

## **POLICY: FAMILY MEDICAL LEAVE ACT AND NEW JERSEY MEDICAL LEAVE ACT:**

It is the policy of the City of Camden to provide unpaid leave as provided by the Family Medical Leave Act (FMLA) and the New Jersey Family Leave Act (NJFLA). The acts are intended to balance the demands of the workplace with the needs of families, to promote the stability and economic security of families, and to promote national interests in preserving family integrity.

### **PROCEDURE**

The following steps must be complied with when seeking leave under FMLA and/or NJFLA. For additional information regarding the following steps see the Informational Section below.

- STEP 1:** Determine Eligibility (See **A** and **B** in the Information Section)  
**STEP 2:** Determine Type of Leave to Request – continuous, intermittent or reduced (See section **C** in Information Section.)  
**STEP 3:** Give Proper Notice (See **D** in Information Section)  
**STEP 4:** Certification of Health Care Provider must be filled out completely (See **E** in Information Section)  
**STEP 5:** All forms in “Employee Request for Family or Medical Leave” packet must be picked up and returned immediately to the Personnel Office.

**NOTE:** In the event that an employee fails to follow steps 1 through 5, the City of Camden may still designate an absence from the work place as Family Leave

### **INFORMATION SECTION**

#### **A. How is Eligibility Determined?**

1. Employees are eligible for leave benefits under the FMLA if they have been employed by the City for at least twelve (12) months, and must have worked at least 1,250 hours during the twelve months period immediately preceding the commencement of the leave.
2. Employees are eligible for leave benefits under the NJFMLA if they have been employed by the City for at least twelve (12) months, and have worked at least 1,000 hours during the twelve month period immediately preceding the employees request for leave. Overtime hours are excluded.

#### **B. How do you determine if the reason for seeking leave is an Eligible Reason under FMLA and/or NJFLA?**

1. Birth of a child of the employee – **(BOTH)**
2. Placement of a child with the employee for adoption of such child by the employee – **(BOTH)**
3. Placement of a son or daughter with the employee for foster care **(FMLA)**
4. Provide care made necessary by reason of a serious health condition of a family member of the employee **(NJFLA)**
5. To care for a spouse, son, daughter, or parent of the employee with a serious injury or health condition **(FMLA)**
6. Employee’s own serious health condition that makes the employee unable to perform the functions of the position of such employee **(FMLA)**
7. Nursing home place of transfer issues for family members **(BOTH)**
8. To care for a spouse, child, parent or next of kin in the armed forces, including the National Guard and Reserves that returned injured from recent active duty and is undergoing medical treatment, recuperation or therapy, is on an outpatient status or is otherwise on the temporary disability retired list for a serious injury or illness **(FMLA - 26 WEEKS)**

9. For a qualifying exigency because the employee's spouse, child or parent is on active duty or impending call or order to active duty in the armed forces, including the National Guard and Reserves in support of a "contingency operation". (FMLA 12 - WEEKS)

**C. How is the Type of Leave/Duration and Form of Leave Determined?**

1. An eligible employee is entitled to a total of up to twelve (12) workweeks of leave during any twelve (12) month period. **(FMLA)**
2. An eligible employee is entitled to take up to twelve 12 workweeks of leave during any twenty-four (24) month period **(NJFLA)**
3. In some circumstances, the employee may take the leave on an intermittent or reduced schedule **(BOTH)**
4. An eligible employee is entitled to a total of twenty-six (26) workweeks of leave during any ONE twelve (12) month period. (FMLA – Military Provision – See Section B8)
5. An eligible employee is entitled to a total of twelve (12) workweeks of leave during any twelve (12) month period. (FMLA – Military Provision – See Section B9)

**NOTE:** The total period during which in intermittent leave may be taken may not exceed a twelve (12) month period for **EACH** serious health condition. Intermittent leave in connection with more than one serious health condition must be taken within a consecutive twenty-four (24) month period, or until the employee's twelve (12) week leave is exhausted, whichever is shorter.

**NOTE:** An employee may take only one reduced leave during any consecutive twenty-four (24) month period, and a reduced schedule may not exceed 24 consecutive weeks.

- a. For either intermittent or reduced leave, the employee must make a reasonable effort to schedule the leave as not to disrupt unduly the operations of the employer.
- b. The employee may take an intermittent or reduced leave for the birth or adoption of a healthy child only if agreed to by the employer and employee.
- c. For intermittent Leave, the employee will be required to call in whenever absent and provide the City with detailed information about the absence. The City will not treat the absence as Family Medical Leave if the employee has not provided sufficient information that the absence qualifies as a Family Medical Leave.

