



County *of* Galveston

Department of Human Resources

FMLA

Employee Guide & Forms

GALVESTON COUNTY DEPARTMENT OF HUMAN RESOURCES

Family & Medical Leave Act Guide

County of Galveston
Human Resources
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Employee Eligibility

This section will help you determine whether you will qualify for FMLA

Although FMLA is available and the County of Galveston is subject to the provisions of the act, you may or may not be eligible for coverage and protection. There are several factors that must first be satisfied before you can be considered for coverage under FMLA.

To be eligible for FMLA benefits, an employee must:

1. Work for a covered employer;
2. Have worked for the employer for a total of 12 months (this 12 months can be nonconsecutive and accumulated over a period of the past 7 years);
3. Have worked at least 1,250 hours in the immediately preceding 12 months;
4. Work at a location in the US where at least 50 employees are employed by the employer within 75 miles.

If you satisfy ALL 4 of these requirements, you are considered eligible for FMLA. However, this does not mean that your leave request or absence from work will qualify to be designated as FMLA.

Important Note

FMLA is not a civil rights law. It is a federal leave law.

Family and Medical Leave Act of 1993. Public Law 103-3

29 USC §2601 et seq.; 29 CFR Part 825



Leave Entitlement

This section will explain how much time the act will provide to you

FMLA should be considered a limited resource. It is not available to you on a continual basis and it does not offer you lifetime protection. It does however, offer you a set amount of time each year should you need to handle those difficult times in life.

Amount of Entitlement:

- 12 work weeks during any 12 month period for family, medical or military exigency leave. Up to 26 weeks for military caregiver leave.
- The typical county employee works 8 hours a day, 5 days a week. This calculates to 40 hours a week. Therefore your leave breaks down to 480 working hours. This may be taken in one block of time or over several periods.

“Rolling” 12 month period:

- Galveston County calculates your 12 month period using the “rolling” 12-month period measured backward from the date an employee’s FMLA leave request is scheduled to begin.
- Examples:

Joe has taken 8 weeks of leave in the past 12 months. He can take an additional 4 weeks of leave.

Maria used 4 weeks beginning February 1, 4 weeks beginning May 1, and 4 weeks beginning July 1. She is not entitled to any additional leave until February 1. Beginning next February 1, Maria is entitled to 4 weeks of leave. Next May 1 she is entitled to an additional 4 weeks, etc.



Leave Types

This section will explain the different types of leave available to you

FMLA allows for different types of leave depending on your situation and medical needs or that of a covered family member. Each leave request is different and unique and may require different amounts of time away from work.

Full / Block Leave:

FMLA leave taken in a one, continuous block of time due to a single qualifying reason.

Examples:

Joe was recently hospitalized for 1 week with pneumonia and will require an additional week at home for recovery.

Maria has a surgery scheduled next month to correct a serious back issue and will require 2 full months of recovery.

Intermittent and Reduced Schedule Leave:

FMLA leave taken in separate blocks of time or on a reduced work schedule due to a single qualifying reason.

Example:

Caroline is a cancer survivor and has been in remittance for several years. Recently she discovered that her cancer has returned and will need several rounds of chemotherapy. Her treatments are every Monday and Thursday afternoon beginning at 2:00pm. The time that Caroline is out every Monday and Thursday afternoon is protected under FMLA as well as any time the Caroline's condition renders her unable to perform the essential functions of her job.



Eligible Reasons for Leave

This section will explain the eligible reasons that fall under FMLA

Not all reasons are eligible for FMLA. The act allows for a specific core of reasons that fall under the protections and provisions of FMLA. Generally, the common seasonal cold will not qualify for FMLA designation.

Eligible Reasons:

The birth of a child and to care for the newborn child within one year of birth;

The placement with the employee of a child for adoption or foster care and to care for the newly placed child within one year of placement;

To care for the employee's spouse, child, or parent who has a serious health condition;

A serious health condition that makes the employee unable to perform the essential functions of his or her job;

Any qualifying exigency arising out of the fact that the employee's spouse, son, daughter, or parent is a covered military member on "covered active duty."

