Dear Employee,

20-1923 **(05-08)**

You may be eligible for leave under the Family and Medical Leave Act (FMLA) as described in the attachment, "Your Rights Under the Family and Medical Leave Act of 1993", and applicable state laws. The enclosed materials describe your rights and obligations under FMLA. The company will comply with any state laws and contractual bargaining agreements. In order to be approved for FMLA, you must complete and submit the enclosed *Family and Medical Leave Act (FMLA) Medical Certification Form.*

Note that you may apply for leave on an intermittent basis or reduced schedule. Section B of the form covers this. It is your responsibility to ensure that your completed form is received by our office, via fax or mail, within 25 days of your first day of absence or 25 days from the date the absence was reported. Please allow for appropriate mail time. We strongly recommend that you retain a copy of the application and proof of mailing/ faxing for your records. The Family and Medical Leave Act (FMLA) Medical Certification Form must be completed by:

- Your health care provider - if you are requesting an absence for yourself due to a serious health condition.
- Your family member's health care provider - if you are requesting an absence to care for a family member with a serious health condition.
- Yourself - if you are requesting an absence to care for a newborn under twelve months old, or for the placement of a child with you for adoption or foster care. Please also provide proof of birth or placement.

Fees charged by health care provider for completion, copying or faxing of the Family and Medical Leave Act (FMLA) Medical Certification Forms are the responsibility of the employee.

We will notify you of the status of your FMLA request after receiving and reviewing the completed *Family and Medical Leave Act (FMLA) Medical Certification Form.* Generally, you should receive written notice of the approval or denial of FMLA leave for this absence within approximately a week from receipt of your completed form.

If approved:

- The period of your approved leave will be counted toward your twelve (12) workweek FMLA allotment, and state allotment, if applicable.
- Your FMLA leave will run concurrent with any periods of approved payments under any applicable plan, policy, program, or collective bargaining agreement.
- If you are not entitled to payment during FMLA leave, you may supplement your leave with other available paid time off, such as vacation or personal days.
- Recertification will be required if your leave exceeds the period designated by the health care provider. When applying for intermittent leave for a health condition which is chronic or requires periodic treatments or a reduced leave schedule, please be certain that your health care provider indicated the duration of the leave required on the *Family and Medical Leave Act (FMLA) Medical Certification Form.*
- If you fail to return to work upon the expiration of your FMLA leave, and you have not made any alternative arrangements, the company may treat your failure to return as a voluntary resignation, unless your absence has been approved under the provisions of the Sickness and Accident Disability Benefit Plan.

Your FMLA request may be denied, and therefore, the absence may be subject to the provisions of the established attendance plan and practices in your area, if:

- The completed form is not received by our office within 25 days (calendar days) from the first day of absence or 25 days (calendar days) from the date the absence was reported.
- The information provided by your health care provider regarding your health condition does not establish a serious health condition under FMLA regulations.
- Your absence exceeds your remaining FMLA entitlement.

Please remember that it is your responsibility to follow-up with your health care provider to ensure the completed form is received by our office within 25 days from the first day of absence or 25 days (calendar days) from the date the absence was reported. You are responsible for communicating with your Supervisor/ Absence Administrator during your absence period.

If your absence is approved under the applicable disability plan within 39 days from the date the absence was reported into AMTS, the absence will also be approved under FMLA. However, you will not have another opportunity to apply for FMLA leave for this absence if your short term disability is not approved within this 39 day period. Accordingly, to ensure that your absence is considered for FMLA leave coverage, you must return a completed FMLA Medical Certification Form within the time frame specified.

If you have any questions, please contact the FMLA Administrator at (877) 275-8947 or visit the Verizon eweb and search for fmla.

Medical certification forms will NOT be accepted prior to the first day of a reported absence.