**D. How do you determine when and what type of Notice is required to be given to the employer?**

1. An employee must give written notice that he/she is intending to take family leave at least 30 days prior to the commencement of leave for the birth or adoption of a child **(NJFLA)**
2. An employee must give written notice that he/she is intending to take family leave at least 30 days prior to the commencement of leave for a serious health condition of a family member **(BOTH)**
3. An employee must give at least 30 days written notice that he/she is intending to take a family leave for the birth or adoption of a child, and for a serious health condition that is foreseeable based upon planned medical treatment **(FMLA)**
4. In emergent circumstances, however, an employee can give oral notice when written notice is not practical but subsequently must promptly provide the City with written notice **(BOTH)**
5. Notice, either written or oral, must be given to the employee's supervisor or the Personnel Officer.

## **E. When is a Certification of Health Care Provider required?**

1. In accordance with the NJFLA, the City shall require any period of leave to be supported by certification issued by a health care provider with respect to the following:
  - a. When leave is to care for a seriously ill family member the City shall request:
    - i. the date that the serious health condition commenced
    - ii. the probable duration of the condition
    - iii. the medical facts within the provider's knowledge concerning the condition.
  - b. When the leave is for the birth or adoption of the employee's child, the City shall require the certification to state the date of birth or placement of the child.
2. In accordance with the FMLA, the City shall require certification from a health care provider for leave to care for a seriously ill family member or because of the employee's own medical condition. In addition to the information required to be included in the health care provider certification under the NJFLA, the certification shall also include:
  - a. when leave is to care for a family member, a statement that the employee is needed to care for the family member and an estimate of the amount of time that the employee is needed to care for the family member;
  - b. when the leave is due to the serious health condition of the employee, a statement that the employee is unable to perform the essential functions of the employee's job; and
  - c. when leave is sought on an intermittent or reduced schedule for treatment, the dates on which such treatment is expected to be given and the duration of such treatment.
3. The City may require, at its expense, that the employee or seriously ill family member obtain a second opinion from a health care provider designated by the City. If this opinion differs, the City can require, at its expense, a third opinion, which is a final and binding, to be obtained by a health care provider selected by both the City and the employee. **(BOTH)**
4. The City shall also require the employee to sign a form of certification attesting that he/she is taking leave for the birth or adoption of a child or to care for a seriously ill family member. **(NJFLA)**
5. All sections of the Certification of Health Care Provider form must be filled out completely.
6. In the event that an employee fails to provide any of the certifications required under this section, the City reserves the right to declare that any medical leave constitutes a family leave.

## **F. Does Health Benefits coverage continue?**

1. Health benefits will be maintained while on approved Family Medical Leave. However, if the employee fails to return from leave, the cost of benefits must be repaid, unless the failure is due to circumstances beyond the employee's control. **(FMLA)**
2. The employer must continue to provide other benefits (medical leave, sick leave, life insurance, and pensions) to employees absent on leave on the same terms as (stated in CITY Policy) regarding benefits for employees on unpaid leave. **(NJFLA)**

## **G. Does Vacation/Sick/Holiday time accrue while on an unpaid Family Medical Leave?**

1. The employee shall not accrue any vacation time, sick time or holidays during any period of unpaid Family Medical leave unless stated otherwise in the employee's respective collective bargaining agreement. Accordingly, an employees time will be pro-rated upon the employees return to work.

## **H. What are Grounds for Denial of Leave?**

- 1 Under certain circumstances, the city may deny family leave to employees who are among the highest paid 5% of its employees, or are one of the seven highest paid employees, which ever is greater, if granting such leave would lead to substantial and grievous economic injury to the City. **(NJFLA)**
- 2 Leave may be denied if the employee refuses to sign a certification or provides a false certification or health care provider information does not support said request. **(BOTH)**

## **I. Can an employee be employed during leave?**

- 1 An employee is prohibited from working full-time or part-time for any person whom the employee did not work immediately prior to commencement of the leave. **(NJFLA)**.

## **J. How does an employee return to work for his/her illness?**

1. An employee who has been out of work for his/her own illness must complete the return to work request form and must provide medical documentation that they are able to return to work to the Office of Risk Management .

