronic Condition Requiring Treatment \_\_\_\_\_
- (d) Permanent/Long-Term Condition Requiring Supervision \_\_\_\_\_
- (e) Non- Chronic Condition Requiring Multiple Treatments \_\_\_\_\_
- (f) Pregnancy or Prenatal Care \_\_\_\_\_
- (g) Treatment for Substance Abuse \_\_\_\_\_

4) Information about the condition.

i) State the approximate **date** the condition commenced, and the probable duration of the condition (and also the probable duration of the patient's present **incapacity** if different):

ii) What type of leave will the employee need to take:

- (1) Full time leave? -----
- (2) Part time leave? -----
- (3) Intermittent leave? -----



5) If the employee is taking intermittent leave or will be working less than a full schedule as a result of the condition (including for treatment described in Item E below)? If yes, give the probable duration of the leave and a statement as to the frequency of the leave and duration of each absence?

i) If the condition is a **chronic condition** (condition (c)) or **pregnancy**, state whether the patient is presently incapacitated and the likely duration and frequency of **episodes of incapacity**

6) Information About the Treatment.

i) 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 of and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any:

ii) 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:

iii) **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)

7) Abilities at Work.

i) 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?

ii) 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)?

(a) If yes, please let the essential functions the employee is unable to perform:

iii) If neither 1 nor 2 applies, is it necessary for the employee to be **absent from work for treatment**?

8) Care for a Family Member.

i) 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?

ii) Would the employee's presence to provide **psychological comfort** be beneficial to the patient or assist in the patient's recovery?

iii) If the patient will need care only **intermittently** or on a part-time basis, please indicate the probably **duration** of this need:

**SERIOUS HEALTH CONDITION:** A “serious health condition” is defined in 29 CFR 825.114 to 825.117 as an illness, injury, impairment or physical or mental condition that includes any of the following:

- a) **Inpatient Care:** Inpatient care means an overnight stay in a hospital, hospice, or residential medical facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.
- b) **Continuing Treatment:** 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:
  - i) *Treatment two or more times within 30 days of the first day of incapacity 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 the orders of, or on referral by, a health care provider; or
  - ii) *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.
  - iii) The requirement for treatment by a health care provider means an in person visit to a health care provider. The first (or only) in-person treatment visit must take place within seven days of the first day of incapacity.
- c) **Chronic Conditions Requiring Treatments:** A chronic condition which:
  - (i) 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; and
  - (ii) Continues over an extended period of time (including recurring episodes of a single underlying condition); and
  - (iii) May cause episodic rather than continuing periods of incapacity (e.g. asthma, diabetes, epilepsy, etc.)
- d) **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. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment from, a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.
- e) **Multiple Treatments (Non-Chronic Conditions):** Any period of absence to receive multiple treatments (including any period of recovery there from) 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 incapacity of more than three consecutive calendar days in the absence of medical intervention for treatment, such as cancer (*chemotherapy, radiation, etc.*), severe arthritis (*physical therapy*), kidney disease (*dialysis*).
- f) **Pregnancy or Prenatal Care:** The mother is entitled to FMLA leave for incapacity due to pregnancy, for prenatal care, or for her own serious health condition following the birth of a child. The mother is entitled to leave for incapacity due to pregnancy even though she does not receive treatment from a health care provider during the absence, and even if the absence does not last for more than three consecutive calendar days.
- g) **Non- Qualifying Conditions:** Routine physical exams, eye or dental exams, cosmetic treatments, cold, flu and earaches, upset stomach etc. that require only brief treatment and recovery are *not "serious health conditions" unless inpatient hospital care is required or complications develop.*

- h) **Treatment for substance abuse** may be a serious health condition and is covered only if the conditions of FMLA are met. Leave may only be taken for treatment of substance abuse by a health care provider or by a provider of health care services on referral by a health care provider. Absence due to an employee's use of the substance, rather than for treatment, does not qualify for FMLA leave.

