

**BOARD OF TRUSTEES
CHURCHILL COUNTY SCHOOL DISTRICT**

FAMILY AND MEDICAL LEAVE ACT

As a public employer, the District is covered under the Family and Medical Leave Act (FMLA), will comply with the requirements of the FMLA, and will advise employees if they meet all the FMLA eligibility requirements.

A. Eligibility

Employees who have been employed by the District for at least one (1) year and have worked for the District at least 1,250 hours during the preceding twelve (12) month period and are employed at a work site where 50 or more employees work for the District within 75 miles of that work site are eligible for family and medical leave. Employees at a rural school are not eligible for FMLA leave if that rural school has fewer than fifty (50) employees and there are no other schools within the District's jurisdiction within seventy-five (75) miles.

B. Compensation During Leave

Family and medical leave will be unpaid leave unless the employee has accrued paid leave and is otherwise eligible to use the leave. If leave is requested for the employee's own serious health condition or for the serious health condition of the employee's spouse, child, or parent, the employee must use all of his/her accrued paid annual leave or sick leave as part of the FMLA leave. (See the applicable collective bargaining agreement for any alternate provisions which may apply.) If leave is requested for any of the other reasons identified below, an employee must use all of his/her accrued paid annual leave as part of the FMLA leave. The remainder of the leave period will then consist of unpaid FMLA leave. Unless otherwise agreed to in writing, employees are not permitted to work in an outside job during FMLA leave.

C. Intermittent or Reduced Schedule Leave

When medically necessary (as distinguished from voluntary treatments and procedures), leave may be taken on an intermittent or reduced schedule basis. Employees needing intermittent leave or reduced schedule leave must attempt to schedule their leave so as not to disrupt the District's operations. The District may require an employee on intermittent leave to transfer temporarily to an available alternative position for which the employee is qualified if the position has equivalent pay and benefits and better accommodates the employee's intermittent or reduced schedule leave. Intermittent leave and reduced schedule leave reduces the twelve (12) week entitlement only by the actual time used.

NOTE: FMLA leave that is taken for a period that ends with the school year and begins the next semester is considered consecutive rather than intermittent leave. The District will not count the period during the summer vacation when the employee would not have been required to report for duty against the employee's FMLA leave entitlement.

D. Intermittent or Reduced Schedule Leave

Definition: Instructional employees are those whose principal function is to teach and instruct students in a class, a small group, or an individual setting. The term includes teachers, athletic coaches, driving instructors, and special education assistants, such as signers for the hearing impaired. The term does not include nor do the special rules apply to teacher assistants or aides who do not have as their principal job actual teaching or instructing. Furthermore, the term does not include auxiliary personnel, such as counselors, psychologists, or curriculum specialists. Also excluded are cafeteria workers, maintenance workers, and bus drivers.

The District will provide instructional employees who are on FMLA leave at the end of the school year any benefits over the summer vacation that employees would normally receive if they had been working at the end of the school year.

If an eligible instructional employee needs intermittent leave or leave on a reduced leave schedule to care for a family member or for the employee's own serious health condition, which is foreseeable based on planned medical treatment, and the employee would be on leave for more than twenty (20) percent of the total number of working days over the period the leave would extend, the District may require the employee to choose either to:

1. Take leave for a period or periods of a particular duration, not greater than the duration of the planned treatment; or
2. Transfer temporarily to an available alternative position, for which the employee is qualified, which has equivalent pay and benefits and which better accommodates recurring periods of leave than does the employee's regular position.

If an instructional employee does not give required notice of foreseeable FMLA leave to be taken intermittently or on a reduced leave schedule, the District may require the employee to take leave of a particular duration, or to transfer temporarily to an alternative position. Alternatively, the District may require the employee to delay the taking of leave until the notice provision is met.

E. Duration of and Reasons for Leave

Any eligible employee, as defined above, may be granted a total of twelve (12) weeks of unpaid family and medical leave (during a rolling twelve [12] month period measured backward from the date an employee uses any FMLA leave) for the following reasons:

1. The birth of the employee's child and in order to care for the child;
2. The placement of a child with the employee for adoption or foster care;
3. To care for the employee's spouse, child, or parent who has a serious health condition; or
4. An employee's serious health condition that prevents the employee from performing the functions of his/her job. Serious health conditions may include conditions resulting from job-related injuries and/or illnesses.