Analysis of Terms:

"To care for" Includes either physical or psychological care.

"Spouse" Legally married spouse. Verification in the form of a valid marriage license may be requested.

"Child" Means a biological, adopted, or foster child, a stepchild, a legal ward who is either under 18 years of age or, 18 years of age or older and incapable of self-care because of a mental or physical disability.

"Parent" Parent of employee only. In-laws do not qualify for FMLA.



Application & Certification

This section will explain how to apply and submit the proper documentation for your leave

You have determined that you are eligible and your leave falls under one of the eligible reasons for leave. Now, you need to complete all of the proper paperwork and submit everything to human resources for review and designation.

Step 1 - Application:

Complete and submit the one page application to human resources. County policy requires at least 30 days advance notice when possible and practical.

Step 2 - Certification:

This is perhaps the most important step in the entire FMLA process. Galveston County uniformly requires that all FMLA leave requests be medically certified and all certifications must be submitted directly to human resources within 15 *calendar* days. Certifications that are incomplete and vague will result in a delay of your leave approval.

WH-380-E	Certification of Health Care Provider for <i>Employee's Serious Health Condition</i>
WH-380-F	Certification of Health Care Provider for <i>Family Member's Serious Health Condition</i>
WH-384	Certification of Qualifying Exigency for Military Family Leave
WH-385	Certification for Serious Injury or Illness of Covered Service member for Military Family Leave
WH-385-V	Certification for Serious Injury or Illness of a Veteran for Military Caregiver Leave

Important Note

Never just leave work and assume everything is okay! Communication is key. Always coordinate your leave with both your department and human resources. If human resources is unaware of your leave and status, there is no way for us to help you.



FAMILY AND MEDICAL LEAVE ACT

Application

Section I – Employee Information

Please print clearly and answer all

_____	_____	_____	_____	_____
Last Name	First Name	MI	Employee ID / Social Security Number	
_____			_____	_____
Mailing Address	City	State	Zip	Preferred Contact Phone Number

Section II – Type of Leave Requested

Please check one and provide estimated dates

Full / Block Leave Expected leave to begin: _____ Expected date of return: _____

Intermittent Leave Expected leave to begin: _____ Expected date of return: _____

Section III – Leave Details

Appropriate certification must be provided to HR

- The birth of a child, or placement of a child with you for adoption or foster care.
Employee must contact HR to enroll the child in the medical plan within 30 days of occurrence.
- Your own serious health condition.
- Because you are needed to care for your ____ spouse; ____ child; ____ parent due to his/her serious health condition.
- Because of a qualifying exigency arising out of the fact that your ____ spouse; ____ son or daughter; ____ parent is on active duty or call to active duty status in support of a contingency operation as a member of the United States Armed Forces.
- Because you are the ____ spouse; ____ son or daughter; ____ parent; ____ next of kin of a covered service member with a serious injury or illness.

Section IV – Short-Term Disability & Sick Leave Pool

Please answer all

Is employee enrolled in voluntary short-term disability coverage?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Is this leave the result of a work related injury?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Request for donation from sick leave pool?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Does employee have 10 days leave at onset of condition?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Contributed a minimum of 24 hours to the sick leave pool?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

Section V – Signatures

Return completed application to Human Resources

_____	_____
Employee	Date
_____	_____
Human Resources	Date

*Signatures are for verification and acknowledgement purposes only. They do not guarantee leave approval.
This page may be sent to your department for informational purposes only to verify dates for payroll reporting.*

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: County of Galveston Human Resources Phone: 409-770-5345 Fax: 409-766-4599

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

Employee's essential job functions: _____

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.