## **K. DEFINITIONS:**

- 1 **Serious Health Condition NJFLA:** an illness, injury, impairment or physical or mental condition which requires:
  - i. inpatient care in a hospital, hospice, placement in or transfer from nursing facilities or residential medical care facility;
  - ii. continuing medical treatment or continuing supervision by a health care provider
- 2 **Serious Health Condition FMLA:** an illness, injury, impairment, or physical or mental condition that involves:
  - i. inpatient care in a hospital, placement in or transfer from nursing facilities, hospice or residential medical care facility;
  - ii. continuing treatment by a health care provider.
- 3 **Family Member (NJFLA):** child, parent or spouse
- 4 **Child( FMLA):** a biological, adopted, or foster child, stepchild, legal ward, or child of a parent who is
  - i. under 18 years of age
  - ii. 18 years of age or older but incapable of self-care because of mental or physical impairment.

- 5        **Son or Daughter (FMLA):** a biological, adopted, or foster child, a stepchild, a legal ward, or a child of a person standing in loco parentis who is:
- i.        under 18 years of age
  - ii.       18 years of age or older but incapable of self-care because of mental or physical impairment
- 6        **Parent (NJFLA):** is the biological parent of the employee, adoptive parent, foster parent, step-parent, parent-in-law, or legal guardian, having a “parent-child” relationship with the child, or having sole or joint legal or physical custody, care guardianship or visitation with a child.
- 7        **Parent (FMLA):** a biological parent of the employee or an individual who stood in loco parentis to an employee when the employee was a son or daughter.
- 8        **Spouse (FMLA):** husband or wife
- 9        **Spouse NJFLA):** a person to whom an employee is lawfully married as defined by NJ law.
- 10       **Next of Kin (FMLA):** nearest blood relative of the injured veteran.
- 11       **Reduced Leave Schedule (NJFLA):** leave scheduled for fewer than an employee’s usual number of hours worked per workweek but not for fewer than an employees usual number of hours worked per day, unless agreed to by the employee and the employer, and that is scheduled for not more than 24 consecutive weeks and which can be utilized only once during a 24 month period.
- 12       **Reduced Leave Schedule (FMLA):** a leave schedule that reduces the usual number of hours per workweek, or hours per workday, of an employee.
- 13       **Intermittent Leave (NJFLA):** a non-consecutive leave comprised of intervals, each of which is at least one but less than 12 workweeks within a consecutive 12 month period.
- 14       **Intermittent Leave (FMLA):** leave taken in separate blocks of time due to a single qualifying event.



**CITY OF CAMDEN  
FAMILY MEDICAL LEAVE ACT  
LEAVE REQUEST FORM**

**TO:** Christine T.J. Tucker, Business Administrator

**FROM:**

\_\_\_\_\_  
Employee Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Home Phone:

\_\_\_\_\_  
Cell Phone:

\_\_\_\_\_  
E-Mail Address:

**(Failure to prove the above information shall result in the delay/denial of your leave of absence)**

I respectfully request a leave of absence  with  without pay under the provisions of the Family and Medical Leave Act.

I am requesting the leave for the following reason(s):

- The Birth of a child, or placement of a child for adoption or foster care
- A serious injury or health condition affecting my:
- \_\_\_\_\_ Spouse
- \_\_\_\_\_ Child
- \_\_\_\_\_ Parent
- \_\_\_\_\_ Next of Kin (Only for Military FMLA)
- \_\_\_\_\_ A personal health condition

(Requests for yourself, family member or next of kin must be accompanied by a Certification of Health Care Provider)

**Continuous**

Start Date: \_\_\_\_\_ Expected End Date: \_\_\_\_\_

**Intermittent** (Leave taken in separate blocks of time)

Start Date: \_\_\_\_\_ Expected End Date: \_\_\_\_\_

**Reduced** (Leave taken that reduces the usual number of working hours per week or hours per day)

Usual bi-weekly hours: \_\_\_\_\_ Reduced bi-weekly hours \_\_\_\_\_

Start Date: \_\_\_\_\_ Expected End Date: \_\_\_\_\_

**TO BE COMPLETED BY THE EMPLOYEE WHEN REQUESTING LEAVE TO CARE FOR A FAMILY MEMBER OR NEXT OF KIN:**

Provide information regarding the care that you will provide and the time period in which the care will be provided.