Unpaid FMLA leave will run concurrently with paid vacation, sick, and/or personal leave, unless otherwise prohibited by any relevant collective bargaining agreement. Unpaid FMLA leave may also run concurrently with workers' compensation leave or other benefits. The entitlement to family and medical leave for the birth or placement of a child for adoption or foster care will expire twelve (12) months from the date of the birth or placement. If both an employee and his/her spouse are employed by the District, their combined time off may not exceed twelve (12) work weeks during any twelve (12) month period for the birth, adoption, or foster care, or care of a parent with a serious health condition. Each spouse is, however, eligible for the full twelve (12) weeks within a twelve (12) month period to care for a son, daughter, or spouse with a serious health condition.

F. Application for Leave

In all cases, an employee requesting leave must complete the District's approved leave form (reference: Application for Family or Medical Leave) and return it to the administration office. The completed application must state the reason for the leave, the expected duration of the leave, and the starting and ending dates of the leave.

The District may require the use of FMLA leave for any absence which would otherwise qualify as FMLA leave, even if no formal application for such leave was made by the employee, provided notice is given to the employee (reference: Response to Employee's Application for FMLA Leave – if employee has applied for FMLA leave, or Notice Placing an Employee on FMLA Leave – if no application for FMLA leave was made).

G. Notice of Leave

An employee intending to take family or medical leave because of an expected birth or placement, or because of a planned medical treatment, must submit an application for such leave at least thirty (30) days before the leave is to begin. If a requested leave will begin in less than thirty (30) days, the employee must give notice to his/her immediate administrator/supervisor as soon as the necessity for the leave is known. Reasonable advance notice is required for all leaves, even if the event necessitating the leave is not foreseeable.

H. Medical Certification of Leave

An application for leave based on the serious health condition of the employee or the employee's spouse, child, or parent must be supported by an District approved "medical certification statement" (reference: *Certification of Health Care Provider - Long Form or Short Form*) completed by the treating health care provider. The certification must state the date on which the health condition commenced, the probable duration of the condition, and the medical facts regarding the condition.

If the employee is needed to care for a spouse, child, or parent, the certification must so state, along with an estimate of the amount of time the employee will be needed. If the employee has a serious health condition, the certification must state that the employee cannot perform the functions of his/her job.

If the District questions the validity of the certification, the District may require, at its expense, that the employee obtain a second opinion. If the second opinion conflicts with the original opinion, the District may require, at its expense, that the employee obtain the opinion of a third health care provider designated or approved jointly by the District and the employee. This third opinion will be considered final and binding on both parties. The District may require the employee to obtain subsequent recertification on a reasonable basis. Any employee on FMLA leave must notify his/her supervisor periodically of his/her status and intention to return to work. The supervisor/administrator has the authority to determine how often the employee must provide this notification.

I. Benefits Coverage During Leave

During a period of family or medical leave, the District will retain an employee on the District's health plan under the same conditions that would apply if the employee were not on family or medical leave. To continue health coverage, the employee must continue to make any contributions that s/he would otherwise be required to make. Failure of the employee to pay his/her share of the health insurance premium may result in loss of coverage.

If the employee fails to return to work after the expiration of the family or medical leave, the employee will be required to reimburse the District for payment of health insurance premiums during the leave, unless the reason the employee cannot return is due to circumstances beyond the employee's control. The definition of "beyond the employee's control" includes a large variety of situations, such as: the employee being subject to layoff, continuation, recurrence, or the onset of an FMLA qualifying event, or the unexpected relocation of more than 75 miles from the District's worksite.

An employee is not entitled to the accrual of any seniority or employment benefits during any unpaid leave. An employee who takes family or medical leave will not lose any seniority or employment benefits that accrued before the date the leave began

J. Restoration to Employment

Upon returning to work, an employee on family or medical leave will be restored to his/her most recent position or to a position with equivalent pay, benefits, and other terms and conditions of employment. The District cannot guarantee that an employee will be returned to his/her original job. The District will determine whether a position is an "equivalent position" as well as how an employee is to be restored to "an equivalent position" upon return from FMLA leave on the basis of school board policies and practices, and collective bargaining agreements regarding transfers and reassignments. The established policies and collective bargaining agreements relied on by the District as a basis for restoration must be in writing, must be made known to the employee prior to the taking of FMLA leave, and must clearly explain the employee's restoration rights upon return from leave.

K. Return from Leave

An employee must complete the District's notice of intent to return from FMLA leave (reference: *Notice of Intent to Return from FMLA Leave*) before s/he will be returned to active status. If an employee wishes to return to work prior to the expiration of a family or medical leave absence, s/he must notify the administrator/supervisor at least five (5) working days prior to the employee's planned return. Employees may be required to provide a fitness-for-duty certification prior to returning to work if the family or medical leave of absence was due to the employee's own serious health condition.