\_\_\_\_\_  
Signature of Health Care Provider

\_\_\_\_\_  
Date

Address of Health Care Provider  
(Stamp Accepted)

\_\_\_\_\_  
Address 1

\_\_\_\_\_  
Type of Practice

\_\_\_\_\_  
Address 2

\_\_\_\_\_  
Street

\_\_\_\_\_  
City, Town, Zip Code

\_\_\_\_\_  
Telephone Number



Certification of Serious Injury or Illness  
Of COVERED SERVICE MEMBER  
Family Military Leave Act

SECTION I: TO BE COMPLETED BY THE EMPLOYEE

**PART A: EMPLOYEE INFORMATION**

1) Employees Name:

\_\_\_\_\_

Department:

\_\_\_\_\_

Employee ID number:

2) Name of Covered Military member on active duty or call to active duty status in support of contingency operation \_\_\_\_\_

a) Relationship of covered military member to you: \_\_\_\_\_

**PART B: COVERED SERVICE MEMBER INFORMATION:**

1) Is the Covered Servicemember a current member of the Regular Armed Forces, the National Guard or Reserves?

\_\_\_\_\_ Yes \_\_\_\_\_ No

2) If yes, please provide the covered servicemember's military branch, rank and unit currently assigned to: \_\_\_\_\_

a) Is the covered servicemember 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 medical hold or warrior transition unit)? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please provide the name of the medical treatment facility or unit: \_\_\_\_\_

3) Is the covered servicemember on the Temporary Disability Retired List (TDRL)?

\_\_\_\_\_ Yes \_\_\_\_\_ No

**PART C: CARE TO BE PROVIDED TO COVERED SERVICE MEMBER:**

Describe the care to be provided to the Covered Servicemember and an Estimate of the leave Needed to Provide the Care:

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**SECTION II: MEDICAL CERTIFICATION**

For completion by a United States Department of Defense (DOD) Health Care Provider or a Health Care Provider who is either (1) a United States Department of Veterans Affairs (“VA”) health care provider, (2) a DOD TRICARE network authorized private healthcare provider or (3) a DOD non network TRICARE authorized private health care provider. If you are unable to make certain of the military related determinations contained below in Part B, you are permitted to rely on determinations from an authorized DOD representative (such as a DOD recovery care coordinator.)

**PART A: HEALTH CARE PROVIDER INFORMATION**

Health care Provider’s Name and Business Address, Telephone and Fax number:

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Type of Practice/ Medical Specialty: \_\_\_\_\_

Please state whether you are either:

- a. \_\_\_\_\_ a DOD Health care provider
- b. \_\_\_\_\_ a United States Department of Veterans Affairs (“VA”) health care provider,
- c. \_\_\_\_\_ a DOD TRICARE network authorized private healthcare provider
- d. \_\_\_\_\_ a DOD non network TRICARE authorized private health care provider

**PART B: MEDICAL STATUS OF SERVICEMEMBER**

- 1) Covered Service member’s medical condition is classified as (Check the appropriate Boxes):
  - a) \_\_\_\_\_ (VSI) Very Seriously Ill/ Injured – Illness/ injury is of such a severity that life imminently endangered. Family members are requested at bedside immediately. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)
  - b) \_\_\_\_\_ (SI) Seriously Injured - Illness/ injury is of such a severity that there is cause for immediate concern but there is not 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.)
  - c) \_\_\_\_\_ Other Ill/injured. A serious injury or illness that may render the servicemember medically unfit to perform the member’s office, grade, rank or rating.

d)  None of the Above ( Note to Employee: if this box is checked you are not eligible

2) Was the condition for which the Covered Service member is being treated incurred in line of duty on active duty in the armed forces?  Yes  No

3) Approximate date condition commenced? \_\_\_\_\_

4) Probable duration of condition and/or need for care: \_\_\_\_\_

5) Is the covered service member undergoing medical treatment, recuperation or therapy?  
 Yes  No If yes , please describe the medical treatment, recuperation or therapy:  
\_\_\_\_\_  
\_\_\_\_\_

**PART B: COVERED SERVICEMEMBER'S NEED FOR CARE BY FAMILY MEMBER**

1) Will the covered servicemember need care for a single continuous period of time, including any time for treatment and recovery?  Yes  No  
If yes, estimate the beginning and ending dates for this period of time: \_\_\_\_\_

2) Will the covered servicemember require periodic follow-up treatment appointments?  
 Yes  No  
If yes, estimate the treatment schedule: \_\_\_\_\_  
\_\_\_\_\_

