Kimberly-Clark

FMLA: Family Member's Health Condition

The Family and Medical Leave Act (FMLA) provides up to 12 weeks of unpaid, job-protected time off for certain qualifying events such as caring for a covered family member with a serious health condition. This document includes the paperwork you need to apply for FMLA, along with a checklist to help you stay organized when applying for and using FMLA.

Learn More

K-C's FMLA Policy provides full details about your rights and responsibilities under the FMLA. The policy is available on @myHR > Total Rewards > Time and Attendance > Leave of Absence Policies.

Get Help / Report FMLA Absences

Contact the K-C HR Contact Center either online using AskHR or by calling 866-444-4516. Representatives are available Monday through Friday from 8 a.m. to 6 p.m. ET.

Applying for FMLA and Reporting Absences		
FMLA Application	You're responsible for completing this form and submitting it to the K-C HR Contact Center.	
Certification of Health Care Provider	**You:**	**1.** Section I: Enter all requested information. **2.** Write your Employee ID on pages 2 through 4. **3.** Give the form to your family member's health care provider to complete all other sections.
	Health Care Provider:	Fully completes all other sections of the form; incomplete forms will cause a delay in your FMLA request.
	You or your family member's health care provider's office can submit the completed form to the K-C HR Contact Center.	
FMLA Eligibility Verification	When all completed paperwork has been submitted, the K-C HR Contact Center will verify your FMLA eligibility and send notification to you, your Team Leader, HR representative and site nurse (if applicable).	
Reporting Absences	When you're away from work due to your health condition, you're responsible for: **1.** Reporting your absence to the K-C HR Contact Center no later than the next business day following your absence, **and** **2.** Following your site's call-in procedure. Contact your Team Leader or HR representative if you have questions about your site's call-in procedure.	

This form can be used by you and/or a health care provider when submitting completed **paperwork to the K-C HR Contact Center.**

FAX COVER SHEET

TO: **K-C HR Contact Center Leave of Absence Team**

FAX #: 866-386-4645

OF PAGES: _____ (including cover sheet)

ALTERNATE SUBMISSION OPTIONS

Scan or take a picture of your paperwork with your smart phone or tablet (be sure picture is clear and legible) and send to the K-C HR Contact Center. No cover sheet is required when using these submission methods:

Online: AskHR via the @myHR Portal

Email: AskHR.Response@kchrcontact.com

IMPORTANT

Completed FMLA paperwork should be submitted to the K-C HR Contact Center within 15 days of first requested absence. If additional time is needed, call the K-C HR Contact Center at 866-444-4516 Monday through Friday from 8 a.m. to 6 p.m. ET to discuss your options.

FMLA APPLICATION

Instructions: This application should be completed by the employee for new FMLA requests and FMLA recertification only. Do not submit this application to report an intermittent absence for an existing FMLA case. Submit the completed application to the K-C **HR Contact Center using AskHR, email to askhr.response@kchrcontact.com or fax to 866-386-4645.**

Name: _____ Employee ID: _____

Start Date of Leave: _____ Expected Return to Work Date: _____

Is this a request for intermittent leave or a reduced work schedule? Yes ____ No ____

Reason for Leave:

☐ For birth of the employee's child or for placement with the employee of a son or a daughter for adoption or foster care:

Expected Date of Birth or Placement: _____

☐ To care for a spouse, domestic partner, parent or child who has a serious health condition:

Name: _____ Relationship: _____

☐ Because of employee's own serious health condition. Is this a chronic condition? Yes ____ No ____

☐ Because of the illness or injury of employee's immediate family member resulting from service in the Armed Forces

Name: _____ Relationship: _____

☐ To deal with "any qualifying exigency" that arises from employee's family member's active duty in the Armed Forces.

Name: _____ Relationship: _____

If the leave is requested based on a serious health condition (either of the employee or the employee's spouse, parent, or child), the health care provider must complete a Certification of Health Care Provider Form (Document 7). A copy of the form is attached. This certification form must be submitted to the Company prior to the start of the leave unless the serious health condition prevents you from doing so, in which case the form must be provided to the Company as soon as possible after the leave starts and no later than 15 days from today's date. Failure to provide a completed certification within 15 days may result in delay or denial of FMLA leave. If you were unable to submit your medical certification prior to beginning your leave, your leave will be conditionally designated as FMLA and that designation will be confirmed or revoked based on the certification you provide.

INFORMED CONSENT TO RELEASE HEALTH CARE INFORMATION

I authorize the health care provider who completes the certification to disclose to the Company's health care provider information related to the medical condition for which I am requesting FMLA for the purpose of determining the authenticity of the certification or to clarify the certification in order to determine whether my leave qualifies for FMLA. I authorize contact with my health care provider for the purposes of clarification and authentication of information presented on my Certification for Health Care Provider Form or any certification of fitness for duty. Once information is disclosed pursuant to this authorization, it is no longer considered protected health information under the privacy provisions of the Health Insurance Portability and Accountability Act ("HIPAA") and may be subject to redisclosure. However, I do not give permission for other use or disclosure of this information. This authorization will be effective for one year. I understand that I may revoke this authorization at any time, except to the extent the Company or health care provider has already taken action in reliance on it, by providing my written revocation request to Human Resources. I understand that my ability to receive treatment, enroll in my employer's health plan(s) or become eligible for health plan benefits is not conditioned on my signing this authorization.

_____ _____

Employee Signature Date

_____ _____

Personal Email Address Home/Cell Phone Number

For unpaid leaves

☐ I wish to take this leave unpaid.

☐ I wish to use paid time (vacation, flex, personal holidays) for this leave. _____ hours/days

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: Kimberly-Clark K-C HR Contact Center Phone: 866-444-4516 Fax: 866-386-4645

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

Employee ID:_____

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.