RCUH Research Corporation of the University of Hawai'i

Human Resources Department

RCUH Family Leave Request Form (B-11)

(Care for Family Member)

Please submit the form and supporting documents (if applicable) via encrypted email.

Section I: Employee/Project Contact Information: Please fill out all blanks requested below:

Employee Name:	RCUH Employee ID#:
Daytime Phone #:	Email:
PI Name:	Email:
Time Keeper Name:	Email:

Section II: Leave Request Information: Please notate start date and return to work date. Leave will be requested on a 'per calendar year' basis (i.e., January 1 through December 31).

A. Please select if leave is ☐ Continuous ☐ Intermittent

B. Start Date of Leave: ___/___/___ ***Expected Return to Work Date:** ___/___/___

***If the expected return to work date changes, please notify your Principal Investigator/Supervisor ASAP.**

C. Please select the applicable box(es) below indicating the reason for your Family Leave request.

☐ **D. Serious Health Condition of a Family Member:**
For My Child, Spouse/Reciprocal Beneficiary/Civil Union Partner, Sibling or Parent (includes parents-in-law, grandparents, and grandparents-in-law) **Additional form: WH-380F**

☐ **E. Child/Care for Newborn (select from the following options):**
- ☐ Father of a Newborn – Care for/Bond with Newborn ****Provide reasonable documentation**
- ☐ Father of a Newborn – Care for Spouse After Birth **Additional form: WH-380F**

☐ **F. Adoption of Child** ****Provide reasonable documentation**

☐ **G. Placement of Child into my Home Through Foster Care**

☐ **H. Military Caregiver Leave (Check box)**
- ☐ Care for a Covered Service member (spouse, child, parent or next of kin) with a Serious Injury or Illness **Additional form: WH-385**
- ☐ Qualifying Exigency for Military Dependent (arising out of the foreign deployment of the employee's spouse, son, daughter, or parent) **Additional form: WH-384**

Section III: Employee Certification:

A. Employee's Print Name & Signature:_____Date:_____

Section IV: Principal Investigator/Supervisor Acknowledgement:

A. PI/Supervisor's Print Name & Signature:_____Date:_____

Please return this form via email to RCUH Benefits at rcuh_benefits@rcuh.com or via fax at (808) 956-5022 at least thirty (30) days before the requested start date of leave (if leave is foreseeable) or as soon as possible (if leave is not foreseeable). RCUH Benefits will contact you within five (5) business days of receipt of your Family Leave Request Form to provide you with our determination on your eligibility status for Family Leave.

Instructions to complete WH380F Form

(Questions: Call (808) 956-3100 or email: nsakamoto@rcuh.com)

Section I – For completion by EMPLOYER: This section will already be completed if you obtain this WH380F form from the RCUH Human Resources Department.

Section II – For Completion by EMPLOYEE: Listed by lines, please read and follow instructions:

A. Your Name: Print your legal First Name, Middle Name, Last Name
B. Name of family member for whom you will provide care: Print your Family Member's First Name, Middle Name, Last Name
C. Relationship of family member to you: Be specific identify as: Your Child (Son or Daughter), Spouse, *Reciprocal Beneficiary, Civil Union Partner*, *Sibling*, Parent, *Parent-In-Law*, *Grandparent, Grandparent-In-Law. (Italicized is for Hawai`i Family Leave only).*
D. If family member is your son or daughter, date of birth: Month, Day, Year
E. Describe care you will provide your family member and estimate leave needed to provide care: Examples may be "For Care/Bonding of New Born", "Care of Family Member due to incapacitation due (a) Illness, (b) Injury, (c) recovery from surgery, or (d) other medical/health related reason. Then provide a brief statement of how you will be providing aid, care or assistance to your family member along with the approximate duration of care (this can be expressed in "From _____ to _____"
F. Your signature and date: Sign your name and date the document.