3) Is there a medical necessity for the covered servicemember to have periodic care for these follow-up treatment appointments?  
 Yes  No

4) Is there a medical necessity for the covered servicemember to have periodic care for other than scheduled follow up treatment appointments (e.g.: episodic flare-ups of medical condition)?  
 Yes  No  
If yes, estimate the frequency and duration of the periodic care: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SIGNATURE OF THE HEALTH CARE PROVIDER:**

\_\_\_\_\_  
SIGNATURE OF HEALTH CARE PROVIDER

\_\_\_\_\_  
DATE



Certification of Qualifying Exigency  
For Family Military Leave Act

1) Employees Name: \_\_\_\_\_

Department: \_\_\_\_\_

Employee ID number: \_\_\_\_\_

2) Name of Covered Military member on active duty or call to active duty status in support of contingency operation \_\_\_\_\_

a) Relationship of covered military member to you: \_\_\_\_\_

b) Period of covered military member's active duty: \_\_\_\_\_

A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes written documentation confirming a covered military member's active duty or call to active duty status in support of a contingency operation. Please check one of the following:

\_\_\_\_\_ A copy of the covered military member's active duty orders is attached.

\_\_\_\_\_ Other documentation from the military certifying that the covered military member is on active duty (or has been notified of an impending call to active duty) in support of a contingency is attached.

\_\_\_\_\_ I previously provided to the County sufficient written documentation confirming the covered military members active duty or call to active duty status in support of a contingency operation.

**PART A: QUALIFYING REASON FOR LEAVE**

1. Describe the reason you are requesting FMLA leave due to a qualifying exigency ( include the specific reason you are requesting leave):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



2. A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes any available written documentation which supports the need for leave: such documentation may include a copy of a meeting announcement for informational briefings sponsored by the military, a document confirming an appointment with a counselor or school official, or a copy of a bill for services for the handling of legal or financial affairs. Available written documentation supporting this request for leave is attached.
- \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ None available

**PART B: AMOUNT OF LEAVE NEEDED**

1. Approximate date exigency commenced: \_\_\_\_\_

Probable duration of exigency: \_\_\_\_\_

2. Will you need to be absent from work for a single continuous period of time due to the qualifying exigency? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, estimate the beginning and ending dates for the period of absence:

\_\_\_\_\_  
\_\_\_\_\_

3. Will you need to be absent from work periodically to address this qualifying exigency?

\_\_\_\_\_ Yes \_\_\_\_\_ No

Estimate schedule of leave, including the dates of any scheduled meetings or appointments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PART C: LEAVE NEEDED TO MEET WITH A THIRD PARTY**

If leave is requested to meet with a third party (such as to arrange for childcare, to attend counseling, to attend meetings with school or childcare providers, to make financial or legal arrangements, to act as the covered military member's representative before a federal, state, or local agency, for purposes of obtaining arranging or appealing military service benefits, a complete and sufficient certification includes the name, address, and appropriate contact information of the individual or entity with whom you are meeting (i.e. Either the telephone or fax number, or email address of the individual or entity.) This information may be used by the County to verify that the information contained on this form is accurate.

Name Of Individual \_\_\_\_\_ Title: \_\_\_\_\_

Organization: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

Describe nature of meeting:

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**PART D: Certification**

I certify that the information I provided above is true and correct.

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

\_\_\_\_\_  
Date



**NOTIFICATION OF RETURN FROM FAMILY MEDICAL LEAVE**

To: Nassau County Human Resources

From: \_\_\_\_\_

Date: \_\_\_\_\_

**The employee listed below has returned from leave to active employment:**

NAME \_\_\_\_\_

LEAVE TYPE \_\_\_\_\_

RETURN DATE \_\_\_\_\_



## FAMILY MEDICAL LEAVE APPROVAL/DENIAL LETTER

Date

Name

Address #1

Address #2

Dear \_\_\_\_\_,

On \_\_\_\_\_(date), you notified us of your need to take family/medical leave due to:

- ( ) The birth of a child, or the placement of a child with you for adoption or foster care; or
- ( ) A serious health condition that makes you unable to perform the essential functions for your job; or
- ( ) A serious health condition affecting your spouse/domestic partner, child, parent, for which you are needed to provide care.

