REQUEST FOR FAMILY OR MEDICAL LEAVE

Employee Notification

Request for Family or Medical Leave must be made in writing, if practical, at least 30 days prior to the date the requested leave is to begin.

Name Frances Kerr

Date Feb. 3, 2014

School Maya Angelou Position 1st Grade Teacher

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I request a family or medical leave for one or more of the following reasons. I understand that a physician's certification and all required information must be submitted before this request is processed.

Because of the birth of my child, or because of the placement of a child with me for adoption or foster care.

In order to care for my spouse/child/parent who has a serious health condition.

For a serious health condition that makes me unable to perform my job. THIS CONDITION IS IS NOT WORK RELATED.

Requested intermittent or reduced leave scheduled - need to take a few days off when he initially comes home on 2/6/14 and then days as needed from there.

Leave to start 2/6/14 Expected return date / /

I would like to use my sick/personal days

I would not like to use my sick/personal days

Original request for leave

Request for extended leave

Employee Signature Frances Kerr Date 2/3/14

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Loretta [illegible]

S. [illegible]

2/4/14

87.50 - sick days

1.50 - personal days

02-04-14A10:48 RCVD

Certification of Health Care Provider for Family Member's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 2/28/2015

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

Employer name and contact: Harvey School District 152

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your family member or his/her medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a covered family member with a serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Your name: Frances (First) (Middle) Kerr (Last)

Name of family member for whom you will provide care: Romeyn (First) Frances (Middle) Kerr (Last)

Relationship of family member to you: parents

If family member is your son or daughter, date of birth: ———

Describe care you will provide to your family member and estimate leave needed to provide care:

When my father is discharged from the hospital, I will assist him in his daily activities (walking, dressing, doing his rehab exercises, meals, laundry) as well as doctors' appts, physical therapy appts, etc. As to my mother, her ability to walk or stand is limited. As my father does many things for her and their household, I would assist as my father recovers. In the interim, my mother may need assistance as well as my father in handling matters.

Employee Signature Date

SECTION II: To Be Completed by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the patient needs leave. Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address: CHRIS KOLLYVAS MD 301 N MADISON ST STE 207 JOLIET IL 60435

Type of practice / Medical specialty: CARDIOLOGY

Telephone: (815) 729.3280 Fax: 815 729.3294

Part A: Medical Facts

1. Approximate date condition commenced: 12-25-13

Probable duration of condition: _____

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
__No X Yes. If so, dates of admission: 12-25-13 to 1-10-14 then 1-10-14 to current

Date(s) you treated the patient for condition: 1-10-14 to current

Was medication, other than over-the-counter medication, prescribed? __No X Yes.

Will the patient need to have treatment visits at least twice per year due to the condition? __No X Yes

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
__ No ✓ Yes. If so, state the nature of such treatments and expected duration of treatment:
Physical therapy

2. Is the medical condition pregnancy? X No __Yes. If so, expected delivery date: _____

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):
Severe heart disease. Post traumatic fall
Very debilitated

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ____No ____Yes.

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per _____ week(s) _____ month(s)

Don't know. Chronic heart disease

Duration: _____ hours or ____ day(s) per episode

Does the patient need care during these flare-ups? ____No ____Yes.

Explain the care needed by the patient, and why such care is medically necessary: _____

[redacted]

Signature of Health Care Provider

1-29-14

Date

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210.
DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.