L. Failure to Return from Leave

Failure of an employee to return to work upon the expiration of a family or medical leave absence will subject the employee to disciplinary action, up to and including termination, unless the District has granted an extension. An employee who requests an extension of family or medical leave due to the continuation, recurrence, or onset of his/her 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 immediate administrator or supervisor. This written request should be made as soon as the employee realizes that s/he will not be able to return at the expiration of the leave period. Any additional time granted or extended will not be considered as FMLA. Rather, such time will be characterized as either paid or unpaid leave, thereby ending the District's return to duty obligations included in Section II.B.j. Nothing in this policy limits District's obligations of reasonable accommodation under the Americans with Disabilities Act.

SAMPLE FORM
Application for Family or Medical Leave

Employee Name: _____ Date of Request: _____

Department: _____ Position Title: _____

Your Date of Hire: _____

I request a family / medical leave for the following reason (check one):

- _____ A. A serious health condition that makes me unable to perform the essential functions of my job. **(Must submit "Certification of Health Care Provider" within 15 days.)**
- _____ B. To care for spouse, child, or parent with a serious health condition. **(Must submit "Certification of Health Care Provider" within 15 days.)**
- _____ C. The birth of a child and in order to care for such child or the placement of a child for adoption or foster care.

Date leave is requested to begin: _____ Requested ending date of leave: _____

Type of leave requested:

- _____ A. Leave will be taken for a period of consecutive workdays.
- _____ B. Leave will be taken on an intermittent schedule or require a reduced work schedule. **(Must submit "Certification of Health Care Provider" within 15 days.)**
(Specify schedule) _____

Conditions: (Please initial each section)

_____ If the duration of my family / medical leave (total of paid and unpaid time) does not exceed 12 weeks, I will be returned to my same or an equivalent position. I understand that if my family / medical leave should exceed 12 weeks, I will be returned to my same or similar position, only if available, in accordance with applicable laws. If my same or similar position is not available, I understand that I may be terminated.

_____ I hereby authorize a physician on behalf of the Churchill County School District to contact my physician to verify the reason for my requested leave or for any other information necessary to evaluate my requested leave pursuant to the Family and Medical Leave Act.

_____ I understand that a failure to return to work at the end of my leave period may be treated as a resignation unless an extension has been agreed upon and approved in writing by the Churchill County School District.

I certify that I have received a copy and understand the requirements and conditions set forth in the Churchill County School District Family and Medical Leave policy.

Employee Signature: _____ Date: _____

APPROVED BY:

Signature: _____ Title: _____ Date: _____

SAMPLE FORM

RESPONSE TO EMPLOYEE’S APPLICATION FOR FMLA LEAVE

TO: _____
(Employee’s Name)

FROM: _____
(Name of Appropriate Employer Representative)

DATE: _____

SUBJECT: Application for Family / Medical Leave Act

On _____ [date], you notified us of your need to take family / medical leave due to:

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

You notified us that you need this leave beginning on _____ [date] and that you expect the leave to continue until on or about _____ [date].

Except as explained below, you have a right under the FMLA for up to 12 weeks of unpaid leave in a 12-month period for the reasons listed above. Also, your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work, and you will be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from leave. 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; or (2) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave.

This is to inform you that: (check appropriate boxes; explain where indicated)

1. You are eligible 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. We will will not require that you substitute accrued paid leave for unpaid FMLA leave. If paid leave will be used, the following conditions will apply: (Explain)