You notified us that you need this leave beginning on \_\_\_\_\_(date) and that you expect leave to continue until on or about \_\_\_\_\_(date).

This is to inform you that you:

1. ( ) Are eligible ( ) are not eligible for leave under the FMLA.
2. The requested leave ( ) will ( ) will not be counted against your annual FMLA leave entitlement.
3. You ( ) will ( ) will not be required to furnish medical certification of a serious health condition. If required, you must furnish certification by \_\_\_\_\_(date) (must be at least 15 days after you are notified of this requirement), or we may delay the commencement of your leave until the certification is submitted.
4. If you normally pay a portion of the premiums for your health insurance, these payments will continue during the period of FMLA leave. Arrangements for payment have been discussed with you and it is agreed that you will make premium payments as follows:
5. 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 canceled, 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. We will not pay your share of health insurance premiums while you are on leave.

6. You ( ) will ( ) will not be required to present a fitness-for-duty certification prior to being restored to employment. If such certification is required, but not received, your return to work may be delayed until certification is provided.


If you wish to request an extension of your leave, you must put it in writing and send it to the attention of County Human Resources no later than 30 days prior to your return date.

All leave extensions are at the discretion of the County.

Sincerely yours,

**DEPARTMENT HEAD or  
DEPARTMENT Human Resources Representative**

cc: Human Resources  
Comptroller's Office  
Civil Service

<b>POLICY/PROCEDURE TITLE:</b> County-wide Procedure HR-04 <b>DOMESTIC PARTNER LEAVE</b>	<b>DATE ISSUED:</b> June 2012
<b>DEPARTMENT ISSUING:</b> Office of Human Resources	<b>AUTHORIZED and SIGNED BY:</b> <b>Richard R. Walker</b>  Chief Deputy County Executive

<b>POLICY</b>	<b>Domestic Partner Policy:</b> The Domestic Partner Leave Policy extends leave benefits to employees with domestic partners similar to those available under the FMLA Policy for employees with spouses. The FMLA itself affords leave benefits only to a “spouse” which is defined as a “husband or wife as defined or recognized under State law”. Since New York State law does not legally recognize a domestic partner as a husband or wife, the FMLA does not entitle employees to attend to a domestic partner under the circumstances that the law requires leave to be provided to attend to a spouse (i.e. spouse with either a “serious health condition” or who is a “covered service member” with a “serious injury or illness” or a “qualifying exigency”). As a result, leave granted to care for a domestic partner may not legally be counted as FMLA leave or deducted from an employee’s FMLA leave balance.
<b>PURPOSE</b>	<b>Domestic Partner Policy:</b> To establish a policy and guideline for the use of the County’s Domestic Partner leave under the FMLA provisions for eligible employees.
<b>SCOPE</b>	All Nassau County Departments and Agencies
<b>FORMS</b>	Form # 1 Instructions for Enrolling Domestic Partners Form # 2 Application for Domestic Partner Benefits and Affidavit of Domestic Partnership and Financial Interdependence

<b>DEFINITIONS</b>	<b>DOMESTIC PARTNER:</b> a “Domestic Partner” is an unmarried same or opposite sex partner for whom the employee has assumed long term financial responsibility or with whom the employee has mutual financial responsibility and who have filed with the request for domestic partner leave both the Affidavit of Domestic Partnership and Affidavit of Financial Interdependence [Form #2]. The six-month period referred to in Form #1 applies to all County benefits and policies <i>with the exception</i> of health and vision benefits. In the case of vision and health benefits, coverage is available after one (1) year of Domestic Partnership.
<b>REQUESTING DOMESTIC PARTNER LEAVE</b>	Domestic Partner Leave is to be requested, reviewed and calculated in the same manner as FMLA leave under the County’s FMLA Policy.



State of New York  
Department of Civil Service  
Alfred E. Smith State Office Bldg.  
80 South Swan Street  
Albany, NY 12239

**EMPLOYEE BENEFITS DIVISION**  
Instructions for Enrolling Domestic Partners for  
Enrollee in Participating Agencies

PS-427 (10/06)

Participating Agencies in the New York State Health Insurance Program (NYSHIP) may offer Empire Plan coverage to the domestic partners of their enrollees. Your employer has elected this benefit effective \_\_\_\_\_.