This form can be faxed to Galveston County Human Resources at 409-766-4599

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: County of Galveston Human Resources Phone: 409-770-5345 Fax: 409-766-4599

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

This form can be faxed to Galveston County Human Resources at 409-766-4599

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.



Short-Term Disability

This section will explain your optional Short-Term Disability coverage

While you are out on FMLA, county policy requires you to use all of your personal, paid leave. This includes sick, vacation and compensatory time. Your FMLA leave entitlement runs concurrently with your personal leave. FMLA is not a tool only to be used once you run out of paid leave.

What happens when you run out of paid leave?

Galveston County offers voluntary short-term disability coverage through Lincoln financial to help you supplement your income if any part of your leave is un-paid. Listed below are some features of the plan:

- Pays you **60%** of your weekly salary up to \$1,750 per week **after** you exhaust all available paid leave (vacation, sick and comp). You will not be able to draw from short-term coverage while still receiving pay from the county.
- 8, 15 & 31 day waiting period available depending on your needs. You elect the waiting period you want when you enroll in the coverage.
- Maximum benefit duration of 26 weeks.
- Once you satisfy the 180 day elimination period for long-term disability (LTD), your short-term disability (STD) will automatically rollover to LTD without a separate claim process.

If you are unsure if you are enrolled in this coverage please contact human resources to verify. Once you and your doctor complete your appropriate sections please submit the claim packet to HR for final completion and submission. The completed claim will be sent to Lincoln for review. Galveston County does not approve or deny short-term disability claims.

Important Note

FMLA is not paid leave protection. FMLA only provides for up to 12 weeks of unpaid, job-protected leave. Do not assume that you will be paid for your entire leave.



Short Term Disability Claim Form Statement Of Employee

The Lincoln National Life Insurance Company
PO Box 2609, Omaha, NE 68103-2609
Toll Free (800) 423-2765 Fax (877) 843-3950
www.LincolnFinancial.com
disabilityclaims@lfg.com

1. Your Information

Full Name (First)	(M.I.)	(Last Name)
Street Address		
City	State	Zip Code

Social Security Number	Date of Birth
Phone Number	<input type="checkbox"/> Male <input type="checkbox"/> Female
Email Address	

2. Your Employer

Employer Name	
Group ID	Job Title
Policy Number	Billing Location

3. Reason for inability to work

Description of Sickness, Injury or Pregnancy	
Date Last Worked	Injury work related? <input type="checkbox"/> Yes <input type="checkbox"/> No

4. Other Income Being Received

	Amount \$	Date Began	Date Will Terminate	Date Applied For
Social Security	_____	___/___/___	___/___/___	___/___/___
Workers' Comp	_____	___/___/___	___/___/___	___/___/___
Salary Continuance	_____	___/___/___	___/___/___	___/___/___
State Disability	_____	___/___/___	___/___/___	___/___/___
Other Disability	_____	___/___/___	___/___/___	___/___/___
Sick Pay	_____	___/___/___	___/___/___	___/___/___

If approved, should Lincoln National Life Insurance Co. withhold Federal Income Taxes from your benefits?

Yes No If yes, indicate how much? _____
(Minimum: \$20 per week Short-Term Disability) (Minimum: \$88 per Month Long-Term Disability)

6. Account for Direct Deposit Checking Saving

Bank Name
Routing Number
Account Number

5. Who is your treating health care provider?

This is your primary health care professional. Please have them complete the Attending Physician's Statement. If you have additional health care providers, please also complete the Treating Medical Professional form.

Physician's Full Name	
Phone Number	Fax Number
Street Address	
City	State Zip Code

The above statements are true and complete to the best of my knowledge and belief. I have read and understand Fraud Warning Statements. I have completed and attached the Authorization for Release of Information.

Signature	Date
Print Name	

(Please see FRAUD NOTICES attached)

Illness or Injury Supplemental Questionnaire

Instructions: Please answer the questions to the best of your ability and sign and date below.

