I. Salary Schedule

A. Effective July 1, 2017

<table>
<thead>
<tr>
<th>Resident PGY Level</th>
<th>2017-18 Base Salary Amount (Effective July 1, 2017)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PGY 1</td>
<td>$50,128</td>
</tr>
<tr>
<td>PGY 2</td>
<td>$50,875</td>
</tr>
<tr>
<td>PGY 3</td>
<td>$51,719</td>
</tr>
<tr>
<td>PGY 4</td>
<td>$52,994</td>
</tr>
<tr>
<td>PGY 5</td>
<td>$54,371</td>
</tr>
<tr>
<td>PGY 6</td>
<td>$56,149</td>
</tr>
<tr>
<td>PGY 7</td>
<td>$56,289</td>
</tr>
<tr>
<td>Medical Oncology Fellow</td>
<td>$58,010</td>
</tr>
<tr>
<td>Selective Pathology Fellow</td>
<td>$58,010</td>
</tr>
</tbody>
</table>

B. Salary Schedule Effective July 1, 2016

<table>
<thead>
<tr>
<th>Resident PGY Level</th>
<th>2016-17 Salary Amount (Effective July 1, 2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PGY 1</td>
<td>$48,900</td>
</tr>
<tr>
<td>PGY 2</td>
<td>$49,940</td>
</tr>
<tr>
<td>PGY 3</td>
<td>$50,460</td>
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<tr>
<td>PGY 4</td>
<td>$51,710</td>
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<tr>
<td>PGY 5</td>
<td>$53,060</td>
</tr>
<tr>
<td>PGY 6</td>
<td>$54,495</td>
</tr>
<tr>
<td>PGY 7</td>
<td>$54,940</td>
</tr>
<tr>
<td>Medical Oncology Fellow</td>
<td>$58,010</td>
</tr>
<tr>
<td>Selective Pathology Fellow</td>
<td>$58,010</td>
</tr>
</tbody>
</table>
II. Resident Vacation, Sick Leave & Holidays

A. Vacation & Sick Leave

NOTE: If a Residency Review Committee (RRC) or Accreditation Board requires a minimum number of weeks of training per year in conflict with this vacation policy, the policy shall automatically be amended to comply with the requirements of the RRC or Accreditation Board of the program in question.

Subject to the above condition, each resident is entitled to accrue up to twenty (20) days of vacation and sick time annually at the rate of 1 2/3 days per month.

EXCEPTION: General Dentistry Residents are entitled to ten (10) vacation days and five (5) sick days due to the Dental Accreditation requirements and the length of the program.

All vacations shall be taken upon reasonable prior notice as approved by the program director in consultation with the department head. Unused vacation time may not be accumulated from year to year. However, sick time may be accumulated up to a maximum of one hundred twenty (120) days. Monetary reimbursement will not be given for unused sick or vacation time under any circumstance.

Vacation or sick time used but unearned at the time of termination of employment (with or without cause) must be reimbursed to the employer by the resident. For example, if a resident completes six (6) months of his twelve (12) month training, he would be entitled to ten (10) vacation days (and sick days) or one-half of the annual accrual. Vacation time taken in excess of this amount will be deducted from the last paycheck. If the final paycheck has already been issued, the resident must reimburse the employer. Checks should be made payable to UMRS or UDRS, as applicable.

B. Holidays

Provided that the resident will meet all accrediting body requirements as to time spent in training, residents may be given up to ten (10) paid holidays per year in addition to vacation and sick leave. These days must be scheduled at the discretion of the program director. Any unused holiday time may not be accumulated from year to year. Monetary reimbursement will not be given for unused holidays at the end of a resident’s training program. Program directors are encouraged to rotate national holidays (i.e., Christmas and New Year’s) among residents so that residents alternate working during highly sought days off. Holiday schedules shall be made available in the program director’s office.
III. Resident Leave Policies

A. Short Term Disability

1. UMRS and UDRS purchase short term disability insurance for all residents as required under New York State law.

2. The Office of Graduate Medical Education (GME) must be notified by the program of any disability leave.

3. A resident is considered disabled and therefore eligible for NYS Short Term Disability insurance benefits in the event of any qualified medical leave for a continuous period in excess of seven (7) consecutive days. Benefits will be paid for a period determined by the disability insurance carrier not to exceed a maximum of twenty six (26) weeks.

4. Residents are required to file a disability claim for all medical leaves in excess of seven (7) consecutive days. UMRS/UDRS reserves the right to request detailed medical documentation to support a claim.

5. The first seven (7) days of a disability claim are considered a “waiting period” during which no disability payments are made. Residents must use accrued but unused sick time in order to receive pay for this period.