Please complete and return to:

Verizon West (fGTE) Employees
The FMLA Team
700 Hidden Ridge Mailcode: HQW03H65
Irving, TX 75038
Fax: (214) 285-1587
Phone: (877) 275-8947

Verizon East (fBA N/S & VIS) Employees
The Absence Reporting Center
500 Summit Lake Drive, 4th
Valhalla, NY 10595
Fax: 877-786-4500
Phone: (877) 275-8947

Family and Medical Leave Act (FMLA) Medical Certification Form

FMLA is a federal law that guarantees "eligible" employees up to twelve (12) workweeks of job-protected absence for certain family and medical reasons. You are eligible to request an FMLA absence if you have worked for the company for at least one year, worked a minimum of 1250 hours over the previous twelve (12) months, and need to be absent for one of the following reasons:

- A serious health condition that makes you unable to perform any one of the essential functions of your job.
- To care for your immediate family member (spouse, child, or parent) who has a serious health condition.
- To care for your newborn child, or placement of an adopted or foster child.

Family and Medical Leave Act Definitions for Health Care Providers

as defined by the Department of Labor's Regulations

Activities of daily living (ADLs): Examples include adaptive activities such as caring appropriately for one's grooming and hygiene, bathing, dressing and eating.

Health Care Provider (HCP): Authorized health care providers include any of the following who are authorized to practice under State law, and who are practicing within the scope of that practice: doctors of medicine or osteopathy, podiatrists, dentists, clinical psychologists, optometrists and chiropractors, nurse practitioners, nurse-midwives, clinical social workers, and any other person determined by the Secretary of Labor to be capable of providing health care services.

Incapacity: The inability to work or perform regular daily activities due to the patient's serious health condition, treatment for that condition, or recovery from that condition.

Instrumental activities of daily living (IADLs): Activities include cooking, cleaning, shopping, paying bills, maintaining a residence, using a post office and telephone.

Regimen of Continuing Treatment: Treatment including, 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.

Serious Health Condition: An illness, injury, impairment, or physical or mental condition that meets one of the following criteria:

1. **Hospital Care:** Inpatient care (e.g. 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 (Acute):** 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) Two or more treatments by an HCP or by a nurse or physician's assistant under direct supervision of an HCP, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, an HCP; or
   (B) At least one treatment by an HCP which results in a regimen of continuing treatment under the supervision of the HCP.
3. **Pregnancy:** Any period of incapacity due to pregnancy, or for prenatal care.
4. **Chronic Health Condition Requiring Treatments:** A chronic condition which:
   (A) Requires periodic visits for treatment by an HCP, or by a nurse or physician's assistant under direct supervision of an HCP;
   (B) Continues over an extended period of time; and
   (C) May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).
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, e.g. Alzheimer's, a severe stroke. The patient must be under the continuing supervision of, but need not be receiving active treatment by, an HCP.
6. **Scheduled Multiple Treatments:** Any period of absence to receive scheduled multiple treatments (including any period of recovery) by an HCP or by a provider of health care services under orders of, or on referral by, an HCP, 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).

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.

Family and Medical Leave Act (FMLA) Certification Form

Verizon 05/08

Employee's Name: _____ **First Day of Absence** _____ **BAID** _____

INSTRUCTIONS : We estimate that it will take an average of ten (10) minutes to complete this form.
Please note : Incomplete Form Will Be Returned For Completion

1. **Employee** Complete Section **A**
2. **Employee's Treating Health Care Provider** - Complete Sections **B** and **D**
3. **Family Member's Treating Health Care Provider** - Complete Sections **B, C,** and **D**

SECTION A: (TO BE COMPLETED BY THE **EMPLOYEE.** PLEASE BE ADVISED THAT KNOWINGLY PROVIDING FALSE OR INACCURATE INFORMATION IN THIS CERTIFICATION IS A VIOLATION OF THE COMPANY'S CODE OF BUSINESS CONDUCT.)

