King County

Protected Family and Medical Leave Response Form

Family and Medical Leave Act (FMLA) ◆ King County Family and Medical Leave (KCFML)
Washington Family Leave Act (WFLA) ◆ Washington Family Care Act (WFCA)
Pregnancy, Childbirth, and Pregnancy Related Conditions (PCPRC)

Read all instructions before completing this form.

- You (supervisor or department human resources contact or designee) must complete this form _ASAP_ to respond to the employee's leave request. Refer to the employee's Protected Family and Medical Leave Request Form for information to complete this form.
- When you have completed this form, provide copies to:
  - Employee (if leave has already begun, mail copy to employee's home address; if leave is denied, advise employee about leave of absence without pay request process and provide employee with a Leave of Absence Without Pay Request Form)
  - Your department human resources contact or designee
  - Benefits and Retirement Operations (mail copy via interoffice or U.S. mail to The Chinook Building CNK-ES-0240, 401 Fifth Avenue, Seattle, WA 98104-2333; mark envelope "confidential"; call 206-684-1556 for details).

Employee Requesting Leave

Name _____ PeopleSoft Employee ID _____

Leave Request Type and Response – Check all that apply.

If leave is for a family member, enter name and relationship of family member: _____

FMLA/WFLA leave is for one of these reasons:* *paid or unpaid leave	1.	Serious health condition of: ☐ Self ☐ Spouse ☐ Child ☐ Parent or an individual who stands or stood in loco parentis
	2.	☐ Birth of son/daughter, care for newborn, placement for adoption/foster care
	3.	☐ Employee workers' compensation injury/illness Claim No. _____
	4.	Serious health condition of: ☐ Military service member
	5.	☐ Active-duty military family leave
KCFML leave is for one of these reasons:* *unpaid leave only (includes donated leave)	1.	Serious health condition of: ☐ Self ☐ Spouse ☐ Domestic Partner (DP) ☐ Child of self, spouse or DP ☐ Parent of self, spouse or DP or an individual who stands or stood in loco parentis to self, spouse or DP
	2.	☐ Birth of son/daughter, bonding with newborn, placement for adoption/foster care
	3.	☐ Employee workers' compensation injury/illness Claim No. _____
WFCA leave is for one of these reasons*: *paid leave only		Serious health condition or emergency condition of employee's: ☐ Parent ☐ Spouse ☐ Child ☐ Grandparent ☐ Parent-in-law
Pregnancy, Childbirth and Pregnancy Related Conditions (PCPRC)*: *paid or unpaid leave		☐ Female King County employee temporarily disabled because of pregnancy-related or childbirth-related condition
If caring for a family member, the nature of assistance to be provided includes:		☐ Basic medical needs ☐ Personal needs ☐ Transportation ☐ Safety ☐ Emergency room ☐ Care of minor ☐ Psychological comfort

☐ Provisionally approved (see Medical Certification section below)   ☐ Approved

☐ Denied (comments)

_____

_____

_____

Employee name _____

Medical Certification and Documentation

Medical certification submitted on (date) _____ ☐ is sufficient ☐ is insufficient.

☐ The employee must resubmit a Protected Family and Medical Leave Medical Certification form on the following dates:
_____   _____   _____

☐ Medical certification not yet received; employee must provide medical certification by (date)* _____

Documentation of newborn or foster/adopted child submitted ☐ is sufficient ☐ is insufficient.

*If medical certification is not submitted as required, start of leave may be delayed (if employee is already absent from work, leave may not be treated as approved protected family and medical leave). Employee may be subject to recertification every 30 days.

Accruals and Entitlements

Before using KCFML, accrued compensatory time must be exhausted.

As of (date) _____, the employee has the following hours of accrued and other paid leave:
_____ Vacation leave   _____ Sick leave   _____ Compensatory time   _____ Executive leave   _____ Other (describe) _____

In the 12 months before the leave start date indicated on the Protected Family and Medical Leave Request Form, employee has used:
_____ hours/weeks of 12-week FMLA/WFLA entitlement and has   ☐ _____ weeks remaining   ☐ _____ hours remaining
_____ hours/weeks of 18-week KCFML entitlement and has   ☐ _____ weeks remaining   ☐ _____ hours remaining

Key Dates

Department must notify Benefits and Retirement Operations if and when circumstances of leave change, including return-to-work date.

_____ Employee's last day at work before ☐ intermittent ☐ continuous or ☐ reduced leave begins

_____ Protected Family and Medical Leave start date and designated as (check all that apply):
☐ FMLA/WFLA   ☐ KCFML   ☐ WFCA   ☐ PCPRC   ☐ FMLA/Military service member

_____ First (anticipated) date employee enters an unpaid status (exhausted own accruals)

_____ Donated leave begins (if applicable)   _____ Donated leave ends (if applicable)

_____ First actual date of employee's unpaid status begins and will be concurrently designated as:
☐ FMLA/WFLA   ☐ KCFML   ☐ PCPRC (check all that apply)

_____ FMLA/WFLA leave ends   _____ WFCA leave ends   _____ KCFML leave ends   _____ PCPRC leave ends

_____ Protected Family and Medical Leave (anticipated) return-to-work date

_____ Actual return-to-work date

Additional Employee Responsibilities

- Employee must notify supervisor and department human resources contact or designee if and when circumstances of leave change.
- Employee must notify supervisor and department human resources contact or designee at least two days before date employee intends to return to work, including return-to-work date.
- Failure to notify or provide medical certification or medical releases as required may affect employment status and right to return to work.
- For more information, employee may contact his/her supervisor or department human resources contact or designee.
- Department human resources contact or designee name _____ Phone _____

Supervisor or Department Human Resources Contact or Designee

I am authorized to approve protected family and medical leaves of absence. I will provide copies of this completed form to the employee and Benefits and Retirement Operations, and notify both if and when there are changes to the circumstances of the leave, including return-to-work status.

Signature _____   Date signed _____

Printed name _____   Mail stop _____

Department/work group _____   KC No _____

Contact phone (_____) _____   Date copies sent _____

☐ Employee copy ☐ Benefits and Retirement Operations copy ☐ Dept. medical file ☐ Dept. HR contact copy ☐ Dept. Payroll copy