6. Following the “waiting period”, residents may use accrued but unused sick time in order to continue receiving their normal salary amount. Once the resident has exhausted all available sick time, he/she may become eligible to receive disability payments of up to $170.00 per week.

7. At the residents’ request and with the consent of the program director, any portion of the unused annual allotment of vacation time (both accrued and not accrued) for the current PGY may be converted to sick time in order to continue receiving the normal salary amount. The resident must request the conversion in writing from the program director with a copy to the Office of GME. The program director’s approval must also be made in writing with a copy to the Office of GME. Under no circumstances may residents use the vacation or sick day allotment for future residency years.

8. The Office of GME must be notified as of the first day the resident is determined unable to work. Completion of a disability claim is mandatory and must be completed within 30 days of the last day worked in order to protect resident rights. To avoid any hardship to the resident, UMRS and UDRS routinely continue the resident’s full pay to the extent that accrued sick time will allow. Failure to file a claim or to comply with the request of the disability insurance carrier will result in the loss of potential disability reimbursement and future rights to disability benefits.
9. Under no circumstance may a resident start their training on disability leave.

10. Accreditation Board or RRC requirements may necessitate an extension of the training period upon the residents’ return to work in order for the resident to qualify for certification. If a leave will result in an extension of training, program directors must notify the resident in writing, with a copy to the Office of GME, outlining the educational ramifications of the leave (i.e., delay in graduation, repeat of a module, etc…). A revised employment contract reflecting the necessary extension of the training must be executed upon the residents’ return to employment. All contract extensions must be made in the training year in which the leave was taken.

11. Leave for Pregnancy/Childbirth  Pregnancy / childbirth is a form of disability leave and all above requirements apply. The period of such disability begins at the time the attending physician determines the resident is medically unable to continue work as a resident. The disability time after delivery is determined by the disability insurance carrier based on the time deemed to be medically necessary by the attending physician and supported by appropriate documentation.

B. Short Term Family Sick Leave/Bereavement Leave

1. Residents may use up to fifteen (15) days (three (3) weeks) of accumulated sick leave per year for death or illness in the immediate family. Immediate family is defined as spouse, domestic partner, father, mother, children, in-laws, brothers, sisters, or grandparents.

2. Such use is subject to the approval of the program director, but authorization should not be unreasonably denied. Requests that exceed fifteen (15) days must be charged to vacation time for the current training year, and MUST have the prior approval of the program director.

3. Sick leave for bereavement purposes may not be used to attend the funeral of someone other than a family member. RARE exceptions to the definition of family members may be made at the discretion of the program director.

4. Accreditation Board or RRC requirements may necessitate an extension of the training period upon the residents’ return to work in order for the resident to qualify for certification. If a leave will result in an extension of training, program directors must notify the resident in writing, with a copy to the Office of GME, outlining the educational ramifications of the leave (i.e., delay in graduation, repeat of a module, etc…). A revised employment contract reflecting the necessary extension of the training must be executed upon the residents’ return to employment. All contract extensions must be made in the training year in which the leave was taken.

C. Family and Medical Leave
1. **Background**  Effective 8/5/93, the Family and Medical Leave Act (FMLA), enacted by the federal government, requires employers with fifty (50) or more employees to provide up to twelve (12) weeks of job-protected leave to "eligible" employees for certain family and medical reasons (i.e., birth/adoption and care for a child; physical / psychological care of spouse/child/parent). Spouses who are both eligible and work for the same employer may take a combined twelve (12) week leave if the leave is taken for the birth, adoption, or placement of a foster child, or to care for a seriously ill child or parent. Employees are eligible if they have worked for the current employer at least one year (prior to the leave) consisting of at least 1250 hours actually worked. Employers must return employees to their former or an equivalent position and cover health insurance costs in full for the length of any lawful leave although the employee is not entitled to accrue benefits during the leave. It is the resident’s responsibility to pay for their monthly health insurance premium if they have not returned to work after the twelve (12) weeks.

2. Effective January 28, 2008, a spouse, son daughter, parent or next of kin can take up to twenty six (26) weeks of leave to care for a member of the Armed Forces, including a member of the National Guard or 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. Substitution of paid leave and notice requirements for standard FMLA leave apply.

3. A resident is entitled to take FMLA leave for any qualifying exigency (as the Secretary of Labor shall determine by regulation) arising out of the fact that the spouse, or a son, daughter, or parent of the resident is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation.

4. A copy of the FMLA is available in the Office of GME. If a resident has any questions concerning this policy, contact the Office of GME at 829-2012.