Type of Leave : (check all that apply)

____ New Request ____ Extension/Recertification ____ On the Job Injury

Reason for Leave: (check one)

____ A serious health condition that makes you unable to perform any one of the essential functions of your job.

____ A serious health condition affecting your spouse, child or parent for which you are needed to provide care.

____ The birth of your child, or the placement of a child with you for adoption or foster care for the period beginning ___/___/____ through ___/___/___ . You must attach documentation supporting the date of your child's birth, or the date of foster placement or adoption.

Requested FMLA: (check all that apply)

____ Full Time Leave - Taken in consecutive, full day increments.

____ Intermittent Leave - Taken periodically over an extended period of time.

____ Reduced Work Schedule - Taken on consecutive days; employee is able to work some of his/her work schedule each day.

By placing my signature below, I authorize my health care provider to **(a)** complete this form and **(b)** clarify any information provided on the form that is incomplete or unclear, either verbally or in writing. I hereby certify that the information provided on this certification form is true and accurate.

Signature of Employee or Family Member : _____ **Date :** _____/_____/_____

SECTION B: (TO BE COMPLETED BY THE **TREATING HCP**. PLEASE NOTE: INCOMPLETE FORMS WILL BE RETURNED FOR COMPLETION AND MAY RESULT IN DENIAL OF FMLA.)

1A. Describe the medical facts, which support your certification, including a brief statement as to how the medical facts meet the criteria for a serious health condition under the FMLA (see page one).

_____

_____

1B. If leave is for the **employee's** own health condition, please describe how the health condition interferes with the performance of essential job function(s).

_____

_____

2. This patient has been under my care for this health condition since: _____/_____/_____.

3. Does the patient's condition qualify as a *serious health condition* under the Family and Medical Leave Act (FMLA)? (See page one for *Family and Medical Leave Act Definitions for Health Care Providers.*)

____ **NO**, the patient's condition does not qualify as a serious health condition under FMLA. (If you check this box, go directly to Section D.)

____ **YES**, the patient's condition qualifies as a serious health condition according to the following category as described by FMLA regulations. (Please check all that apply, and complete the applicable information.)

Family and Medical Leave Act (FMLA) Certification Form

Verizon 05/08

Employee's Name: _____ **First Day of Absence** _____ **BAID** _____

SECTION B - continued: (TO BE COMPLETED BY THE **TREATING HCP**. PLEASE NOTE: INCOMPLETE FORMS WILL BE RETURNED FOR COMPLETION AND MAY RESULT IN DENIAL OF FMLA.)

Question 3 (cont'd)

a) _____ **Hospital Care** (Inpatient – overnight stay)

Please answer ALL of the following questions:

- First Day incapacitated for this current episode: ____/____/____
- Last Day incapacitated for this current episode: ____/____/____
- Admit Date: ____/____/____ Discharge Date: ____/____/____
- Follow-up Appointment Date(s): _____
- If employee needs to be absent from work for follow-up appointment(s), please indicate the duration of the follow-up appointment(s): (#)_____(circle one: minutes, hours)

b) _____ **Absence Plus Treatment (Acute)**

Please answer ALL of the following questions:

- First Day incapacitated for this current episode: ____/____/____
- Last Day incapacitated for this current episode: ____/____/____

The patient's period of incapacity exceeded three (3) consecutive calendar days and involved treatment two (2) or more times by the health care provider, or treatment on at least one occasion which resulted in a regimen of continuing treatment. If a regimen of continuing treatment is required under your supervision, provide a general description of the regimen **(e.g., prescribed medication, physical therapy)**:

_____

_____

- Follow-up appointment date(s): _____
- If employee needs to be absent from work for follow-up appointment(s), please indicate the duration of the follow-up appointment(s): (#)_____ (circle one: minutes, hours)

c) _____ **Chronic Condition Requiring Treatment/ Permanent Long Term Condition Requiring Supervision**

The patient requires periodic visits to the health care provider for treatment, the condition continues over an extended period of time, and the condition may cause episodic rather than a continuing period of incapacity. The patient requires the following treatment including **prescribed medication,** examinations and/or evaluations of the condition:

