BAPTIST HEALTH
RESPONSE
TO EMPLOYEE REQUEST FOR FMLA LEAVE

DATE: May 29, 2006

TO: Kimberly Bell EMPLOYEE # 11816

FROM: Ginger McKinnon, Human Resources Department

CC: Scott Edwards

SUBJECT: Request for Family/Medical Leave

Your request for Family and Medical Leave and Health Care Provider's Certification to care for your parent has been received.

You notified us that you need this leave beginning 6/1/06 and you expect to be able to return on or about 6/22/06. Please let us know as soon as possible if your return date should change.

Except as explained below, you have a right under the FMLA for up to 12 weeks of paid or 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 must be reinstated to the same or 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 FML for a reason other than: (1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FML; 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 FML.

This is to inform you that:

1. You are eligible for leave under the FMLA.

2. The requested leave will be counted against your annual FMLA leave entitlement. If you are unable to return to work once your 12-week FMLA entitlement has been exhausted, you will need to request a personal leave of absence. Forms and a copy of the Baptist Health Leave of Absence Policy are enclosed for your information and convenience. Please remember that granting of a personal leave of absence does not guarantee the same position upon return. Reinstatement will be at the decision of Baptist Health.

3. The first 16 hours of absence must be paid by the Paid Time Off Plan. If you have less than 16 hours or no accrued PTO, those hours will be unpaid absence before EID begins. EID may be used on the first day of absence due to hospitalization or outpatient surgery. You will be required to use all applicable accumulated Extended Illness Days (EID), and Paid Time Off down to forty (40) hours prior to going on any non-paid leave of absence.

4. You will be required to furnish an updated medical certification prior to 5/22/06, if you are unable to return to work as scheduled.

5. (a) The portion of premiums you normally pay for your health insurance, supplemental life insurance, disability insurance, cancer insurance, etc., must be continued during the period of FMLA leave. You will need to make a premium payment on the date of each payday that a paycheck is not produced and/or a premium deduction is not taken.

   In the event that your leave of absence extends beyond three months, you will be responsible for paying the full cost of the medical plan and dental plan (if applicable) during an extended leave. The cost per pay period for Blue Cross medical is $192 for employee only; $374.31 for employee and one dependent; and $513.23 for family. The cost for VivaHealth medical is $125.08 for employee only; $243.69 for employee and one dependent; and $333.69 for family. The cost for Blue Cross standard dental per pay period is $9.23 for employee only; $18 for employee and one dependent; and $28.15 for family. The cost for the high option dental Plan is $12 for employee only; $27.69 for employee and one dependent; and $44.31 for family. All other benefit costs that you currently pay will remain the same.

   (b) You have a minimum 30-day grace period in which to make premium payments. If payment is not made in a timely manner, 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.

6. If your leave is due to your own serious health condition or childbirth, you will be required to present a statement from your attending physician. The certification should indicate that you are able to return to work and perform all appropriate/required job functions in accordance with your job description prior to being restored to employment. The determination of your abilities/qualifications will be made by the Employee Health Nurse and a Human Resources Manager based upon the attending physician's statement. If such certification is not received, your return to work may be delayed until certification is provided.

7. If you are unable to return to work due to limitations or restrictions on work activities, you must extend your leave, if eligible, until you are able to perform the functions of your job. You may also discuss transfer options with Human Resources. If leave time has been exhausted and there are not transfer options available, you may have to terminate your employment.

   If you have a disability covered by ADA, you should consult with Human Resources about your current position or available positions that may reasonably accommodate the limitations. In the event that a transfer to an available position is possible, you will receive the pay commensurate

with a new position based on transfer policies. In the event you have a disability covered by ADA and cannot perform the essential functions of the current position with reasonable accommodations and you refuse a transfer, or no alternate position is found, you may have to terminate your employment.

If we can be of assistance, please do not hesitate to contact me at 286-2603.

