Instructions for Family Care Leave of Absence (FCL) Recertification Form

New York and New England Bargained for Employees

Please review the Conditions for Leave within the Family Care Leave Guidelines. Your supervisor should review the Conditions for Leave with you before you sign this form.

Please Note: The FCL Recertification Form (G2518-REC) is to be used for pre-existing Family Care Leave Certifications. If your current Family Care Leave Certification is expiring and you would like to continue your certification, you must complete and submit a new Family Care Leave application (G2518-FCL). Submitting the attached recertification form for these types of instances may result in denial and disciplinary action

.

The minimum period of FCL is 3 calendar days. The FCL Recertification Form (G2518-REC) is to be submitted when you exceed the frequency and/or duration of an existing Family Care Leave. You will be required to submit an FCL Recertification Form within 25 calendar days from either the date you exceed or the date your supervisor notifies you that a recertification form is required; whichever is later. The family member's treating HCP must specifically designate coverage of any time that exceeds the current certification. If the form is incomplete, or if it is received after 25 calendar days, it may result in a denial and you may be subject to disciplinary action.

If your request for leave is denied, you may request an administrative review of the denial. You will need to provide a copy of the completed recertification form along with supporting documentation. Supporting documentation includes, but is not limited to, a copy of a fax transmittal proving that your form was faxed timely, documentation from your family member's treating HCP regarding a processing delay, or documentation of any extenuating circumstances that prevented you from returning the form timely.

Section A: To be completed by Employee and Supervisor/Absence Administrator
Section B: To be completed by the Employee's Family Member
Section C: To be completed by the Employee's Family Member Health Care Provider
Section D: To be completed by the Employee's Family Member Health Care Provider

After completing the application, please make a copy and keep it for your records. Mail or fax the completed application to the Leave of Absence Team for review.

LOA Administrator
500 Summit Lake Drive, 3rd Floor
Valhalla, NY 10595
Fax: 1-877-660-2660

If you have any questions, please contact 1-800-638-4228 or send an e-mail to verizonleavemanagement@Sedgwickcms.com

verizon

Family Care Leave (FCL) Recertification Form **G2518-REC**
(New York/New England Bargained For Employees) **2018**

Section A: Employee Information and Acknowledgements	
Employee Name:	
Employee's EMPLID:	Employee's NCSD:
Name of ill Family Member:	
Relationship to Employee:	Family Member's Date of Birth:

To be completed by the Supervisor / Absence Administrator:

The employee below has exceeded the frequency and/or duration of their Family Care Leave Certification and is being requested to recertify. I have advised the employee of the following, the completed FCL Recertification form must be submitted to the Leave of Absence Team within 25 calendar days from the date exceeded or the date notified, as certified below.

Date Exceeded: ____/____/_____	Date employee was notified: ____/____/_____
Supervisor or Absence Administrator Signature:	Date: ____/____/_____

To be completed by the Employee:

In order for your additional time off to be considered for FCL, it must be specifically designated as FCL qualifying by the treating Health Care Provider (HCP). Once the treating HCP completes this form, it must be returned to the Verizon Leave of Absence Team, either by fax: 1-877-660-2660 or mail: LOA Administrator, 500 Summit Lake Drive, 3rd Floor Valhalla, NY 10595. Please be advised that knowingly providing false or inaccurate information in this certification is a violation of the Company's Code of Business Conduct.

I hereby certify that the information provided on this certification form is true and accurate.

Employee Signature: _____ Date: ___/___/_____

Section B: (To be completed by the Employee's Family Member)

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.

Family Member Signature: _____ Date: ___/___/_____

Section C: (To be completed by the Family Member's Treating Health Care Provider)

Please note: Incomplete forms will be returned for completion and may result in denial of leave.

1. Describe the medical facts, including a brief statement as to how the medical facts meet the criteria for a Serious Illness. A Serious Illness is defined as an illness, injury, impairment or physical or mental condition that either involves inpatient care in a medical facility or continuing treatment by a health care provider. The term serious illness does not apply to short term conditions for which treatment and recovery are very brief. -

   _____

   _____

2. Prescribed Treatment or Therapy _____
3. Length of time your patient has/will have this condition: From ____/____/____ Through ____/____/____
4. Reason employee is needed to take time off from work to care for this family member: _____

   _____
5. Period of incapacity relating to this current episode of absence: From ____/____/____ Through ____/____/____. If the exceeded period of incapacity was less than 1 day, please indicate the #_____ (circle one: minutes, hours).

Section D: (To be completed by the Family Member's Treating Health Care Provider)

I certify that the above information is true and correct:

Health Care Provider's Printed Name: _____ Type of Practice: _____

Address: _____ Phone # _____

Health Care Provider's Signature: _____ Date: ___/___/_____

verizon

VERIZON
Leave of Absence Team
500 Summit Lake Drive
3rd Floor
Valhalla, NY 10595

Family Care Leave
Fax Cover Sheet

Name: _____

EMPLID: _____

First Day of Leave: _____

Date: _____

Fax #: 1-877-660-2660

From: _____

Pages including cover sheet: _____

CONFIDENTIAL AND PRIVATE

verizon