5. **Policy**  All residents who meet eligibility requirements, and who provide the required notice of a qualifying condition shall have access to up to twelve (12) weeks of continuous leave, a reduced schedule leave, or an intermittent leave per academic year with continuation of health benefits not to exceed twelve (12) weeks.

6. Residents who seek FMLA should submit a letter to their program director requesting leave and describing the reason for leave with a copy to the Office of GME. Appendix A ("Resident Request for Family or Medical Leave") may be used in lieu of a letter of request. Letters must be submitted at least thirty (30) days in advance for foreseeable leave requests (i.e. extended maternity leave, scheduled surgeries, etc...). Leave requests related to an employee’s health or the need to care for a relative requires the employee to demonstrate a serious health condition. In the case of leave related to an employee’s health or for the
care of a relative, the letter of request must be accompanied by a “Certification of Health Care Provider for Employee’s Serious Health Condition” or by a “Certification of Health Care Provider for Family Member’s Serious Health Condition” Form ) or copy of adoption or foster care papers as relevant to the requested leave. FMLA Certification forms can be found here and as attached:

7. The Office of GME may designate a resident’s leave as a family and medical leave if the resident meets the qualifications regardless of whether the resident has requested such leave.

8. The Office of GME will notify the program director and resident in writing of the residents’ eligibility for FMLA. Accommodations will be made, if possible, for temporary increases in program size resulting from approved leaves of absence.

9. Residents who utilize FMLA benefits must satisfy all training guidelines prior to graduation. Accreditation Board or RRC requirements may necessitate an extension of the training period in order for the resident to qualify for certification. If a leave will result in an extension of training, program directors must notify the resident in writing, with a copy to the Office of GME, outlining the educational ramifications of the leave (i.e., delay in graduation, repeat of a module, etc...). A revised employment contract reflecting the necessary extension of the training must be executed upon the residents’ return to employment. All contract extensions must be made in the training year in which the leave was taken.

10. In the case of resident medical leave, the resident must use accrued and unused sick time and/or converted vacation time in order to receive the normal salary amount. In the case of resident non-medical leave, unused vacation allotment for the current PGY may be used concurrently with FMLA with the mutual consent of the resident and program director.

D. Unpaid Leave of Absence

1. Program directors may, at their discretion, approve a resident’s request for leave without pay. All leave of absence requests must be communicated in advance and in writing to the program director with a copy to the Office of GME.

2. Program directors must consider the applicable Accreditation Board and RRC requirements in determining whether such leave may be granted. These requirements may necessitate an extension of the training period in order for the
resident to qualify for certification. If a leave will result in an extension of training, program directors must notify the resident in writing, with a copy to the Office of GME, outlining the educational ramifications of the leave (i.e., delay in graduation, repeat of a module, etc.). A revised employment contract reflecting the necessary extension of the training must be executed upon the residents’ return to employment for the year of training in which the leave was taken.

3. Leave without pay will result in termination of resident benefits according to standard practice for termination of benefits. Residents have the option to continue health benefits under the appropriate COBRA rules, and solely at the residents’ expense. Notice of COBRA eligibility and cost will be sent to the resident by the Office of GME upon receipt of the notice that a leave has been approved by the program director.

E. Paternity Leave

1. Residents may use their accrued and unused sick time for paternity leave. Such leave may not exceed two (2) weeks and must be requested in advance whenever possible. Use is subject to the approval of the program director, but requests should not be unreasonably denied.

2. Accreditation Board or RRC requirements may necessitate an extension of the training period in order for the resident to qualify for certification. If a leave will result in an extension of training, program directors must notify the resident in writing, with a copy to the Office of GME, outlining the educational ramifications of the leave (i.e., delay in graduation, repeat of a module, etc.). A revised employment contract reflecting the necessary extension of the current training year must be executed upon the residents’ return to employment.

IV. Employee Benefits

A. Health (Medical & Dental) Insurance

1. All residents employed by UMRS or UDRS are provided with health insurance at no cost to the resident for single or family coverage. Coverage for health insurance is effective on the first day of employment.

a) The Medical Insurance Plan is administered by BlueCross BlueShield of Western New York and includes prescription coverage and vision discounts. The plan has no in-network pre-existing condition clause.

   (1) Residents who are covered under a health insurance plan other than one provided through UMRS or UDRS, may be eligible for a health insurance buy-out option. Residents will be required to request enrollment and provide a certificate of

Employee Benefit & Leave Policy
Established 2004
GMEC Approved Date: January 17, 2017
coverage from their medical plan provider annually to the Office of GME.

