

HAWK OILFIELD SERVICE  
P.O. Box 812  
Zapata, TX 78076  
Ph. 956.765.6080  
info@hawkoilfield.com



Date: \_\_\_\_\_

Employee: \_\_\_\_\_

Dear Employee:

You are receiving this packet because you have either requested a leave of absence from your employer or expressed a possible need for one.

You will find enclosed:

1. **The FMLA Notice (Employee Rights and Responsibilities)** which outlines the basic provisions of FMLA and rights of eligible employees. You should also reference your employee handbook for specific policies of your employer. The FMLA gives employers options in several areas. For example, under the FMLA, an eligible employee is entitled to take up to 12 weeks of FMLA leave during a 12-month period. The options for the employer to use in designating the 12-month period are: the calendar year, any fixed 12-month period such as a fiscal year or a year starting with the employees anniversary date, the 12-month period as measured forward from the date the employees FMLA leave first begins, or a rolling 12-month period measured backward from the date the employee uses any FMLA leave. Your employer will advise us as to which options apply.
2. **Employee Request for FMLA Leave:** You will need to complete this form and return it to us as soon as possible. Please fax the signed document to 210.495.1224.
3. **Certification of Health Care Provider:** You will need to give this form to your health care provider for completion. Your health care provider may return the completed form directly to us (using the enclosed return envelope) or to you for submission. Please be sure that this completed form is returned to us within **15 days** following the request or simply provide us a reasonable explanation for the delay. Failure to provide certification may result in a denial of continuation of leave. Please be assured that medical information received for FMLA leave is considered confidential and shall be disclosed only to those involved in the FMLA leave determination.

#### **Documentation Related to Active Duty or Call to Active Duty**

Employees requesting this type of service member FMLA leave must provide proof of the qualifying family member's call-up or active military service. This documentation may be a copy of the military orders or other official Armed Forces communication.

#### **Documentation Related to the Need for Service member FMLA Leave to Care for an Injured or Ill Service member**

Employees requesting this type of Service member FMLA leave must provide documentation of the family member or next-of-kin injury, recovery or need for care. This documentation may be a copy of the military medical information, orders for treatment, or other official Armed Forces communication pertaining to the service member injury or illness incurred on active military duty that renders the member medically unfit to perform his or her military duties. After receipt and review of the forms, the client company will make a determination on designation of your absence as FMLA leave.

If you have any questions or would like discuss, please contact either your manager or eESI at (210)495-1171.

#### Enclosures:

1. FMLA Notice – Employee Rights and Responsibilities
2. Employee Request for FMLA Leave\*
3. Certification of Health Care Provider for Employee's Serious Health Condition (WH-380-E)\*

\* *To be completed and returned.*

# 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 or 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 with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation 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 a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

## 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 one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

## 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;
- 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. Regulations 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](http://WWW.WAGEHOUR.DOL.GOV)





**Employee Request for FMLA Leave**  
(30 days notice should be given when possible)

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

Work Phone No.: (     ) \_\_\_\_\_ - \_\_\_\_\_     Home Phone No.: (     ) \_\_\_\_\_ - \_\_\_\_\_

Current Position: \_\_\_\_\_ Client Name: \_\_\_\_\_

Manager's Name: \_\_\_\_\_ Mgr Phone: (     ) \_\_\_\_\_ - \_\_\_\_\_

Expected Leave Date: \_\_\_\_\_ Anticipated Return Date: \_\_\_\_\_

Approx. Length of Leave: \_\_\_\_\_

1. All available paid time off will be used during your leave. Once the available paid time off is exhausted, the leave will be unpaid.
2. Employees are not to work while on leave unless such time is approved in writing by the company.

*Type of leave requesting, if applicable:*

Intermittent Leave                      Reduced Schedule Leave

***Describe the intermittent leave or reduced schedule you are requesting.***

**FAMILY LEAVE:**     Name of Family Member: \_\_\_\_\_

Relationship to Employee: \_\_\_\_\_

Reason for Leave: \_\_\_\_\_

**MEDICAL LEAVE:**     Reason for Leave: \_\_\_\_\_

Additional information or comments:

**I acknowledge any premiums paid by the employer for my continued health coverage during my leave may be recovered in the event I do not return from leave.**

**I understand my request is not approved until I receive such notification from the company.**

Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Manager's Acknowledgement: \_\_\_\_\_ Date: \_\_\_\_\_

**Please fax completed form to (210) 495-1244**

Certification of Health Care Provider for  
Employee's Serious Health Condition  
(Family and Medical Leave Act)

U.S. Department of Labor  
Employment Standards Administration  
Wage and Hour Division



OMB Control Number: 1215-0181  
Expires: 12/31/2011

**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.

Employer name and contact: \_\_\_\_\_

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. 20 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. 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.**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

