NALC Form 1 - Family and Medical Leave Act of 1993

Employee Should Deliver Completed Form to Postal Service Supervisor, and Keep a Copy

Employee's Notification of New Child in the Family

To take FMLA leave for a new child in the family, an employee must notify management within 30 days (when practicable) of the anticipated date of the birth, placement in foster care or adoption. This form may be used for that purpose. When the leave begins, complete and submit a Form 3971, Request for or Notification of Absence, for each pay period in which leave will be taken.

Employee Name (Print)

To Postal Supervisor:

This serves as notification under the Family and Medical Leave Act of 1993 that I expect to become the parent of a new child, by (check one)

- ☐ Birth
- ☐ Adoption
- ☐ Placement in foster care

on (approximate date)_____.

Following that date I plan to take time off work to care for my new child. I plan to return to work

on (approximate date)_____.

Employee Signature_____ Date_____

Family and Medical Leave Act Rules: New Child in the Family

The Family and Medical Leave Act guarantees each letter carrier 12 weeks of time off per postal leave year for a new child in the family—by birth, by placement of a foster child or by adoption. The age of a child adopted or placed in foster care does not affect eligibility for leave (except that the child must be under 18, or older but incapable of self-care). When both parents work for the Postal Service, *each parent* may take up to 12 weeks of FMLA leave for this purpose.

Before the child arrives: In the case of a birth, the pregnant employee is entitled to FMLA leave before the actual date of birth, for prenatal care or if her condition makes her unable to work. Accrued paid sick leave may be used for these purposes; the employee also may use annual leave or LWOP in accordance with existing rules.

Before or after a foster or adopted child is placed, the employee is entitled to take FMLA leave for making required arrangements for the placement—to attend counseling sessions, appear in court, consult with his or her attorney or doctors representing the birth parent, or submit to a physical examination. A father or mother is entitled to take FMLA leave for these reasons, and may use annual leave or LWOP in accordance with existing rules.

Caring for the child during the first year. Whether the child arrives by birth or by placement, a mother or father is entitled to FMLA leave to care for the child during the first year. No medical justification is needed—the FMLA leave is guaranteed simply to care for the new child. This particular right to FMLA leave terminates on the first anniversary of the child's birth or placement.

LWOP rules. Under Section 514 of the USPS *Employee and Labor Relations Manual*, as a general rule management has discretion in the granting of LWOP; this is an administrative decision that must be based on the needs of the employee, the needs of the Postal Service and the cost to the Postal Service. However, if the employee has exhausted paid leave then LWOP *must* be granted for an FMLA-covered condition.

NALC Form 2 - Family and Medical Leave Act of 1993

Health Care Provider: Please Complete this Form Using Extra Sheets if Needed, and Return to Employee

Medical Certification—Employee's Own Serious Health Condition

The employee's health care provider must complete this form when an employee requests FMLA leave and *medical documentation is required* (see ELM Sections 512.41, 513.6 and 515.5). A Form PS 3971, Request for or Notification of Absence, also must be completed and submitted as usual.

Employee: Return the completed form to the appropriate Postal Service Supervisor, and keep a copy for your own records.

Employee Name (Print)

1. Description of serious health condition: The back (p. 2) of this form describes what is meant by a "serious health condition" under the Family and Medical Leave Act. Does the employee's condition[1] qualify under any of the categories described? If so, please check the applicable category.

❒ 1 ❒ 2 ❒ 3 ❒ 4 ❒ 5 ❒ 6 ❒ None of these

2. Medical facts: Please describe briefly the medical facts which fit the category checked above, ***without*** including a specific diagnosis or prognosis.

3. Duration of condition and incapacity

a. **Date** the condition began: _____ **Probable duration** of the condition: _____

Probable duration of the patient's present incapacity[2] (if different): _____

b. Will it be necessary for the employee to take time off work only **intermittently or to work on a less than full schedule** as a result of the condition (including for treatment described in Item 4 below)? ❒ Yes ❒ No

If yes, give the probable duration: _____

c. If the condition is a **chronic condition** (condition #4) or pregnancy(#3), state whether the patient is presently incapacitated and the likely duration and frequency of **episodes of incapacity:**

4. If **additional treatments** will be required for the condition, please describe: the nature of such additional treatments or continuing regimen of treatment under your supervision (e.g., prescription drugs, physical therapy requiring special equipment); the probable number of such treatments; the length of absence required; and the actual or estimated dates of the treatments, if known.

5. Is the employee able to perform the functions of his or her position? ❒ Yes ❒ No

If not, please describe the employee's restrictions and their duration: _____

Health Care Provider Signature _____ Date _____

Address _____ Phone _____

"Serious Health Condition"
Definition under Family and Medical Leave Act of 1993

A "serious health condition" of a family member is defined in the FMLA regulations as any illness, injury, impairment or physical or mental condition that involves one of the following:

1. Hospital care:
This means **inpatient care** (that is, 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.

2. Absence plus 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:

- **a.** **Treatment[3] 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
- **b.** **Treatment** by a health care provider on **at least one occasion** which results in **a regimen of continuing treatment**[4] 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

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

5. 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 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 incapacity 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).

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

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

[3] **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.

[4] 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.

NALC Form 3 - Family and Medical Leave Act of 1993

Employee Should Deliver Completed Form to Postal Service Supervisor, and Keep a Copy

Employee's Certification of Own Serious Health Condition

An employee should use this form to request FMLA leave in situations where *medical documentation is not required* (see ELM Sections 512.41, 513.36 and 515.5). A Form PS 3971, Request for or Notification of Absence, also must be completed and submitted as usual.