1. Is someone else responsible for your illness/injury? Yes No
2. Are you making a claim against anyone or any insurance company other than Lincoln Financial Group? Yes No

If you answered yes to either question above, please answer the following questions:

3. Please describe in detail the cause of your illness or injury:
4. Please provide the location and address where the illness or injury occurred:
5. Please provide the Responsible Party's information:
 1. Name: _____
 2. Address: _____
 3. Telephone Number: _____
 4. Insurance Company's Name: _____
 5. Claim Number: _____
6. If you have hired an attorney to investigate or prosecute a claim related to your illness or injury, please provide your attorney's information:
 1. Name: _____
 2. Address: _____
 3. Telephone Number: _____
7. If you have any documents related to any investigation into how your illness or injury occurred, please attach them.

I have answered the above questions to the best of my ability. I understand that fraudulently answering any of these questions could result in the suspension or termination of my benefits. I further understand that I have an obligation to supplement any of the above responses should any of the above information change in the future.

Print Name: _____

Signature: _____ Date: ____/____/____



Short Term Disability Claim Form Statement Of Employer

The Lincoln National Life Insurance Company
PO Box 2609, Omaha, NE 68103-2609
Toll Free (800) 423-2765 Fax (877) 843-3950
www.LincolnFinancial.com
disabilityclaims@lfg.com

*Please submit a written job description for the employee's position with this claim form

*Please submit a copy of this employee's enrollment statement with this claim form

1. This claim is for:

Full Name (First) (M.I.) (Last Name)

Social Security Number

____/____/____
Coverage Start Date

3. Describe Employee's Role

Job Title

Description of Duties

4. Other Income Being Received

	Amount \$	Date Began	Date Will Terminate	Date Applied For
Retirement Income	_____	___/___/___	___/___/___	___/___/___
Workers' Comp	_____	___/___/___	___/___/___	___/___/___
Salary Continuance	_____	___/___/___	___/___/___	___/___/___
State Disability	_____	___/___/___	___/___/___	___/___/___
Other Disability pay	_____	___/___/___	___/___/___	___/___/___

5. Employer Contact

Employer Contact Name

Street Address

City State Zip Code

Phone Number

Fax Number

Email Address

2. Employee's Coverage & Policy

Organization Name

Insurance Class

Group ID

Policy Number

Billing Location

Claim Location

Have you considered job accommodations? Yes No

Injury work related? Yes No

____/____/____
Date hired

Hours worked in a standard day

____/____/____
Date last worked

Hours worked in a standard week

____/____/____
Date back to work full-time

Hours worked on day last worked

\$_____
Earnings

Frequency (W/M/Y etc.)

The above statements are true and complete to the best of my knowledge and belief. I have read and understand the attached Fraud Warning Statements. I have completed and attached the Authorization for Release of Information.

Signature

____/____/____
Date

Print Name

(Please see FRAUD NOTICES attached)

1. Patient Information

Full Name (First)		(M.I.)	(Last Name)	Social Security Number
Height	Weight	Blood Pressure		Employer Name

2. Diagnosis

Primary ICD diagnostic Code (Required)	Primary ICD diagnosis Description
Secondary ICD Diagnosis Code	Secondary ICD Diagnosis Description

Pregnancy

First Treated	Estimated Delivery	Date of Delivery	<input type="checkbox"/> Vaginal	<input type="checkbox"/> C-Section
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Symptoms

Objective Findings (Include copies of any x-rays, laboratory data, EKG's, MRI's, scans and any clinical findings)

3. Disability Circumstances - Check if applicable

- Illness
 Injury
 Work Related

If work related or injury, summarize circumstances

Date of:		
Symptoms first Appeared	Reduced Ability to work	Advised to stop work
Initial Treatment	Most Recent Treatment	Next Treatment
Dates hospital confined:		to

The Lincoln National Life Insurance Company is not responsible for charges incurred due to completion of this form. The patient is responsible for any charges associated with form completion.

