Request to Postpone Certification Due to Impossibility to Receive Health Care Provider Certification

Employee Name: Employee No.:

Company Name: Leave Request No.:

Purpose of this Form

- You should not use this form if you are able to have your health care provider certify your leave within 15 days (for such situations, use the Certification of Health Care Provider form attached to this packet of information you received)
- However, in the event that, given current circumstances, it would be impossible for you to have your health care provider complete a medical certification within the next **15 days**, you may complete the following form and return it via the email or fax as listed in step 4.
- We will then review your request and determine whether your leave can be provisionally approved.
- This form applies to requests for an unpaid leave of absence (e.g., an FMLA leave). If your request is for your own serious health condition, be advised that this form is not applicable to request for benefits under a short-term disability plan (or another form of paid leave for which certification is required.)
- Be advised that, at some later date at which circumstances would allow you to receive a certification in a timely manner, your employer may request certification if there is reason to question the appropriateness of the leave or its duration.

Instructions - Complete all 4 following sections

Step 1 – Affirming that you need to take this leave

Step 2 – In steps A-C, describe your, or your family member's, relevant health condition

Step 3 – Provide the dates of your leave and whether it is continuous, intermittent or reduced schedule

Step 4 – Provide any supporting documentation and sign the form

STEP 1: AFFIRMATION RELATED TO YOUR LEAVE

I, the employee, am requesting leave for myself or a family member. I affirm that:

- I have, or my family member for whom I need to care for has, a serious health condition under the law.
- I am not (or my family member is not) able to have a health care provider (HCP) certify my request for a leave of absence because, despite any diligent, good faith efforts on my (or my family member's) part, it is impossible to gain access to my HCP for such a certification at this time.
- I understand that if I were to misrepresent my need for leave or the serious health condition, within this document, that such fraud would not qualify for FMLA protection and such actions would violate my employer's code of conduct or handbook.
- I may be required to provide a certification for the leave at a later date, and if I am, I understand that if I do not provide that certification

Please explain why you (or your family member) cannot see a health care provider within the 15 day period

Estimate when you (or your family member) will be able to see a health care provider

X

Please sign to indicate you affirm the statements above:

For purposes of California: The California Genetic Information Nondiscrimination Act of 2011 (CalGINA) prohibits employers and other covered entities from requesting, or requiring, genetic information of an individual or family member of the individual except as specifically allowed by law. To comply with the Act, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information," as defined by CalGINA, includes information about the individual's or the individual's family member's genetic tests, information regarding the manifestation of a disease or disorder in a family member of the individual, and includes information from genetic services or participation in clinical research that includes genetic services by an individual or any family member of the individual. "Genetic Information" does not include information about an individual's sex or age.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact than an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

STEP 2: Your, or your family member's, condition

A. Briefly Describe Appropriate Medical Facts: The medical facts must be sufficient to support the need for leave.

B. Select Appropriate Description of Condition. At least one section, and all that apply, must be completed.

Section 1:
A single reason accounts for your, or your family member's medically necessary absence from work:

- ☐ Inpatient care in a hospital, hospice, or residential medical care facility; or any recovery or treatment in connection with such inpatient care[2]
- ☐ Permanent or long-term condition requiring continuing supervision of a health care provider
- ☐ Out of work to undergo multiple treatments and related recovery for one of the below:

1. Restorative surgery after an accident or other injury **-or-**
2. A condition that would likely result in a period of incapacity of more than three (3) full, consecutive calendar days in the absence of such treatment

Section 2:
A combination of reasons account for your, or your family member's, medically necessary absence from work:

- ☐ Unable to work/perform job duties for more than three (3) full, consecutive calendar days, coupled with one of the following **(select at least one and provide dates of treatment):**
  - ☐ Two (2) or more in-person treatments within the first 30 days of the employee's incapacity: Dates:_____
  - ☐ At least one (1) examination/treatment followed by continuing treatment (e.g., physical therapy or prescription medication), under the supervision of or referral by a health care provider: Dates: _____
- ☐ A chronic health condition which continues over an extended period of time and **BOTH:**

1. Requires at least two (2) visits for treatment by a health care provider per year **-and-**
2. May cause episodic incapacity or flare-ups or would cause periods of reoccurrence without treatment (e.g., asthma, diabetes, epilepsy)

C. If the leave is for yourself, confirm you cannot perform the essential functions of the job.

Are you unable to perform any of your job functions due to the condition? ☐ No ☐ Yes, I am unable to perform all/some functions.

If so, identify the job functions you are unable to perform and the nature of the work restrictions and the duration of such inability:

[1] Such medical facts may include information on symptoms, diagnosis, hospitalization, doctor visits, whether medication has been prescribed, referrals for evaluation or treatment (e.g., physical therapy) or any other regimen of continuing treatment such as the use of specialized equipment (Not required in California).

[2] For purposes of California, an employee who is admitted to a health care facility with the expectation that he or she will remain at least overnight, even if he or she is later discharged such that he/she did not remain overnight.

STEP 3: DATES OF LEAVE Consider all dates you, or your family member, have been or will be unable to work then check and complete the section below that applies. If you cannot provide a certain date for any applicable entry, **you must provide your best estimate.**

☐ **Continuous Leave:** Are you, or your family member, unable to work for a single, continuous period of time?

i. Start date of incapacity____/____/____ (MM/DD/YYYY)

ii. Estimated end date of incapacity____/____/____ (MM/DD/YYYY)

☐ **Intermittent Leave:**

You are able to work but need occasional time off for a single illness or injury or time you need to care for yourself or your family member. Please indicate whether you require time for **appointments/treatments** and/or **flare-ups/episodes,** below:

i. Start date for leave or initial appointment date____/____/____ (MM/DD/YYYY)

ii. Probable end date for leave____/____/____ (MM/DD/YYYY) **or** ☐ Condition is lifelong **(check if applicable)**

iii. **Appointments/treatments** - Will you need to miss work for appointments or treatments related to your condition or to care for your family member? ☐ No ☐ Yes – If yes, estimate your treatment schedule:

Frequency: Up to____times per_____(week/month/year) **Duration:** Lasting up to_____hours **or**_____days

Please include the dates of any scheduled appointments and the time required for each appointment:_____

iv. **Flare-ups/Episodes** - Will you need to miss work for episodes of incapacity/flare-ups of your health condition or to care for yourself or your family member? ☐ No ☐ Yes – If yes, estimate your treatment schedule:

Frequency: Up to_____times per_____(week/month/year) **Duration:** Lasting up to_____hours **or**_____days

v. Dates you have already been treated or your family member has been treated for this condition:

_____

_____

☐ **Reduced Schedule Leave:**

Are you working on a FIXED part-time schedule or taking predictable regularly scheduled absences?

Start Date of Leave _____/_____/_____ (MM/DD/YYYY)

Probable End Date of Leave:_____/_____/_____ (MM/DD/YYYY)

(Please indicate the hours of time you will need to miss each day related to your condition or to care for your family member)

Sunday	
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	

STEP 4: DOCUMENTATION

If you have any supporting documentation or information, please attach that as well.

Sign here: _____

Confidential fax: 877.309.0218 or **E-Mail:** Absence@Sunlife-ams.com

- **When emailing please use subject:** Request to Postpone

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