Employee Name (Print)

1. Description of serious health condition: To qualify for leave for your own serious illness under the Family and Medical Leave Act, your condition[1] must qualify as a "serious health condition" under the special definition in the law, described on the back (p. 2) of this form. Does your condition qualify under any of the categories described? If so, please check the applicable category.

❒ 1 ❒ 2 ❒ 3 ❒ 4 ❒ 5 ❒ 6

2. Duration of condition

a. Date the condition began: _____

b. Probable duration of the condition: _____

Employee Signature _____ Date _____

"Serious Health Condition"
Definition under Family and Medical Leave Act of 1993

A "serious health condition" of a family member is defined in the FMLA regulations as any illness, injury, impairment or physical or mental condition that involves one of the following:

1. Hospital care:
This means **inpatient care** (that is, 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.

2. Absence plus 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:

- **a.** **Treatment[3] 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
- **b.** **Treatment** by a health care provider on **at least one occasion** which results in **a regimen of continuing treatment**[4] 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

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

5. 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 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 incapacity 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).

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

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

[3] **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.

[4] 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.

NALC Form 4 - Family and Medical Leave Act of 1993

Health Care Provider: Please Complete this Form Using Extra Sheets if Needed, and Return to Employee

Medical Certification—Family Member's Serious Health Condition

Employee: Return the completed form to the appropriate Postal Service Supervisor, and keep a copy for your own records.

Employee Name (Print)

1. Patient's name: _____

Relationship to employee: ❒ Child ❒ Spouse ❒ Parent

2. Description of serious health condition: The back (p. 2) of this form describes what is meant by a "serious health condition" under the Family and Medical Leave Act. Does the patient's condition[1] qualify under any of the categories described? If so, please check the applicable category.

❒ 1 ❒ 2 ❒ 3 ❒ 4 ❒ 5 ❒ 6 ❒ None of these

3. Medical facts: Please describe briefly the medical facts which fit the category checked above, without including a specific diagnosis or prognosis.

_____

4. Duration of condition and incapacity

a. **Date** the condition began: _____ **Probable duration** of the condition: _____

Probable duration of the patient's present incapacity[2] (if different): _____

b. If the condition is a **chronic condition** (condition #4) or pregnancy(#3), state whether the patient is presently incapacitated and the likely duration and frequency of **episodes of incapacity:**

_____

_____

5. If **additional treatments** will be required for the condition, please describe: the nature of such additional treatments or continuing regimen of treatment under your supervision (e.g., prescription drugs, physical therapy requiring special equipment); the probable number of such treatments; the length of the employee's required absence for the treatments; and the actual or estimated dates of the treatments, if known.

_____

6. Need for employee's care

a. Does the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation? ❒ Yes ❒ No

b. If no, would the employee's presence to provide **psychological comfort** be beneficial to the patient or assist in the patient's recovery? ❒ Yes ❒ No

c. Will it be necessary for the employee to take time off work **intermittently or to work on a less than full schedule** as a result of the patient's condition and/or treatments? ❒ Yes ❒ No

If yes, give the probable duration: _____

Health Care Provider Signature _____ Date _____

Address _____ Phone _____

"Serious Health Condition"
Definition under Family and Medical Leave Act of 1993

A "serious health condition" of a family member is defined in the FMLA regulations as any illness, injury, impairment or physical or mental condition that involves one of the following:

1. Hospital care:
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2. Absence plus 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:

- **a.** **Treatment[3] 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
- **b.** **Treatment** by a health care provider on **at least one occasion** which results in **a regimen of continuing treatment**[4] 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

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

5. 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 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 incapacity 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).

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

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

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[4] 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.

NALC Form 5 - Family and Medical Leave Act of 1993

Employee Should Deliver Completed Form to Postal Service Supervisor, and Keep a Copy

Employee Notice of Need for Intermittent Leave or for a Reduced Work Schedule

An employee should use this form to request FMLA leave involving intermittent periods of time off or a reduced daily or weekly work schedule. When the reason for the leave is the employee's or a family member's ***serious health condition*** (including incapacity due to pregnancy or childbirth), the appropriate additional form (NALC FMLA Form 2, 3 or 4) should also be completed and attached. Management must grant the intermittent leave or reduced work schedule leave when medical necessity is shown; subject to the health care provider's instructions, where leave is foreseeable the employee should try to work out a schedule with management that meets the carrier's medical needs, or family member's need for care, without unduly disrupting management's operation.

When intermittent leave or a reduced work schedule is requested to ***care for an employee's new child*** during the first year after the birth, placement in foster care or adoption (non-health reasons), management approval is needed. (Under ELM Section 514, as a general rule management has discretion in the granting of LWOP; this is an administrative decision that must be based on the needs of the employee, the needs of the Postal Service and the cost to the Postal Service.) The employee should seek the assistance of an NALC representative where needed.

A Form PS 3971, Request for or Notification of Absence, also must be completed and submitted as usual for each pay period.

Employee Name (Print)

1. Reason for reduced or intermittent schedule: The reason for this notice of a need for intermittent leave or a reduced work schedule is:

- ❒ My own serious health condition, or I am needed to care for a family member with a serious health condition, as defined in the Family and Medical Leave Act (see attached certification).
  or
- ❒ To care for my new child (non-health reasons).

2. Description of intermittent leave or reduced work schedule, including duration:

Employee Signature _____ Date _____