5. Your health benefits will be maintained during your FMLA leave under the same conditions as if you continued to work. Additionally:
- (a) 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: _____. (Specify dates, e.g., the 10th of each month, pay periods, etc. -- whatever has been agreed upon with the employee.)
 - (b) 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. We will will not pay your share of health insurance premiums while you are on leave.
 - (c) We will will not do the same with other benefits (e.g., life insurance, disability insurance, etc.) while you are on FMLA leave. If we do pay your premiums for other benefits, when you return from leave you will will not be expected to reimburse us for the payments made on your behalf.
6. You will will not be required to present a fitness-for-duty certificate 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.
7. (a) You are are not a “key employee” as described in Section 825.218 of the FMLA regulations. If you are a “key employee,” restoration to employment may be denied following FMLA leave on the grounds that such restoration will cause substantial and grievous injury to us.
- (d) We have have not determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic harm to us. (Explain below whether (a) and/or (b). See Section 825.219 of the FMLA regulations.)
8. While on leave, you will will not be required to furnish us with periodic reports every _____ (indicate interval of periodic reports as appropriate for the particular leave situation) of your status and intent to return to work (see Section 825.309 of the FMLA regulations). If the circumstances of your leave change and you are able to return to work earlier than the date indicated on page 1 of this form, you will will not be required to notify your supervisor at least two workdays prior to the date you intend to report for work.
9. You will will not be required to furnish recertification relating to a serious health condition. (Explain below, if necessary, including the interval between certifications as prescribed in Section 825.308 of the FMLA regulations.)
10. You must seek and receive extensions to the FMLA leave, in writing, before the expiration date of your current leave. Unless otherwise agreed to in writing in advance of the leave, you may not work for another employer during the term of your FMLA leave.

If you have any questions, please contact _____.

SAMPLE FORM

NOTICE PLACING AN EMPLOYEE ON FMLA LEAVE

TO: _____
(Employee's Name)

FROM: _____
(Name of Appropriate Employer Representative)

DATE: _____

SUBJECT: Family and Medical Leave Act Status of Absence

From the facts known to us at this time, your absence qualifies under the Family and Medical Leave Act. Therefore, you are notified that your leave (FMLA) will begin on _____ (date) and will continue for up to a maximum of _____ weeks presuming the leave remains FMLA qualified.

The reason for the FMLA leave is:

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

Except as explained below, you have a right under the FMLA for up to 12 weeks of unpaid leave in a 12-month period for the reasons listed above. Also, your health benefits will be maintained during any period of unpaid leave under the same conditions as if you continued to work, and you will be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from leave. 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; or (2) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave.

This is to inform you that: *(check appropriate boxes; explain where indicated)*

1. You are eligible not eligible for leave under the FMLA.
2. The 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).

4. We **will** **will not** require that you substitute accrued paid leave for unpaid FMLA leave. If paid leave will be used, the following conditions will apply: *(Explain)*
5. Your health benefits will be maintained during your FMLA leave under the same conditions as if you continued to work. Additionally:
- (a) If you normally pay a portion of the premiums for your health insurance, these payments will continue during the period of FMLA leave. To make arrangements for payments, contact _____ or arrangements for payment have been discussed with you and it is agreed that you will make premium payments on _____. *(Specify dates, e.g., the 10th of each month, pay periods, etc. – whatever has been agreed upon with the employee.)*
- (b) 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. We **will** **will not** pay your share of health insurance premiums while you are on leave.
- (c) We **will** **will not** do the same with other benefits (e.g., life insurance, disability insurance, etc.) while you are on FMLA leave. If we do pay your premiums for other benefits, when you return from leave you **will** **will not** be expected to reimburse us for the payments made on your behalf.
6. You **will** **will not** be required to present a fitness-for-duty certificate 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.
7. (a) You **are** **are not** a “key employee” as described in Section 825.218 of the FMLA regulations. If you are a “key employee,” restoration to employment may be denied following FMLA leave on the grounds that such restoration will cause substantial & grievous injury to us.
- (b) We **have** **have not** determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic harm to us. *(Explain below whether (a) and/or (b). See Section 825.219 of the FMLA regulations.)*
8. While on leave, you **will** **will not** be required to furnish us with periodic reports every _____ *(indicate interval of periodic reports as appropriate for the particular leave situation)* of your status and intent to return to work *(see Section 825.309 of the FMLA regulations)*. If the circumstances of your leave change and you are able to return to work earlier, you **will** **will not** be required to notify your supervisor at least two workdays prior to the date you intend to report for work.
9. You **will** **will not** be required to furnish recertification relating to a serious health condition. *(Explain below, if necessary, including the interval between certifications as prescribed in Section 825.308 of the FMLA regulations.)*
10. You must seek and receive extensions to the FMLA leave, in writing, before the expiration date of your current leave. Unless otherwise agreed to in writing in advance of the leave, you may not work for another employer during the term of your FMLA leave.

If you have any questions, please contact _____.

SAMPLE FORM

NOTICE OF INTENTION TO RETURN FROM FMLA LEAVE

TO: _____
(Supervisor's Name)

FROM: _____
(Employee's Name)

DATE: _____

SUBJECT: Notice Of Intention to Return from FMLA Leave

I have been on FMLA leave since _____ (Date Leave Began).

I plan to return to work on _____ (Date of Planned Return).

