Kimberly-Clark

FMLA: Your Serious 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 managing your 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.

NOTE: for continuous absences related to your own health condition to be considered for FMLA protection, the period of incapacity must be more than three consecutive calendar days.

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.

Note: If you're approved for disability benefits during your absence from work and are FMLA-eligible with available FMLA hours, you're not required to complete FMLA paperwork. FMLA protection will automatically be applied to absences during an approved disability leave (until FMLA hours are exhausted).

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 your job title, work schedule and job functions. **2.** Section II: Enter your name and Employee ID. **3.** Write your Employee ID on pages 2 through 4. **4.** Give the form to your 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 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 taking steps shown on next page:	

	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.

K-C Employee ID:_____

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: Kimberly-Clark Corporation K-C HR Contact Center Phone: 866-444-4516_____

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 and K-C ID name: _____

First Middle Last K-C Employee ID

ECTION 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:(_____)_____

K-C Employee ID:_____

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):

   _____

   _____

   _____

   _____

   _____

   _____

CONTINUED ON Form WH-380-E

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.

_____

_____

_____

_____

_____

CONTINUED ON Form WH-380-E

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.**