_____

_____

Please complete ALL of the following questions that apply:

_____ Current Absence

- Period of incapacity for this absence : From ____/____/____ Through : ____/____/____

_____ Future Intermittent Absences (Please complete the following information.)

- How often do you expect this patient to be incapacitated due to their health condition? (indicate range, if applicable) (#)_____ times per (circle one: week, month, year) each lasting (indicate range, if applicable) (#)_____ (circle one: minutes, hours, days, weeks) for a period of (#)_____(circle one: weeks, months)

Family and Medical Leave Act (FMLA) Certification Form

Employee's Name: _____ **First Day of Absence** _____ **BAID** _____

SECTION B - continued: (TO BE COMPLETED BY THE **TREATING HCP**. PLEASE NOTE: INCOMPLETE FORMS WILL BE RETURNED FOR COMPLETION AND MAY RESULT IN DENIAL OF FMLA.)

Question 3 (cont'd)

d) ____ **Scheduled Multiple Treatments**

Please answer ALL of the following questions:

- First Day incapacitated for this current incident: ____/____/____
- Last Day incapacitated for this current incident: ____/____/____
- The patient will receive the following treatment:

  _____

  _____
- Treatments will commence on ____/____/____ through ____/____/____.
- The frequency of treatment is (#) ____ times per (circle one: week, month, year)
- The approximate length of the appointment (including travel time) is _____ (circle one: minutes, hours, days, weeks, months) (indicate range, if applicable)
- The period required for recovery from treatment is (#) ____ (circle one: minutes, hours, days, weeks).

e) ____ **Pregnancy**

- The patient's pregnancy was confirmed on ____/____/____ with an estimated delivery date (EDC) of ____/____/____.
- The patient is scheduled for approximately (#) ____ prenatal appointments.
- The approximate length of the prenatal appointment is (#) ____ (circle one: minutes, hours)
- Do you presently anticipate a need for the patient to be absent from work during her pregnancy?

  ____ Yes ____ No
  - If yes, please describe the medical facts that support this need: _____

    _____
  - How often do you expect this patient to be incapacitated due to this medical condition? (indicate range, if applicable)

    (#) ____ times per (circle one: week, month, year) each lasting (indicate range, if applicable)

    (#) ____ (circle one: minutes, hours, days, weeks) for a period of (#) ____ (circle one: weeks, months)

4. If a ***Reduced Work Schedule*** is necessary upon an employee's return to duty, please provide a description of the required work schedule.(i.e. number of hours per day) (#) _____ from ___/___/___ through ___/___/___

SECTION C: (TO BE COMPLETED BY THE **TREATING HCP** IF THE LEAVE REQUEST IS **TO CARE FOR A FAMILY MEMBER**. PLEASE NOTE: INCOMPLETE FORMS WILL BE RETURNED FOR COMPLETION AND MAY RESULT IN DENIAL OF FMLA.)

Patient's Name _____ Relationship to Employee _____ Date of Birth ___/___/___

5. It is necessary for the employee to be absent from work from ___/___/___ through ___/___/___ to care for this family member. (Please check any of the following and complete the applicable information.)

____ **Full Time Leave** - Taken in consecutive, full day increments

____ **Follow-up appointment to Full Time Leave**

- Duration of the follow-up appointment, that employee needs to be away from work: (#) ____ (circle one: minutes, hours)

____ **Intermittent Leave -** Taken periodically over an extended period of time, with a likely frequency of (#)___ -(#)____ times per (circle one: week, month, year) with a probable duration of (#)____ (circle one: minutes, hours, days, weeks) for a period of (#) ____ (circle one: weeks, months)

____ **Reduced Work Schedule** -Taken on consecutive days; the employee is able to work some of his/her work schedule each day. The employee is able to work (#)____ hours per day.

