Kimberly-Clark

FMLA: Military Caregiver Leave

The Family and Medical Leave Act (FMLA) provides up to 26 weeks of unpaid, job-protected time off for the care of a covered family member who is a current service member of the Armed Forces and suffering from a serious injury or illness sustained during active duty. 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 for Serious Injury or Illness of a Veteran for Military Caregiver Leave	**You:** **1.** Section I: Enter all requested information in parts A, B, and C. **2.** Write your Employee ID on pages 2 through 5. **3.** Give the form to a qualified health care provider who's involved with your family member's care 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 the 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 (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 for Serious Injury or Illness of a Current Servicemember - -for Military Family Leave (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

Notice to 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 serious injury or illness of a current servicemember to submit a certification providing sufficient facts to support the request for leave. 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 CFR 825.310. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees or 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 CFR 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 CFR 1635.9, if the Genetic Information Nondiscrimination Act applies.

SECTION I: For Completion by the EMPLOYEE and/or the CURRENT SERVICEMEMBER for whom the Employee Is Requesting Leave

INSTRUCTIONS to the EMPLOYEE or CURRENT SERVICEMEMBER: Please complete Section I before having Section II completed. The FMLA permits an employer to require that an employee submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a serious injury or illness of a servicemember. If requested by the employer, your response is required to obtain or retain the benefit of FMLA-protected leave. 29 U.S.C. 2613, 2614(c)(3). Failure to do so may result in a denial of an employee's FMLA request. 29 CFR 825.310(f). The employer must give an employee at least 15 calendar days to return this form to the employer.

SECTION II: For Completion by a UNITED STATES DEPARTMENT OF DEFENSE ("DOD") HEALTH CARE PROVIDER or a HEALTH CARE PROVIDER who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; (3) a DOD non-network TRICARE authorized private health care provider; or (4) a health care provider as defined in 29 CFR 825.125

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed on Page 2 has requested leave under the FMLA to care for a family member who is a current member of the Regular Armed Forces, the National Guard, or the 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. For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty in the Armed Forces or that existed before the beginning of the member's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces that may render the servicemember medically unfit to perform the duties of his or her office, grade, rank, or rating.

A complete and sufficient certification to support a request for FMLA leave due to a current servicemember's serious injury or illness includes written documentation confirming that the servicemember's injury or illness was incurred in the line of duty on active duty or if not, that the current servicemember's injury or illness existed before the beginning of the servicemember's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces, and that the current servicemember is undergoing treatment for such injury or illness by a health care provider listed above. 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 servicemember's condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 CFR 1635.3(f), or genetic services, as defined in 29 CFR 1635.3(e).

SECTION I: For Completion by the EMPLOYEE and/or the CURRENT SERVICEMEMBER for whom the Employee Is Requesting Leave:

(This section must be completed first before any of the below sections can be completed by a health care provider.)

Part A: EMPLOYEE INFORMATION

Name and Address of Employer (this is the employer of the employee requesting leave to care for the current servicemember):

Kimberly-Clark Corporation 400 Goodys Lane Suite 100, Knoxville TN 37922

Name and K-C ID of Employee Requesting Leave to Care for the Current Servicemember:

_____

First Middle Last K-C Employee ID

Name of the Current Servicemember (for whom employee is requesting leave to care):

_____

First Middle Last

Relationship of Employee to the Current Servicemember:

Spouse☐ Parent ☐ Son ☐ Daughter ☐ Next of Kin ☐

Part B: SERVICEMEMBER INFORMATION

(1) Is the Servicemember a Current Member of the Regular Armed Forces, the National Guard or Reserves?

Yes☐ No☐

If yes, please provide the servicemember's military branch, rank and unit currently assigned to:

_____

Is the servicemember assigned to a military medical treatment facility as an outpatient or to a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients (such as a medical hold or warrior transition unit)?

Yes☐ No☐

If yes, please provide the name of the medical treatment facility or unit:

_____

(2) Is the Servicemember on the Temporary Disability Retired List (TDRL)?

Yes☐ No☐

Part C: CARE TO BE PROVIDED TO THE SERVICEMEMBER

Describe the Care to Be Provided to the Current Servicemember and an Estimate of the Leave Needed to Provide the Care:

_____

SECTION II: For Completion by a United States Department of Defense ("DOD") Health Care Provider or a Health Care Provider who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; (3) a DOD non-network TRICARE authorized private health care provider; or (4) a health care provider as defined in 29 CFR 825.125. If you are unable to make certain of the military-related determinations contained below in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator).

(Please ensure that Section I above has been completed before completing this section. Please be sure to sign the form on the last page.)

Part A: HEALTH CARE PROVIDER INFORMATION

Health Care Provider's Name and Business Address:

_____

Type of Practice/Medical Specialty: _____

Please state whether you are either: (1) a DOD health care provider; (2) a VA health care provider; (3) a DOD TRICARE network authorized private health care provider; (4) a DOD non-network TRICARE authorized private health care provider, or (5) a health care provider as defined in 29 CFR 825.125:

_____

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

PART B: MEDICAL STATUS

(1) The current Servicemember's medical condition is classified as (Check One of the Appropriate Boxes):

☐ **(VSI) Very Seriously Ill/Injured** – Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

☐ **(SI) Seriously Ill/Injured** – Illness/injury is of such severity that there is cause for immediate concern, but there is no imminent danger to life. Family members are requested at bedside. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

☐ **OTHER Ill/Injured** – a serious injury or illness that may render the servicemember medically unfit to perform the duties of the member's office, grade, rank, or rating.

☐ **NONE OF THE ABOVE** (Note to Employee: If this box is checked, you may still be eligible to take leave to care for a covered family member with a "serious health condition" under § 825.113 of the FMLA. If such leave is requested, you may be required to complete DOL FORM WH-380-F or an employer-provided form seeking the same information.)

(2) Is the current Servicemember being treated for a condition which was incurred or aggravated by service in the line of duty on active duty in the Armed Forces? Yes☐ No☐

(3) Approximate date condition commenced: _____

(4) Probable duration of condition and/or need for care: _____

(5) Is the servicemember undergoing medical treatment, recuperation, or therapy for this condition? Yes☐ No☐

If yes, please describe medical treatment, recuperation or therapy:

_____

PART C: SERVICEMEMBER'S NEED FOR CARE BY FAMILY MEMBER

(1) Will the servicemember need care for a single continuous period of time, including any time for treatment and recovery? Yes☐ No☐

If yes, estimate the beginning and ending dates for this period of time: _____

(2) Will the servicemember require periodic follow-up treatment appointments? Yes☐ No☐

If yes, estimate the treatment schedule: _____

(3) Is there a medical necessity for the servicemember to have periodic care for these follow-up treatment appointments? Yes☐ No☐

(4) Is there a medical necessity for the servicemember to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)?
Yes☐ No☐

If yes, please estimate the frequency and duration of the periodic care:

_____

_____

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, in accordance with 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 PATIENT.**