To determine if your domestic partner qualifies for enrollment, carefully read these instructions, which includes important tax information and the Domestic Partner Affidavit (PS-427.1)

The affidavit and documents you are required to submit are only intended to establish the eligibility of your domestic partner for benefits available to you as a NYSHIP Participating Agency Enrollee. However, it is recommended that you seek advice from your attorney regarding any possible legal and financial implications before you take the actions required to provide this coverage to a domestic partner.

### Who can be Covered as a Domestic Partner

Unmarried enrollees may cover same or opposite sex partners with whom they resided with for at least six (6) months, have a committed, long term relationship of mutual support, and for whom they have assumed long term financial responsibility or have mutual financial responsibility. See the Affidavit of Domestic Partnership and Financial Interdependence (PS-427.1) for details.

Persons who live together for economic reasons, but who have not made a commitment to an exclusive enduring domestic partnership as described in these documents, will not be considered to be domestic partners for the purposes of enrollment in New York State administered benefit programs.

### How to Enroll a Domestic Partner

1. Complete the following forms:  
Affidavit of Domestic Partnership and Financial Interdependence (PS-427.1)  
Health Insurance Transaction Form (PS-503.1)
2. In addition to the above, **IF** your partner qualifies as your dependent for federal tax purposes and you wish to avoid the additional taxes that may result from this benefit (see Income Tax Implications), you must also complete the Dependent Tax Affidavit (PS-427.3) and return it with the other documents.
3. Return the completed forms and the **REQUIRED PROOFS OF RESIDENCE AND FINANCIAL INTERDEPENDENCE** (see PS-427.1) to your agency Health Benefits Administrator.

Applications filed without the required affidavit or proofs will not be processed. Ambiguity or lack of clarity will not be interpreted in the employee's/partner's favor.

### When Coverage Begins

Your employer may establish a special enrollment period when this benefit is initially extended. If you are enrolled in NYSHIP, apply during the special enrollment period, have satisfied the six (6) month residency and financial requirements, and you have submitted all required documentation to your agency Health Benefits Administrator, coverage for your partner begins on the first day of the month following the month in which you have submitted all required documentation. For new employees an additional waiting period may apply.

After the special enrollment period, if you are enrolled in NYSHIP, have satisfied the six (6) month residency and financial requirements, and you have submitted all required documentation to your agency Health Benefits Administrator on or before your partner's first eligibility, the coverage for your partner may begin on the date of first eligibility. If you apply after the date of first eligibility but less than 30 days after the date of first eligibility, coverage for your partner may begin on the first day of the month following the month in which you have submitted all required documentation to your agency Health Benefits Administrator. If you apply more than 30 days after the date of first eligibility, you will be subject to a late enrollment period and coverage for your partner will begin no earlier than the first day of the third month following the month in which you apply. **Your partner's date of first eligibility is the day that is exactly six (6) months after the latest date of the residency and financial support documents submitted with your application for coverage.**



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If you are not enrolled in NYSHIP, coverage for both you and your partner may be deferred until you satisfy the new employee or late enrollment waiting period. Ask your agency Health Benefits Administrator for exact information on your employer's effective date policies.

### **When Coverage Ends**

Coverage for your partner will end the end of the month in which you and/or your partner no longer meet one or more of the requirements on the affidavit you both have signed. The terms and conditions of your coverage require you to report this relationship termination within **14 days** of its occurrence.

### **How to Report that the Partnership has Ended**

You must complete and submit the form PS-427.4 "Termination of Domestic Partnership" within **14 days** of the date the partnership ends. The form is available from your agency Health Benefits Administrator. **If you do not file the form on a timely basis, you may be liable for claims paid for your former partner for services rendered on and after the date the partnership ended.** You may not enroll another domestic partner, or re-enroll the same domestic partner, until one year after the date the "Termination of Domestic Partnership" form is filed with your agency Health Benefits Administrator. Your former partner's 60 day eligibility period for applying for COBRA continuation coverage starts on the date the relationship terminates, not the notification date.