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\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Approved

\_\_\_\_\_  
Business Administrator

\_\_\_\_\_  
Date.

Disapproved

C: Personnel File

## LETTER TO EMPLOYEE FOR RETURN TO WORK

This letter serves as follow up to our previous communication to you at the outset of your Family and Medical Leave period regarding the date on which that leave will be exhausted and when you will need to return to work. As you know, under the Family and Medical Leave Act and the New Jersey Medical Leave Act, the extent of protected leave is 12 workweeks, when taken in one block or over a more extended period through the use of intermittent or reduced schedule leave.

Your leave period will conclude on \_\_\_\_\_. Accordingly you are expected to return to work on \_\_\_\_\_. Since your use of leave was linked to your own serious health condition, accordingly you are to report to the Risk Management Office for Medical Clearance prior to returning to work.

If you fail to return to work on the date indicated above, the City of Camden will conclude that you have abandoned your position and will proceed with disciplinary action. If there are additional circumstances that may be relevant or that you may wish to bring to our attention regarding your absence or your condition, please feel free to contact the Personnel Office regarding your scheduled date of return.

Thank you for your attention in this matter.

Sincerely,



(When completed, this form goes to the employee, **Not to the Department of Labor.**)

OMB No.: 1215-0181  
Expires: 09-30-2010

1. Employee's Name

2. Patient's Name (If different from employee)

3. Page 4 describes what is meant by a "serious health condition" under the Family and Medical Leave Act. Does the patient's condition<sup>1</sup> qualify under any of the categories described? If so, please check the applicable category.

(1) \_\_\_\_\_ (2) \_\_\_\_\_ (3) \_\_\_\_\_ (4) \_\_\_\_\_ (5) \_\_\_\_\_ (6) \_\_\_\_\_, or None of the above \_\_\_\_\_

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

5. 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**<sup>2</sup> if different):

b. Will it 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 for 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<sup>2</sup> and the likely duration and frequency of **episodes of incapacity**<sup>2</sup>:

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

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7. 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**?

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8. 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:

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Signature of Health Care Provider

Type of Practice

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Address

Telephone Number

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Date

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**To be completed by the employee needing family leave to care for a family member:**

State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule:

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Employee Signature

Date

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A “**Serious Health Condition**” means an illness, injury impairment, or physical or mental condition that involves one of the following:

1. Hospital Care

**Inpatient care** (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity<sup>2</sup> or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

(a) A period of incapacity<sup>2</sup> of **more than three consecutive calendar days** (including any subsequent treatment or period of incapacity<sup>2</sup> relating to the same condition), that also involves:

- (1) **Treatment**<sup>3</sup> **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
- (2) **Treatment** by a health care provider on **at least one occasion** which results in a **regimen of continuing treatment**<sup>4</sup> 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:

- (1) 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;
- (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 incapacity<sup>2</sup> (e.g., asthma, diabetes, epilepsy, etc.).

5. Permanent/Long-term Conditions Requiring Supervision

A period of **Incapacity**<sup>2</sup> 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 there from) 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<sup>2</sup> 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), and kidney disease (dialysis).

This optional form may be used by employees to satisfy a mandatory requirement to furnish a medical certification (when requested) from a health care provider, including second or third opinions and recertification (29 CFR 825.306).

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*Note:* Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

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.

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**Public Burden Statement**

We estimate that it will take an average of 20 minutes 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 of information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, Department of Labor, Room S-3502, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

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# City of Camden Administration - Memorandum

Christine T. J. Tucker  
Business Administrator

Gwendolyn A. Faison  
Mayor

**TO:**

**FROM:**

**DATE:**

**RE: NOTICE OF INTENTION TO RETURN FROM LEAVE**

Please accept this memorandum as my intention to return from leave effective \_\_\_\_\_.

I understand that my restoration to employment is subject to the following conditions:

1. As a condition of restoration, each employee must provide a written certification from his or her health care provider that the employee is able to resume working.
2. Every attempt will be made to restore an employee returning from leave to his or her original position. If the employee's original position is unavailable, the employee will be placed in an equivalent position with the equivalent pay and benefits.
3. An employee returning from Family and Medical leave shall not be entitled to the accrual of any seniority or employment benefits during the period of leave.

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## DOCTOR'S CERTIFICATION

I have examined the above referenced employee of the City of Camden and certify that he/she is fully able to resume working.

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Health Care Provider's Signature

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Date