Kimberly-Clark

FMLA: Military Family Leave

The Family and Medical Leave Act (FMLA) provides up to 12 weeks of unpaid, job-protected time off for qualifying exigency that arises when your covered family member is called to foreign deployment with the Armed Forces. 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 Qualifying Exigency for Military Family Leave	• You're responsible for completing this form and submitting it to the K-C HR Contact Center. • Along with your completed certification, also submit a copy of your family member's active duty orders.
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 (request for leave under the Family and Medical Leave Act) 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.**

Notice Requirements:

- When the need for FMLA leave can be anticipated, such as for birth, adoption, or planned medical treatment, you must provide written notice through submission of this application at least 30 days prior to the start of the requested leave.
- If the need for FMLA leave can be anticipated but 30 days' notice is not possible, you must provide written notice through submission of this application as soon as practicable, which typically should be either the same day or the next business day after you learn of the need for leave.
- If the need for FMLA leave cannot be anticipated, such as in the event of emergencies or other unforeseeable circumstances, you must provide notice as soon as practicable; oral notice may be sufficient. "As soon as practicable" typically means that notice should be given in accordance with your department's established call-in procedures.
- Failure to comply with these notice requirements could result in the delay or denial of approval of the requested leave.

Employee Name: _____ Employee ID: _____

This Request is for (please check one or more as applicable):

_____Intermittent Leave _____Reduced Work Schedule _____Continuous Leave

Anticipated Time Period During Which Leave Is Needed (Duration of Leave): From_____ To:_____

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, or to bond with such child:

Expected Date of Birth or Placement: _____

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

Name: _____ Relationship: _____

☐ Because of employee's own serious health condition.

☐ Because of the serious illness or injury of a covered servicemember of whom the employee is the spouse, domestic partner, son, daughter, parent or next of kin.

Name: _____ Relationship: _____

☐ To deal with "any qualifying exigency" that arises from the foreign deployment of a military member who is the employee's spouse, domestic partner, son, daughter or parent.

Name: _____ Relationship: _____

Appropriate certification from a health care provider and/or other documentation (documentation of relationship and/or documentation supporting need for qualifying exigency leave) may be required. Failure to provide a complete and sufficient certification or other documentation within 15 calendar days from when it is requested 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.

By signing below, you certify that the information provided herein is truthful and complete.

_____ _____

Employee Signature Date

Employee Contact Information (at which employee may be reached during leave):

Personal Email Address

Home/Cell Phone Number

Personal Mailing Address

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

Note: Submission of this FMLA Application does not mean that your FMLA leave request has been granted. After receiving this Application, [INSERT] will inform you: (a) whether you are eligible to take FMLA leave; and (b) if you are eligible, of your rights and responsibilities under the FMLA, including your obligation to submit any additional information (such as a certification from a health care provider) so that a determination can be made regarding your FMLA leave request.

Certification of Qualifying Exigency For Military Family Leave (Family and Medical Leave Act)

U.S. Department of Labor

Wage and Hour Division

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 leave due to a qualifying exigency to submit a certification. Please complete Section I before giving this form to your employee. Your response is voluntary, and 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 CFR 825.309.

Employer name: Kimberly-Clark Corporation

Contact Information: 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 fully and completely. The FMLA permits an employer to require that you submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a qualifying exigency. Several questions in this section seek a response as to the frequency or duration of the qualifying exigency. Be as specific as you can; terms such as "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Your response is required to obtain a benefit. 29 CFR 825.310. While you are not required to provide this information, failure to do so may result in a denial of your request for FMLA leave. Your employer must give you at least 15 calendar days to return this form to your employer.

Your Name and K-C ID: _____

First Middle Last K-C Employee ID

Name of military member on covered active duty or call to covered active duty status:

_____

First Middle Last

Relationship of military member to you: _____

Period of military member's covered active duty: _____

A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes written documentation confirming a military member's covered active duty or call to covered active duty status. Please check one of the following and attach the indicated document to support that the military member is on covered active duty or call to covered active duty status.

☐ A copy of the military member's covered active duty orders is attached.

☐ Other documentation from the military certifying that the military member is on covered active duty (or has been notified of an impending call to covered active duty) is attached.

☐ I have previously provided my employer with sufficient written documentation confirming the military member's covered active duty or call to covered active duty status.

CONTINUED ON NEXT PAGE

PART A: QUALIFYING REASON FOR LEAVE

K-C Employee ID:_____

1. Describe the reason you are requesting FMLA leave due to a qualifying exigency (including the specific reason you are requesting leave):

_____

_____

_____

_____

2. A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes any available written documentation which supports the need for leave; such documentation may include a copy of a meeting announcement for informational briefings sponsored by the military; a document confirming the military member's Rest and Recuperation leave; a document confirming an appointment with a third party, such as a counselor or school official, or staff at a care facility; or a copy of a bill for services for the handling of legal or financial affairs. Available written documentation supporting this request for leave is attached.

Yes ☐ No ☐ None Available ☐

PART B: AMOUNT OF LEAVE NEEDED

1. Approximate date exigency commenced: _____

Probable duration of exigency: _____

2. Will you need to be absent from work for a single continuous period of time due to the qualifying exigency?

Yes☐ No☐

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

_____

3. Will you need to be absent from work periodically to address this qualifying exigency? Yes☐ No☐

Estimate schedule of leave, including the dates of any scheduled meetings or appointments:

_____

_____

Estimate the frequency and duration of each appointment, meeting, or leave event, including any travel time (i.e., 1 deployment-related meeting every month lasting 4 hours):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours ___ day(s) per event.

CONTINUED ON NEXT PAGE

PART C: K-C Employee ID:_____

If leave is requested to meet with a third party (such as to arrange for childcare or parental care, to attend counseling, to attend meetings with school, childcare or parental care providers, to make financial or legal arrangements, to act as the military member's representative before a federal, state, or local agency for purposes of obtaining, arranging or appealing military service benefits, or to attend any event sponsored by the military or military service organizations), a complete and sufficient certification includes the name, address, and appropriate contact information of the individual or entity with whom you are meeting (i.e., either the telephone or fax number or email address of the individual or entity). This information may be used by your employer to verify that the information contained on this form is accurate.
Name of Individual: _____ Title: _____

Organization: _____

Address: _____

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

Email: _____

Describe nature of meeting: _____

_____

_____

_____

_____

_____

_____

PART D:

I certify that the information I provided above is true and correct.

Signature of Employee _____ 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 CFR 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 AV, NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE EMPLOYER.**