### **Coverage of Domestic Partner's Children**

You may provide coverage under State administered benefit programs for you partner's child (children) if the child permanently resides in your household and you provide more than 50% of the child's support. To enroll the child, ask your agency Health Benefits Administrator for form PS-457, "Statement of Dependence". After you complete the form and return it to your agency Health Benefits Administrator, you will be advised whether the child is eligible for coverage. Documentation of the statements made on the PS-457 may be required. If approved, the child will be considered an "Other" dependent and you will need to recertify this dependent every two years. Contact your agency Health Benefits Administrator for additional information about "Other" dependents.

### **Changes of Coverage**

Changes of coverage involving domestic partners and their children follow the same rules that apply to other dependents. If your agency offers pre-tax payment options, restrictions may apply. See your agency Health Benefits Administrator for more details.

## **INCOME TAX IMPLICATIONS**

### **Imputed Income**

Under IRS rules, if a domestic partner is not a "dependent" within the meaning of Section 152 of the Internal Revenue Code (IRC), the "fair market value" of the partner's coverage, less any contribution by the enrollee, is treated as income for federal tax purposes. Check with your agency Health Benefits Administrator for an approximation of the fair market value for State administered health coverage. These values, referred to as "imputed income", will be added to your annual salary for income tax purposes and apply even if you cover other dependents in addition to your partner. If your partner qualifies as a dependent under IRC 152, there is no imputed income. If you qualify under this section, (and ONLY if you qualify) you must complete PS-425.3 Dependent Tax Affidavit and submit it with your other enrollment documents. If your domestic partner's tax status changes during the year, no retroactive changes will be made to imputed income. It is your responsibility to amend your tax return to correct taxable income. If you have questions regarding your eligibility under Section 152, please contact your tax advisor.





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 Application for Domestic Partner Benefits and Affidavit of Domestic  
 Partnership and Financial Interdependence for  
 Enrollees of Participating Agencies

PS-427.1 (10/06)

The undersigned, being duly sworn, depose and declare as follows:

1. We are both eighteen years of age or older and not married to other individuals. If either or both of us have been married, we submit evidence of the termination of the marriage(s).
2. We are not related by blood in a manner that would bar marriage under the laws of the State of New York.
3. We are each other's sole domestic partner, have been so for at least six (6) months prior to the date of this affidavit, and intend to remain so indefinitely. We are in a relationship of mutual support, caring and commitment, and have assumed responsibility for each other's welfare.
4. We have been living together on a continuous basis for at least six (6) months prior to the date of this affidavit and submit proof of qualifying cohabitation (see reverse side for proof of residency).
5. As domestic partners we are financially interdependent. We submit clearly unaltered copies of documents with two proofs of our financial interdependence (see reverse side for proofs of financial interdependence).
6. One of us is enrolled in the New York State Health Insurance Program (NYSHIP).
7. I, the enrollee, affirm that I have not had a domestic partner enrolled in NYSHIP as my dependent within the last year.
8. I, the enrollee, affirm that I will file a *Termination of Domestic Partnership* form (PS-425.4) within 14 days of the date I/my partner no longer meet one or more of the qualifying criteria set forth above.
9. I, the enrollee, understand that any false or misleading statements made in order to receive benefits for which I do not qualify will subject me to financial responsibility for any benefits paid on behalf of my partner and potential disciplinary action by my employer.

Print Name (Enrollee)
Social Security No.
Address
Signature <i>(sign in presence of notary)</i>

Print Name (Partner)
Social Security No.
Date of Birth
Address
Signature <i>(sign in presence of notary)</i>

Sworn to before me \_\_\_\_\_ this day of \_\_\_\_\_, \_\_\_\_\_

\_\_\_\_\_  
 NOTARY PUBLIC

**Personal Privacy Protection Law Notification**

The information you provide on this application is requested for the principal purpose of determining the eligibility of a domestic partner for benefits under the New York State Health Insurance Program and/ or Employee Benefit Fund Program. The information will be used in accordance with Section 96 (1) of the Personal Privacy Protection Law, particularly subdivisions (b), (e) and (f). Failure to provide the information requested may prevent the Department from processing this application. This information will be maintained by the Director, Division of Employee Benefits, NYS Dept. of Civil Service, Albany, NY 12239. For information related only to the Personal Privacy Protection Law, call (518) 457-9375.