(Questions: Call (808) 956-3100 or email: nsakamoto@rcuh.com)

Section III – For Completion by the HEALTHCARE PROVIDER: I recommend you provide this instructional sheet to your Family Member's Healthcare Provider (e.g., doctor). **"Dear Healthcare Provider, please follow instructions below. The Employee needs you to complete this section in order for the RCUH (the Employer) to be able to determine whether employee qualifies for Family Leave. Listed by lines, please read and follow instructions:"**

A. Provider's name and business address: Please print full name and business address. Print your name (First Name, Last Name)
B. Type of practice/Medical Specialty: Example – Medical/Orthopedic
C. Telephone and Fax: (Area Code) Number; Example: (808) 222-3333

Part A: Medical Facts: Based upon your medical knowledge, experience, and examination of the patient:

1. Approximate date condition commenced: Date (Month, Day, Year)
(a) Probable duration of condition: XX months, weeks, days
(b) Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ____No ___Yes. If so, dates of admission: Month(s), Day(s), Year
(c) Date(s) you treated the patient for condition: Month(s), Day(s), Year
(d) Was medication, other than over-the-counter medication prescribed? __No __Yes
(e) Will the patient need to have treatment visits at least twice per year due to the condition? __No __Yes

(f) 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: A brief narrative description.

2. Is the medical condition pregnancy? __No __Yes, If so, expected delivery date: Month, Day, Year.
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): This brief narrative will help us (the Employer) to understand the need for the Employee to request a Family Leave to care for his or her family member.

Part B. Amount of Care Needed: This section will provide us (the Employer) with your patient's need for care by the Employee seeking Family Leave. This may include assistance with basic medical (e.g., changing wound dressing), hygienic (e.g., help with baths), nutritional (e.g., help preparing meals and/or feeding), safety (e.g., help walking), transportation needs (e.g., driving to medical appointments), or the provision of physical or psychological care (e.g., helping to get around home, helping to understand doctor's instructions).

4. Will patient be incapacitated for a single continuous period of time, including any time for treatment recovery? __No __Yes (Check one)

(a) Estimate the beginning and ending dates for the period incapacitated? From ___ to ____ expressed in Month(s) Day(s) Year

(b) During this time, will the patient need care? ___No ___Yes (Check one)

(c) Explain the care needed by the patient and why such care is medically necessary: This is a narrative based on your best medical knowledge and/or examination of the patient of why the Employee needs assist his or her Family Member.

5. Will the patient require follow-up treatments, including any time for recovery? __No __Yes (Check one)

(a) Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period: Provide approximate dates (Month(s) Day(s) Year) or approximate number of Months, Days, Years care will be needed.

(b) Explain the care needed by the patient, and why such care is medically necessary: This may include assistance with safety (e.g., help walking), transportation needs (e.g., driving to medical appointments), or the provision of physical or psychological care (e.g., helping to get around home, helping to understand doctor's instructions)

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? __No ___Yes (Check one)

(a) Estimate the hours the patient needs care on an intermittent basis, if any: __hour(s) per day; ___day per week from ____ through _____(complete on your best estimate).

(b) Explain the care needed by the patient and why such care is medically necessary: Provide a brief narrative: This may include assistance with basic medical (e.g., changing wound dressing), hygienic (e.g., help with baths), nutritional (e.g., help preparing meals and/or feeding), or other reasons.

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ___No ___Yes (Check one)

(a) 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 very 3 months lasting 1-2 days): Complete by filling in blanks:

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

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.

OMB Control Number: 1235-0003
Expires: 8/31/2021

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, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: _____

_____

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: _____
First Middle Last

Name of family member for whom you will provide care:_____
First Middle Last

Relationship of family member to you: _____

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:

_____

_____

_____

_____ ____ _____
Employee Signature Date

CONTINUED ON NEXT PAGE

SECTION III: For Completion 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. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e). 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:_____

Type of practice / Medical specialty: _____

Telephone: (_____)_____ Fax:(_____)_____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
   ___No ___Yes. If so, dates of admission: _____

   Date(s) you treated the patient for condition: _____

   Was medication, other than over-the-counter medication, prescribed? ___No ___Yes.

   Will the patient need to have treatment visits at least twice per year due to the condition? ___No ____ 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:

   _____

   _____

2. Is the medical condition pregnancy? ___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):

_____

_____

_____

_____

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ___No ___Yes.

   Estimate the beginning and ending dates for the period of incapacity: _____

   During this time, will the patient need care? __ No __ Yes.

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

   _____

   _____

   _____

   _____

   _____

5. Will the patient require follow-up treatments, including any time for recovery? ___No ___Yes.

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   _____

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

   _____

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? __ No __ Yes.

   Estimate the hours the patient needs care on an intermittent basis, if any:

   _____ hour(s) per day; _____ days per week from _____ through _____

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

   _____

   _____

   _____

   _____

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)

   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: _____

_____

_____

_____

_____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Health Care Provider **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.