(Please see FRAUD NOTICES attached)

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates.

4. Limitations and Restrictions

Restrictions (what the patient SHOULD NOT do)

Limitations (what the patient CANNOT do)

Indicate frequency per day the listed activities below can be used performed using:
 N= Never 0% O= Occasionally <33% F= Frequently 34%-66% C= Continuously 67% - 100%

Lifting/Carrying

1-5 lbs. _____	Standing _____	Crouching _____	Overhead _____
6-10 lbs. _____	Walking _____	Crawling _____	Desk Level _____
11-25 lbs. _____	Sitting _____	Grasping _____	Below Waist _____
26-50 lbs. _____	Balancing _____	Climbing _____	
51-100 lbs. _____	Stooping _____	Pushing _____	
100 + lbs. _____	Kneeling _____	Pulling _____	
	Fingering _____	Bending _____	

Reaching

Activities of Daily Living

If patient cannot complete these activities of Daily living indicate, when they were first unable to do so. (M/D/Y)

Continence _____ / _____ / _____

Dressing _____ / _____ / _____

Transferring _____ / _____ / _____

Bathing _____ / _____ / _____

Toileting _____ / _____ / _____

Eating _____ / _____ / _____

What job modifications would allow the patient to return to work?

5. Treatment

Describe current and recommended treatment plans including any completed or future surgeries. (Include dates)

Date patient experienced loss of

Cognitive Functioning: _____ / _____ / _____

6. Prognosis

Describe the patients prognosis for recovery

Describe ongoing treatment frequency

7. Physician's Information

Name

Street Address

City

State

Zip Code

Patient able to return to work Full-Time on:

_____ / _____ / _____ to _____ / _____ / _____

If a specific date is unavailable, please provide a date range you expect a fundamental or marked change.

Phone Number

Fax Number

Signature

Date

The Lincoln National Life Insurance Company is not responsible for charges incurred due to completion of this form. The patient is responsible for any charges associated with form completion.

(Please see FRAUD NOTICES attached)



Authorization For Release Of Information

The Lincoln National Life Insurance Company
PO Box 2609, Omaha, NE 68103-2609
Toll Free (800) 423-2765 Fax (877) 843-3950
www.LincolnFinancial.com
disabilityclaims@lfg.com

1. In connection with a claim for benefits, I (the undersigned) **authorize** any physician, medical professional, pharmacist or other provider of health care services, hospital, clinic, other medical or medically related facility; insurance or reinsurance company; government agency; department of labor; acquaintance; group policyholder; employer; or policy or benefit plan administrator to release information from the records of:

Name of Insured: _____
(Last) (First) (Middle)

Date of Birth: ____ / ____ / _____ Social Security Number: _____ XXX-XX-

2. **Information to be released (hereinafter referred to as "My Information"):**

- data or records regarding my medical history, treatment, prescriptions, consultations [including medical and psychological reports, records, charts, notes (excluding psychotherapy notes), x-rays, films or correspondence, and any medical condition I may now have or have had];
- any information regarding insurance coverage, claims or benefits; and/or
- any information, data or records regarding my activities (including records relating to my Social Security, Workers' Compensation, retirement income, financial information, earnings and employment history).

3. **Information to be released to:** The Lincoln National Life Insurance Company ("Lincoln")
PO Box 2609
Omaha, NE 68103-2609

4. **I understand My Information will be used by Lincoln to evaluate and administer my claim for benefits. I also authorize Lincoln to release My Information as follows:**

- to its reinsurer, or other persons or organizations performing business or legal services in connection with my claim(s); or
- to a vendor, approved by Lincoln, which specializes in the application for Social Security Disability Benefits
- to vendors/consultants providing me with wellness, disability or leave related services as part of an employer sponsored benefit plan; or
- for self-insured disability plans only, to my employer; or
- for fully insured plans, I understand the information obtained with this Authorization may be used in discussions between Lincoln and my employer regarding my functional capacity, and any related restrictions and limitations, in order to facilitate my return to work; or
- as otherwise may be required by law or as I may further authorize.