For information, related to the Domestic Partnership Program, contact your Agency Health Benefits Administrator. If, after calling your Health Benefits Administrator, you need more information concerning the Domestic Partnership Program, please call (518) 457-5754 or 1-800-833-4344 between the hours of 9:00 a.m. and 3:00 p.m.



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PS-427.1 (10/06)

**YOU NEED A TOTAL OF 3 SEPARATE PROOFS\*, AS DESCRIBED BELOW  
 (1 PROOF OF COHABITATION DURATION AND 2 PROOFS OF FINANCIAL INTERDEPENDENCE)**

\*Proofs should be clearly unaltered copies of original documents.

**Proof of Six Months of Cohabitation**

You must submit proof that you and your partner have resided together for at least six (6) months. The proof may be one document with both names or two separate documents that show the residence of each partner. The following is a list of items that can be used to demonstrate proof of residency.

Submit one (1) of the following (check proof submitted):

- |  |   |
|--|---|
| <input type="checkbox"/> Auto registration   | <input type="checkbox"/> Passport   |
| <input type="checkbox"/> Bank statement  | <input type="checkbox"/> Pay check stub   |
| <input type="checkbox"/> Driver's license  | <input type="checkbox"/> Registration as a domestic partnership in a New York State municipality that has established such a procedure (e.g., Albany, New York City, Rochester, Ithaca) |
| <input type="checkbox"/> Mailed insurance benefits statement   | <input type="checkbox"/> Tax return   |
| <input type="checkbox"/> Mailed joint membership statement with address (e.g., church or family association) | <input type="checkbox"/> Telephone bill   |
| <input type="checkbox"/> Lease agreement listing both parties  | <input type="checkbox"/> Utility bill   |
| <input type="checkbox"/> Mortgage agreement listing both parties   |   |

**Proof of Financial Interdependence**

You must submit two (2) copies of clearly unaltered original documents as proof of financial interdependence of at least six months duration. Below is a list of acceptable proofs (at least one of the two items must be from List A). Check the two (2) proofs you are submitting:

Note: "Joint" proofs must contain both names (enrollee and domestic partner). Original documents will be copied only to the extent necessary to document receipt and returned to you.

**LIST A**

- |  |  |
|--|--|
| <input type="checkbox"/> Joint obligation on a loan (including an affidavit by a corporate creditor for a personal loan)   | <input type="checkbox"/> Designation of one partner as the representative payee for the others government benefits       |
| <input type="checkbox"/> Joint ownership of your residence   | <input type="checkbox"/> Joint ownership or holding of investments   |
| <input type="checkbox"/> Joint renters' or home owners' insurance policy   | <input type="checkbox"/> Joint ownership or lease of a motor vehicle   |
| <input type="checkbox"/> Joint responsibility for child care (e.g., school documents, guardianship) Birth certificate of child alone is not sufficient.          | <input type="checkbox"/> Mutually granted authority to make health care decisions (e.g., health care power of attorney)  |
| <input type="checkbox"/> Designated as beneficiary under the other's life insurance policy, retirement benefits account or will or executor of each other's will | <input type="checkbox"/> Both listed as tenants on the lease of shared residence   |
| <input type="checkbox"/> An affidavit by a corporate creditor or other disinterested third party attesting to partners' shared financial commitment              | <input type="checkbox"/> Same-sex marriage or civil union certificate  |
| <input type="checkbox"/> Mutually granted durable power of attorney  | <input type="checkbox"/> Shared a household budget for the purpose of receiving government benefits                      |
|  | <input type="checkbox"/> Partner claimed as a dependent for federal tax purposes (you must complete and submit PS-425.3) |

**LIST B**

- |   |   |
|---|---|
| <input type="checkbox"/> Joint bank account             | <input type="checkbox"/> Status as authorized signatory on the partner's bank account, credit card or charge card |
| <input type="checkbox"/> Joint credit or charge card(s) | <input type="checkbox"/> Other proof establishing economic interdependence  |

\_\_\_\_\_  
Department

**Acknowledgement and Receipt**

My signature below acknowledges receipt of the following:

Nassau County Family Medical Leave and Family Military Leave Policy (HR-02)

Nassau County Domestic Partner Leave Policy (HR-04)

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

(This acknowledgement will be placed in your Employee File and a copy will be filed with the Nassau County Office of Human Resources).