RCUH Family Medical Leave Request Form (B-11a)
(Care for Self/Own Health Condition)

Please submit this B-11a form to *RCUH_Benefits@rcuh.com* and CC to your Principal Investigator.
You may submit the WH380-E Form via encrypted email to *RCUH_Benefits@rcuh.com* or fax to *808-956-5022.*

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

Employee Name:	RCUH Employee ID#:
Mailing Address:	Preferred Cell #: Preferred Email:
Does your Spouse work for RCUH? ☐ No ☐ Yes If Yes, What is the name of your spouse? _____	

Communication will only be shared between you and the Project of whom are listed below (List if applicable):

Principal Investigator:	Admin (Timekeeper):
Admin:	Admin:

Section II: Leave Request Information: Please notate start date of your leave 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. Approximate Duration

Start Date of Leave: ____/____/____ ***Expected to Return to Work Date:** ____/____/____

***If the expected return to work date changes, you must obtain a Fitness for Duty Certification from our healthcare provider (return to full duty/no restrictions) and notify your Principal Investigator (PI)/Supervisor ASAP.**

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

☐ **C1 - Serious Health Condition:**
For My Own Serious Health Condition (non work-related)

☐ **C2 – Child Birth/Recovery and Care for Newborn** (for care of newborn, proof of birth is required)**:**

For the above reasons, please complete and return the following form: Form WH-380-E

Section III: Employee Certification:

Print Name & Signature:_____Date: _____

Please submit this form 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.

Research Corporation of the University of Hawai`i (RCUH)

Instructions to complete WH380E Form — Section Ill —Completion by the HEALTHCARE PROVIDER:

Dear Healthcare Provider, the employee (your patient) needs you to complete this section in order for the RCUH (the Employer) to be able to determine whether employee qualifies for Family Leave. Please answer all questions on the WH380E Form highlighted in Yellow. **Please sign and date the last page.**

A. **Provider's name and business address: Please print your name (First, Last Name)**
B. **Type of practicemedical 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 please provide responses the following:

1. **Approximate date condition commenced**: This section is to provide your patient's employer (RCUH) with information regarding the duration and nature of the patient's condition.

2. **Is the medical condition pregnancy? No Yes, Expected delivery date: Month, Day, Year.** This typically the starting date that your patient's Family Medical Leave.

3. **Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.** Attached to this form is the employee's job description. We have highlighted in Yellow the sections that pertain to or identify the employee's essential job functions. We have also highlighted other portions that are physical exertion or applicable descriptions to help with your assessment. **If you answer YES, please indicate what duties, tasks or functions the employee will not be able to perform.**

4. **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 RCUH to understand the need for the Employee's request for Family Medical Leave due to the employee's serious health condition.

Part B. Amount of Leave Needed:

5. **Will patient be incapacitated for a single continuous period of time, including any time for treatment recovery?** No Yes (Check one). If YES, provide the duration of incapacity. Please provide dates (e.g., from and to).

6. **Will the patient require follow-up treatments, including any time for recovery? __No __Yes** (Check one). Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period.

7. **Will the condition cause episodic flare-ups periodically preventing the employee form performing his/her job functions?** __No __Yes (Check one). Will the employee's episodic flare-ups cause the employee to absent from work? If so, please explain.

8. **Narrative/Comments:** Provide any additional information that would assist the RCUH in making its determination to qualify the employee for Family Medical Leave. Sign and Date last Page.

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

Certification of Health Care Provider for Employee'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 due to a serious health condition to submit a medical certification issued by the employee's health care provider. 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 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: Research Corporation of the University of Hawaii

Employee's job title: See below Regular work schedule: _____

Employee's essential job functions: See attachment for employee's Job Description (Job Title): ____

_____

Check if job description is attached:

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your 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 due to your own 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. 29 C.F.R. § 825.305(b).

Your name: _____
First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. 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 employee is seeking leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b). 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: _____

   Mark below as applicable:
   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:

   _____

   Will the patient need to have treatment visits at least twice per year due to the condition? ___No ___ Yes.

   Was medication, other than over-the-counter medication, prescribed? ___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. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

   Is the employee unable to perform any of his/her job functions due to the condition: ____ No ____ Yes.

   If so, identify the job functions the employee is unable to perform:

   _____

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

   _____

   _____

   _____

   _____

   _____

   _____

   _____

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___No ___Yes.

   If so, estimate the beginning and ending dates for the period of incapacity: _____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ___No ___Yes.

   If so, are the treatments or the reduced number of hours of work medically necessary? ___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:

   _____

   Estimate the part-time or reduced work schedule the employee needs, if any:

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

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ____No ____Yes.

   Is it medically necessary for the employee to be absent from work during the flare-ups? ____ No ____Yes. If so, explain:

   _____

   _____

   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

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.**