5. I understand My Information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. For Colorado claims, the disclosed information may not be re-disclosed or reused by the recipient under Colorado law.

6. I understand that I may revoke this Authorization in writing at any time, except to the extent Lincoln has taken action in reliance on this Authorization. To initiate revocation of this Authorization, direct all correspondence to Lincoln at the above address. If written revocation is not received, this Authorization will be considered valid for a period of time not to exceed 24 months from the date of my signature below, or the duration of my claim for benefits, whichever is shorter.

7. A photocopy of this Authorization is to be considered as valid as the original. I am entitled to receive a copy of this Authorization.

SIGNATURE _____ **DATE** ____ / ____ / _____

Claimant/legal representative (Nearest relative, legal guardian, or appointed representative to sign only if claimant/patient is a minor, legally incompetent, or deceased.) Power of attorney or guardianship must be attached.

PRINT NAME: _____

Relationship to Claimant/Patient of personal/legal representative signing for Claimant/Patient _____

ADDRESS: _____
(Street)

(City) (State) (Zip Code)

PHONE NO: _____

(Please see FRAUD NOTICES attached)

FRAUD NOTICES. For your protection, certain states require that the following notices appear on this form.

Alabama. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Alaska. A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Arizona. For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas, Louisiana, Rhode Island and West Virginia. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California. For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado. It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware. Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia. It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Idaho. Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement or claim containing any false, incomplete or misleading information is guilty of a felony.

Indiana. A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kentucky. Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine. It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland. Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota. A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire. Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey. Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

New York. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Ohio. Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma. Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon. Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or, (2) conceals for the purpose of misleading, information concerning any material fact, may have committed a fraudulent insurance act.

Pennsylvania. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Puerto Rico. Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Tennessee, Virginia, and Washington. It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

FOR ALL OTHER STATES EXCLUDING CONNECTICUT AND KANSAS. A person may be committing insurance fraud, if he or she submits an application or claim containing a false or deceptive statement with intent to defraud (or knowing that he or she is helping to defraud) an insurance company.



Sick Leave Pool

This section will explain the use and policies of the Sick Leave Pool

While you are out on FMLA, county policy requires you to use all of your personal, paid leave. This includes sick, vacation and compensatory time. Your FMLA leave entitlement runs concurrently with your personal leave. FMLA is not a tool only to be used once you run out of paid leave.

What happens when you run out of paid leave?

Galveston County has established a Sick Leave Pool program for those that need it. However, you must first meet several eligibility requirements. They are as follows:

- Employee or their immediate family member prevented from performing the duties of their position for a minimum period of three (3) weeks
- You must be a full time or half time employee (not an hourly position)
- You must have twelve (12) or more months of continuous employment with the County as of the date of the onset of your injury or illness
- You must have ten (10) or more days of vacation and/or sick leave as of the date of the onset of your injury or illness
- You must have contributed a minimum of three (3) sick days to the pool with the exception of first year eligible employee, who must have contributed at least one (1) day of sick leave to the pool

If you are eligible for an award from the sick leave pool you must first utilize all of your own paid, personal leave (sick, vacation and comp.) before hours will be awarded from the SLP. Once your hours have been depleted, the sick leave pool administrator will review your leave and make the appropriate award.

Important Note

FMLA is not paid leave protection. FMLA only provides for up to 12 weeks of unpaid, job-protected leave. Do not assume that you will be paid for your entire leave.



Maintaining Health Benefits

This section will review the benefits protection portion of FMLA

While you are out on FMLA, Galveston County will continue to maintain your health benefits as mandated by the law. Your health coverage will be maintained on the same conditions as coverage would have been provided if you had been continuously employed during your entire leave period.