Effective April 1, 2005

The attached Request for Family and Medical Leave (FML) form is to be used by all employees who:

1. have been employed at least one year and have also worked at least 1250 hours in the previous 12-month period prior to the start of their FML;

2. and, are requesting a continuous or intermittent FML for the birth of a baby; adoption or foster care of a child; the employee's own serious health condition; or to care for the employee's spouse, child, or parent who has a serious health condition.

A Request for Leave of Absence Form should be completed if:

1. the leave is for a medical reason and the employee has been employed for at least six continuous months but has not been employed for one year and/or has not worked at least 1250 hours in the previous 12-month period;

2. or, the leave is for personal reasons and the employee has been employed for at least six continuous months;

3. or, the employee is requesting a Military Leave of Absence.

All leave (whether FML or Personal Leave) requests must be presented in writing on the appropriate form as far in advance as possible. When need for leave is forseeable (or could be scheduled in order so that notice could be provided), request must be presented in writing at least 30 days before the start of leave.

REQUEST FOR FAMILY AND MEDICAL LEAVE

FORM MUST BE COMPLETED IN ITS ENTIRETY OR WILL BE RETURNED AND COULD RESULT IN A DELAY OF YOUR START OF LEAVE

All employees are eligible to apply for Family and Medical Leave (FML) after **one year of employment** and if they have worked **at least 1,250 hours** in the 12-month period prior to requested commencement date of leave. Family and Medical Leave may be paid or unpaid.

THIS IS MY ☐ INITIAL or ☐ RE-CERTIFICATION for Family and Medical Leave in accordance with Leave of Absence Policy #308 attached.

EMPLOYEE NAME: _____

EMPLOYEE NUMBER: _____ **FACILITY** _____ **DEPT. NAME**_____

DEPT. #_____ **JOB TITLE** _____

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TYPE OF LEAVE REQUESTED:

Regular Family and Medical Leave

- ☐ The birth of a baby
- ☐ Adoption or foster care of a child (legal documentation required)
- ☐ My serious health condition*
- ☐ To care for a spouse, child or parent who has a serious health condition*

Name of Patient_____

Relationship to me_____

Re-certification required initially after 45 days; thereafter, must re-certify every 30 days

Intermittent Family and Medical Leave

- ☐ The birth of a baby
- ☐ Adoption or foster care of a child (legal documentation required)
- ☐ My serious health condition*
- ☐ To care for a spouse, child or parent who has a serious health condition*

Name of Patient_____

Relationship to me_____

Re-certification required initially after 45 days; thereafter, must re-certify every 30 days.

I need Family and Medical Leave for the following reason(s). If for care of parent, spouse or child, state the type of care you will provide.

_____

_____

_____

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DATES OF LEAVE:

- ☐ I expect Family and Medical Leave to begin on _____. If this request is granted, I expect to return to work on _____ **(if you do not know an exact date, you must give an estimated date of return).**
- ☐ I need Family and Medical Leave on an intermittent basis for an estimated period beginning _____ and ending _____. Attach a schedule of dates and/or frequency of estimated absences.

(continued on reverse side)

By initialing and signing below and submitting this request, I certify that I understand the following:

_____ initial I will be required to provide a health care provider certification to support my request for Family and Medical Leave (FML)because of a serious health condition for a family member or myself. I acknowledge that I have received the certification of health care provider and understand that it must be returned within 15 calendar days. **Failure to provide this certification within fifteen (15) calendar days may result in the delay of my FML until proper certification is received and absence may be counted as an occurrence.** If I am requesting FML for my own serious health condition, I understand that I must have a statement from my attending physician certifying that I am able to return to work and perform all appropriate/required job functions in accordance with my job description.

_____ initial I hereby authorize the Employee Health Nurse to contact the health care provider who completes the health care certification supporting my FML to clarify and/or authenticate the information contained in the certification.

_____ initial I understand that if the need for my FML is foreseeable (or could be scheduled in order so that I could provide notice), **I must provide at least 30 days notice before the start of my FML.** My failure to submit this completed written request in a timely manner may result in discipline and/or delay the start of my FML, but will not affect the granting of any FML entitlement I may have under state or federal law.