I understand my return is subject to the following:

1. I was was not required to present a fitness-for-duty certificate prior to being restored to employment. If such certification is required but not received, my return to work may be delayed until certification is provided.
2. I will be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment.
3. I will be entitled to the accrual of any seniority or employment benefits during the period of leave that I would otherwise accrue on other forms of leave (paid or unpaid, as appropriate).

Employee's Signature Date

I have examined _____, have reviewed the attached written job description, and certify that s/he is fully able to resume working.

Health Care Provider's Signature Date

SAMPLE FORM

CERTIFICATION OF HEALTH CARE PROVIDER

1. Name of Employee: _____
2. Name of Patient (if different from Employee): _____
3. The attached sheet describes what is meant by a **“serious health condition”** under the Family and Medical Leave Act. Does the patient’s conditionⁱ qualify under any of the categories described? If so, please check the applicable category.

1) _____	3) _____	5) _____	None of the above _____
2) _____	4) _____	6) _____	
4. Describe the **medical facts** which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories.
5.
 - a) 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**¹ if different):

 - b) Will it be necessary for the employee to take work only **intermittently or to work on a less than full schedule** as a result of the condition (including for treatment described in Item 6 below)? _____ If yes, give the probable duration:

 - c) If the condition is a **chronic condition** (condition #4) or **pregnancy**, state whether the patient is presently incapacitated² and the likely duration and frequency of **episodes of incapacity**ⁱⁱ:

6. a) If additional **treatments** will be required for the condition, provide an estimate of the probable number of such treatments:

If the patient will be absent from work or other daily activities because of **treatment** on an **intermittent** or **part-time** basis, also provide an estimate of the probable number and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery, if any:

b) If any of these treatments will be provided by **another provider of health services** (e.g., physical therapist), please state the nature of the treatments:

c) **If a regimen of continuing treatment** by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment):

7. a) If medical leave is required for the employee's **absence from work** because of the **employee's own condition** (including absences due to pregnancy or a chronic condition), is the employee **unable to perform** work of any kind? _____

b) If able to perform some work, is the employee **unable to perform any one or more of the essential functions of the employee's job** (see attached job description)? _____ If yes, please list the essential functions the employee is unable to perform:

c) If neither a) or b) applies, is it necessary for the employee to be **absent from work for treatment**? _____

8. a) If leave is required to **care for a family member** of the employee with a serious health condition, **does the patient require assistance** for basic medical or personal needs or safety, or for transportation? _____

b) If no, would the employee’s presence to provide **psychological comfort** be beneficial to the patient or assist in the patient’s recovery? _____

c) If the patient would need care only **intermittently** or on a part-time basis, please indicate the probable **duration** of this need:

Signature of Health Care Provider

Type of Practice

Address

Telephone Number

TO BE COMPLETED BY THE EMPLOYEE NEEDING FAMILY LEAVE TO CARE FOR A FAMILY MEMBER:

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

Employee’s Signature

Date

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

1. Hospital Care:

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

2. Absence Plus Treatment:

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

- 1) **Treatmentⁱⁱⁱ two or more times** by a health care provider, by a nurse or physician’s assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or
- 2) **Treatment** by a health care provider on **at least one occasion** which results in a **regimen of continuing treatment^{iv}** under the supervision of the health care provider.

3. Pregnancy:

Any period of incapacity due to **pregnancy**, or for **prenatal care**.

4. Chronic Conditions Requiring Treatments:

A **chronic condition** which:

- 1) 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;
- 2) Continues over an **extended period of time** (including recurring episodes of a single underlying condition; and
- 3) May cause **episodic** rather than a continuing period of incapacity² (e.g., asthma, diabetes, epilepsy, etc.).

5. Permanent / Long-Term Conditions Requiring Supervision:

A period of *incapacity*² which is *permanent or long-term* due to a condition for which treatment may not be effective. The employee of family member must be *under the continuing supervision of, but need not be receiving active treatment by, a health care provider*. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

6. Multiple Treatments (Non-Chronic Conditions):

Any period of absence to receive *multiple treatments* (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for *restorative surgery* after an accident or other injury, or for a condition that *would likely result in a period of incapacity² of more than three consecutive calendar days in the absence of medical intervention or treatment*, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).

ⁱ Here and elsewhere on this form, the information sought relates **only** to the condition for which the employee is taking FMLA leave.

ⁱⁱ **"Incapacity"** for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery therefrom.

ⁱⁱⁱ Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

^{iv} A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.