Employee Responsibilities:

Should any period of your leave be un-paid and you do not qualify for an award from the sick leave pool, you will still be responsible for paying your portion of any insurance premiums. In the event that you owe premiums, you will receive an invoice from the county auditor's office for any and all Boon-Chapman products with amounts and instructions for submission of payment. Failure to pay could lead to the eventual termination of coverage if the matter is not resolved.

If you are enrolled in any products that are administered by First Financial, you will need to contact the company directly to arrange for individual payment of premiums while you are on any sort of un-paid status.

First Financial Group of America
PO Box 670329
Houston, TX 77267-0329
Phone: 800.523.8422
www.ffga.com

Employer Responsibilities:

Galveston County will continue to pay their portion of the medical premium during your leave and maintain all benefits as if you were actively working during your leave entitlement.



Fitness-for-Duty Certificate

This section will explain what you need to do in order to return to work

If the reason that you are away from work is due to your own, personal medical reasons, you will be required to submit a fitness-for-duty certificate to human resources **prior** to your return to work.

Requirements:

For your convenience, human resources has developed a standardized form for you and your doctor to use. However, any note from your doctor will satisfy this requirement. During your initial leave approval, human resources will mail you a copy of your official job description. This job description will list the physical duties of your job. Please take this to your doctor for review. The doctor will release you to work with or without restrictions based on your job description.

Restrictions:

If your doctor has released you to return to work with restrictions, those restrictions must be clearly listed as well as the anticipated time frame.

Important Note

Failure to submit proper a doctor's release to human resources could lead to the delay in your restoration of employment.



FAMILY AND MEDICAL LEAVE ACT

Fitness-for-Duty Certificate

PART I – To be completed by employee

Name of employee (please print clearly): _____

Date leave commenced: _____

Employee's signature: _____

Date: _____

PART II – To be completed by health care provider

Date examined: _____

Effective (date) _____ the above named employee is:

_____ Released to return to work without restrictions (*see attached job description*); or

_____ Released to work with restrictions. Please describe restrictions below:

Health Care Provider's Signature: _____

Health Care Provider's Name (please print): _____

Date: _____

Phone Number: _____

Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

PART III – County of Galveston, Department of Human Resources

Date received: _____

Signature: _____



Unlawful Acts & Complaints

This section explain how to recognize unlawful retaliation for your use of FMLA

FMLA and your use of your leave entitlement is your right and is guaranteed to you by federal law. No one can force you to waive your rights to the protections and benefits of FMLA.

No one can:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA; or
- 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

If you feel that you are being unfairly singled out, harassed or treated different in any way for your use and exercise of your rights under FMLA, please immediately contact human resources to report any violations, either real or perceived, to attempt to resolve any conflict.

Enforcement:

U.S. Department of Labor, Wage and Hour Division

1-866-4US-WAGE (1-866-487-9243)

www.dol.gov/whd



Important Note

You cannot waive your own FMLA rights nor can your employer request that you waive your rights.

EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- for incapacity due to pregnancy, prenatal medical care or child birth;
- to care for the employee's child after birth, or placement for adoption or foster care;
- to care for the employee's spouse, son, 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.

Military Family Leave Entitlements

Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness*; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness.*

***The FMLA definitions of "serious injury or illness" for current servicemembers and veterans are distinct from the FMLA definition of "serious health condition".**

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months*, and if at least 50 employees are employed by the employer within 75 miles.

***Special hours of service eligibility requirements apply to airline flight crew employees.**

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and

a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

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; and
- 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

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

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.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulation 29 C.F.R. § 825.300(a) may require additional disclosures.



For additional information:
1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627
WWW.WAGEHOUR.DOL.GOV

U.S. Department of Labor | Wage and Hour Division



WHD Publication 1420 - Revised February 2013

The FMLA Leave Process

County of Galveston