_____ initial My health insurance as well as any other employee benefits will continue as long as my premium payments are made. My failure to make these payments may result in the cancellation of any coverage I may have.

_____ initial I understand that I must use all applicable accumulated Extended Illness time (EID)and Paid Time Off down to forty (40) hours prior to going on an unpaid FML. EID may be used from first day out if in-patient hospital or if outpatient surgery occurs on the first day out. **For intermittent FML for spouse, parent or child, a physician's excuse is required for each absence for the payment of EID.** For intermittent FML for myself, a physician's excuse may be required each absence for the payment of EID.

_____ initial If I am granted a leave under the Family and Medical Leave Act (FMLA) and I return to work within 12 weeks from the commencement of my FML, I will be reinstated to my previous position or its equivalent. If my leave (1) extends longer than 12 weeks while on Family and Medical Leave OR (2) is a non-FML leave, my job placement upon my return will depend upon position availability, with no assurance of a job unless otherwise required by state or federal law.

_____ initial I am only entitled to twelve (12) weeks of leave in a rolling twelve-month period for qualifying reasons under the FMLA. A week is based on my regularly scheduled hours during a calendar week Sunday through Saturday. For example, an employee who regularly works 20 hours a week would be entitled to 240 hours of FML; an employee who regularly works 40 hours a week would be entitled to 480 hours of FML. Additional leave for non-FMLA reasons is provided by the Company according to the Leave of Absence Policy #308. If I do not return from leave or notify Human Resources in writing by my expected date of return, I may be terminated for job abandonment after two (2) days.

_____ _____

Employee Signature **Date**

_____

Addresss While on Leave Street City State Zip

_____

Phone Number While On Leave (include area code)

Employee, also please sign authorization next page

Acknowledgement by Department Manager _____

Department Manager Signature **Date**

Authorization to Release Medical Information

I hereby authorize _____, my health care provider, to release medical information for the purpose of determining compliance with the Family and Medical Leave Act of 1993. I also give consent to Baptist Health employee health nurse to contact the health care provider listed to clarify and authenticate the information contained herein, if necessary.

_____ _____

Patient Signature Date

CERTIFICATION OF HEALTH CARE PROVIDER

This section is to be completed by the health care provider ONLY. **Employee completion is not acceptable**. Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking Family and Medical Leave. This form is an approved Department of Labor form as required by the Family and Medical Leave Act. Employee must submit completed form to Baptist Health Human Resources within 15 days as required by the Family and Medical Leave Act.

Employee Name: _____

Patient's Name (if different from employee): _____
Relationship of Patient to employee: _____

I. A **"serious health condition"** means an illness, injury, impairment, or physical or mental condition that involves one of the categories below under the Family and Medical Leave Act. Does the patient's condition qualify under any of the categories described? Yes ____ No ____ If Yes, please check the applicable category listed below:

- ☐ **Hospital Care** - **Inpatient care** (i.e. an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity1 or subsequent treatment in connection with or consequent to such inpatient care.

- ☐ **Absence plus treatment** - A period of incapacity of **more than three consecutive calendar days** (including any subsequent treatment or period of incapacity1 relating to the same condition), that also involves:

  1) **Treatment2 two or more times** by a health care provider, by a nurse or physician assistant under direct supervision of a health care provider, or by a provider of health care services (i.e. physical therapist) under orders of, or on referral by, a health care provider; or
  2) **Treatment2** by a health care provider on **at least one occasion** which results in a **regimen of continuing treatment3** under the supervision of the health care provider.

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

- ☐ **Chronic conditions requiring treatments** - A **chronic condition** that:
  1) Requires **periodic visits** for treatment by a health care provider, or by a nurse or physician assistant under direct supervision of a health care provider; (or)
  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 incapacity1 (i.e. asthma, diabetes, epilepsy, etc).

- ☐ **Permanent/Long-term Conditions Requiring Supervision** - A period of **incapacity1** that 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.

- ☐ **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 "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 thereof, or recovery therefrom.

2 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.