Family and Medical Leave Act (FMLA) Certification Form

Employee's Name: _____ **First Day of Absence** _____ **BAID** _____

SECTION C - continued: (TO BE COMPLETED BY THE **TREATING HCP**. PLEASE NOTE: INCOMPLETE FORMS WILL BE RETURNED FOR COMPLETION AND MAY RESULT IN DENIAL OF FMLA.)

6. Does the patient require assistance for :

Basic Medical or Personal Needs	☐ Yes ☐ No	Transportation	☐ Yes ☐ No
Psychological Comfort	☐ Yes ☐ No	Safety	☐ Yes ☐ No

7. If leave is required to care for a child age 18 or older, the child must be incapable of self-care. The individual must require active assistance or supervision to provide daily self-care in three or more of the activities of daily living (ADLs) or instrumental activities of daily living (IADLs). If the employee has requested FMLA leave to care for a child age 18 or older, please provide at least three ADLs/IADLs that the patient requires active assistance or supervision with. (See page one for the definition of ADLs and IADLs.)

_____

_____

SECTION D: (TO BE COMPLETED BY THE **TREATING HEALTH CARE PROVIDER**.)

We strongly recommend that you retain a copy of this form in the event clarification of its content is needed. Incomplete forms will be returned to the employee to be completed. This may result in a delay or denial of the employee's FMLA approval.

I certify that the above information is true and correct :

_____

Treating Health Care Provider's Printed Name | Signature | Date

_____

Type of Practice | Address | Phone# | Fax#

Fax Cover Sheet

Medical certification forms will NOT be accepted prior to the first day of a reported absence.

Employees please ensure to send the FMLA forms to the correct Processing Center:

Verizon West (fGTE) Employees
FMLA Team
700 Hidden Ridge Mailcode:HQW03H65
Irving, TX 75038
FAX 214-285-1587

Verizon East (fBA N/S & VIS) Employees
Absence Reporting Center
500 Summit Lake Drive 4th Fl
Valhalla, NY 10595
FAX 1-877-786-4500

Employee Name: _____

First Day of Absence: _____

Date: _____

Fax#: _____

From: _____

Pages including cover sheet: _____

CONFIDENTIAL AND PRIVATE

Your Rights
Under The
Family and Medical Leave Act of 1993

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to "eligible" employees for certain family and medical reasons.

Reasons for Taking Leave:

Unpaid leave must be granted for *any* of the following reasons:

- to care for the employee's child after birth, or placement for adoption or foster care;
- to care for the employee's spouse, son or daughter, or parent, who has a serious health condition; or
- for a serious health condition that makes the employee unable to perform the employee's job

At the employee's or the employer's option, certain kinds of *paid* leave may be substituted for unpaid leave.

Advance Notice and Medical Certification:

The employee may be required to provide advance leave notice and medical certification. Taking of leave may be denied if requirements are not met.

- The employee ordinarily must provide 30 days advance notice when the leave is "foreseeable."
- An employer may require medical certification to support a request for leave because of a serious health condition, and may require second or third opinions (at the employer's expense) and a fitness for duty report to return to work.

Job Benefits and Protection:

- For the duration of FMLA leave, the employer must maintain the employee's health coverage under any "group health plan."

Employees are eligible if they have worked for a covered employer for at least one year, and for 1,250 hours over the previous 12 months, and if there are at least 50 employees within 75 miles.

- Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.
- The use of FMLA leave cannot result in the loss of any employment benefits that accrued prior to the start of an employee's leave.

Unlawful Acts by Employers:

FMLA makes it unlawful for any employer to:

- interfere with, restrain, or deny the exercise of any right provided under FMLA:
- discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement:

- The U.S. Department of Labor is authorized to investigate and resolve complaints of violations.
- An eligible employee may bring a civil action against an employer for violations.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

For Additional Information:

Contact the nearest office of the Wage and Hour Division, listed in most telephone directories under U.S. Government, Department of Labor.