3 A regimen of continuing treatment includes, for example, a course of prescription medication (e.g. antibiotic) or therapy requiring such 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 initiate without a visit to a health care provider.

II. Describe the medical facts that support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories:

III. 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 if different):

b. Will is 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 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 incapacitated and the likely duration and frequency of episodes of incapacity.

IV. 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 of 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, provider a general description of such regimen. (e.g. prescription drugs, physical therapy requiring special equipment):

V. 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** (the employee or the employer should supply you with information about the essential job functions)? If yes, please list the essential functions the employee is unable to perform:

c. If neither, a. nor b. applies, is it necessary for the employee to be **absent from work for treatment**?

VI. 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 will need care only **intermittently** or on a part-time basis, please indicate the probable **duration** of this need:

_____ _____

Signature of Health Care Provider (**Stamped Signature not Acceptable**) Date

_____ _____

Printed Name of Health Care Provider Type of Practice

_____ _____ _____ _____

Street Address City State Zip

_____

Telephone Number (Include Area Code)

NUMBER:	308
SUBJECT:	LEAVE OF ABSENCE
EFFECTIVE DATE:	June 30, 1996
REVISION DATE:	November 1, 2001 July 1, 2000 August 23, 1998

POLICY

A leave of absence (LOA) is an approved paid or non-paid leave of absence from the job greater than 14 consecutive days and can continue up to three months. All employees are eligible to apply for a personal Leave of Absence after six months of continuous employment. All requests for LOA must be approved in advance.

PROCEDURE

TIME OF REQUEST AND APPROVAL

All LOA requests must be presented in writing by the employee to the manager on an LOA request form as far in advance as possible (30 days preferred). Each leave of absence request will be considered on its own merit and must be approved by the manager prior to taking leave. All completed LOA forms, whether or not approved, should be forwarded to Human Resources immediately. The manager should report the actual date the leave begins and the actual date the employee returns by sending a Personnel Action Request to Human Resources.

All requests for extension of leave must be in writing prior to the expiration date of the original leave of absence and submitted to the manager for approval and forwarded to Human Resources immediately.

It is the employee's responsibility prior to going on leave of absence to contact the Human Resources Department regarding employee benefit coverage. An employee must use all applicable accumulated Extended Illness Days (EID), if on medical leave, and Paid Time Off down to forty (40) hours prior to going on any non-paid leave of absence except for Military Leave.

There are three types of leave:

- Family and Medical Leave
- Personal Leave
- Military Leave

Family and Medical Leave (FML)

Employees are eligible for FML if they have worked for at least twelve months and worked at least 1,250 hours in the past twelve months immediately before the leave begins. An eligible employee is entitled to FML for one of the following reasons:

(a) the birth of a child, or the placement of a child with the employee for adoption or foster care;
(b) to care for a spouse, son, daughter or parent with a serious health condition; or
(c) for the employee's own serious health condition.

Use of accrued paid leave begins at the start of a Family and Medical Leave and is counted concurrently as part of the twelve weeks of Family and Medical Leave.

If an employee goes out unexpectedly, his or her manager should notify the employee verbally that the time out will count towards their FMLA entitlement, if it qualifies, and that Human Resources will mail the necessary paperwork. The manager should then notify Human Resources immediately (preferably by e-mail) that the employee has been notified verbally and include the date that the employee's leave began and the date that the employee was notified.

Leave may be taken intermittently as necessary to care for a qualified family member with a serious health condition or for the serious health condition of the employee, but only if such a schedule is needed for qualified health reasons. Employees are eligible for a total of twelve (12) weeks leave in any twelve (12) month period. Spouses who are both employed by Baptist Health may take a combined total of twelve (12) weeks during any twelve (12) month period for the birth, placement or adoption of a child or an ill parent. The employee will be restored to the original or equivalent position with equivalent pay, benefits and other employment terms unless a reduction in force or job elimination occurs during the leave period.

Employees must complete a Leave of Absence Request thirty (30) days prior to the leave for foreseeable events (such as an expected birth or adoption of a child or for planned medical treatments). In cases where the need for leave cannot be anticipated thirty (30) days in advance, the employee shall give notice as soon as possible after the employee learns of the need for leave.

If you are requesting a medical leave for your own serious health condition or serious health condition of a qualified family member, you must furnish the Certification of Health Care Provider form within 15 days. Baptist Health may require second and third opinions (at Baptist Health's expense).

Employees qualifying for a Family and Medical Leave may apply for a Personal Leave after all Family and Medical Leave has been utilized. All requests for an extension of leave must be in writing prior to the expiration of the Family and Medical Leave and submitted to the Department Director for approval. A second extension of the personal leave, up to an additional three months, may be considered for employees with a serious medical condition only.

Personal Leave

A personal leave not to exceed three months may be granted for personal reasons, family emergencies, civic responsibilities, education or illness which does not qualify for FML. Such leave must be granted at the convenience of Baptist Health. Granting of leave of absence does not guarantee the same position upon return. Reinstatement will be at the decision of Baptist Health based on staffing needs.

Failure to return to work at the end of this three-month leave will result in termination.

Military Leave

Requests for Military Leave should be made as soon as possible in advance of the projected beginning of the leave to enable Baptist Health to adjust the work schedule accordingly.

Active Duty - A leave of absence will be granted to the employee for the purpose of entering the Armed Services of the United States. An employee shall not lose seniority as a result of serving the Armed Services.

Reserve Duty - Members of the Reserve or National Guard receiving official orders for active duty training or training periods while on inactive status will be granted leave from their jobs as required to fulfill their military obligation. Such absences will not affect seniority, status, pay rate, or vacation accrual rate. An employee may elect to use accrued PTO with pay for brief periods of military duty or to take an unpaid leave of absence.

BENEFITS ON LEAVE

Employees on leave for a three-month period may keep their elected coverage by paying the employee portion of the benefit costs. Employees approved for additional leave must pay the full cost of employee benefits to maintain coverage. Paid Time Off and Extended Illness Days accrue only to the extent that the employee is on paid leave.

DISABILITY

Employees who become permanently disabled should report immediately to Human Resources so that the appropriate insurance carriers may be notified for Waivers of Premiums, if qualified.

RETURN TO WORK

Department managers must notify Human Resources immediately by e-mail upon the employee's return to work.

Employees returning from non work related illness or injuries which are not disabilities under the ADA must have a statement from their attending physician certifying them as able to return to work and perform all appropriate/required job functions in accordance with the employee's job description. The determination of the employee's abilities/qualifications shall be made by the Employee Health Nurse and a Human Resources Manager, based upon the attending physician's statement.

Employees unable to return to work due to limitations or restrictions on work activities must extend their leave, if eligible, until they are able to perform the functions of their job. The employee may also discuss transfer options with Human Resources. If the leave time has been exhausted and there are no transfer options available, the employee may have to terminate his/her employment.

Employees with a disability covered by the ADA should consult with Human Resources about their current position or available positions which may reasonably accommodate the limitations. In the event that a transfer to an available position is possible, employees will receive the pay commensurate with a new position based on transfer policies. In the event an employee has a disability covered by the ADA and cannot perform the essential functions of the current position with reasonable accommodations and the employee refuses a transfer, or no alternate position is found, the employee may be terminated.

TERMINATION DUE TO UNSCHEDULED ABSENCES

The organization's ability to offer continuous and cost-effective services to the community it serves is contingent upon the dependable effort of each of its employees. The organization reserves the right to place an individual on LOA or terminate any individual who fails to make the required work contribution due to unscheduled absences.

Baptist Heal
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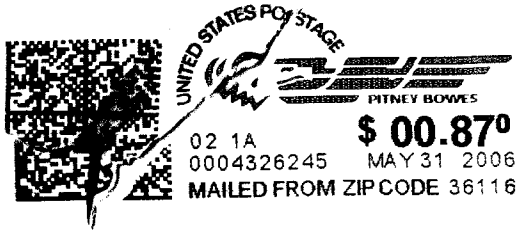
Montgon



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