(2) A resident who is married to another resident and are both employed by UMRS/UDRS must enroll in the UMRS/UDRS family medical insurance plan under one resident. Residents who are covered under the UMRS/UDRS medical insurance through a spouse are not eligible for the medical insurance buy-out.

b) The Dental Insurance Plan is also administered by BlueCross BlueShield of Western New York. The plan provides both in-network and out-of-network benefits.

2. New residents enroll in the health insurance plans during regularly scheduled new resident orientations. Health insurance contracts are in effect from July 1 through June 30 of each year. Open enrollment is held in June of each year for coverage to start on July 1. Residents may make changes to their health insurance coverage only during the annual Open Enrollment period, except in the case of a qualifying life event such as marriage, divorce, birth or adoption of a child, or gain / loss of employment.

3. Residents must notify the Office of GME of any qualifying life event (i.e., marriage, birth, gain or loss of spouse insurance coverage) through the Bswift website in accordance with the notification requirements of the Plan in order to make appropriate changes to health insurance coverage. Failure to do so will result in a delay in coverage until the following Open Enrollment period (June of each year for coverage effective July 1).

4. If the resident terminates employment between the first (1st) and fifteenth (15th) of the month, health insurance coverage ends on the fifteenth (15th) of the month in which employment ends. If the resident terminates employment between the sixteenth (16th) and last day of the month, health insurance ends on the last day of the month in which employment ends.

5. Residents and their dependents are permitted to continue health insurance coverage, typically for up to eighteen (18) months following loss of eligibility under the group plan, at their own expense, through COBRA Continuation Coverage. Plans are available for both out-of-area and local (WNY) coverage. The Office of GME sends notice of the resident and/or dependent’s COBRA rights and conditions for purchase of this coverage upon notice of the loss of eligibility under the group plan.

B. Long-Term Disability Insurance

1. All residents employed by UMRS or UDRS are covered under a group long-term disability insurance plan. This coverage is provided at no cost to the
resident. Residents should refer to the plan contract for specific coverage and eligibility information.

2. This plan offers excellent conversion options provided qualifying conditions are met during residency. Residents should contact Mike Bruno at MJF Financial Services, Inc. to explore these options prior to graduation at (716) 632-4758.

C. Retirement

UMRS and UDRS offer residents the opportunity to establish an IRA or Roth IRA Retirement Plan with an outside financial vendor through the convenience of payroll deduction.

D. Life Insurance

$50,000 of term life insurance is provided at no cost to residents employed by UMRS or UDRS. Residents should refer to the plan contract for specific coverage information.

E. Supplemental Life Insurance

Residents employed by UMRS or UDRS have the opportunity to purchase supplemental life insurance in amounts of $50,000, $100,000, $200,000, or $300,000. Residents may also purchase supplemental life insurance for their spouse who is not employed by UMRS or UDRS in amounts of $25,000, $50,000, $100,000, or $150,000 not to exceed 50% of the coverage purchased for themselves. Evidence of insurability is required for coverage at the $300,000 level (resident) and $150,000 level (spouse). Coverage for dependent children is also available. Residents can enroll in (or increase) this coverage during the annual Open Enrollment period or as a result of experiencing a qualifying life event provided the event has been reported in accordance with the notification requirements of the plan. Residents who wish to elect or increase this coverage at any other time will be required to submit full medical information to the life insurance carrier at their own expense.

F. Flexible Spending Accounts

Residents employed by UMRS or UDRS have the opportunity to contribute to a health care and/or dependent care flexible spending account (FSA) on a pre-tax basis. Contributed funds can be used to offset the cost of eligible out-of-pocket health care and dependent care expenses as determined by the IRS. The minimum annual contribution for a health care FSA is $300 and the maximum annual contribution is $2,000. The maximum annual contribution for a dependent care FSA is $5,000. There is no minimum annual dependent care FSA contribution.

Annual contributions are based on the plan year of July 1 through June 30. Residents can enroll in a FSA during the annual Open Enrollment period. Residents may also enroll in a FSA or make changes to an existing FSA election as a result of experiencing a qualifying life event, provided the election or change is consistent
with the event and the event has been reported in accordance with the notification requirements of the Plan. Enrollments or election changes made at any time during the plan year other than the annual Open Enrollment period are subject to pro-rated (monthly) contribution limits in order to meet plan and IRS requirements.

G. Prescription Stamps
   1. Residents in programs that require the use of a prescription stamp will receive one (1) prescription stamp at no cost through the Office of GME. Residents in these programs will be given their prescription stamp during their orientation or as soon thereafter as practical.
   2. Replacement prescription stamps can be ordered through the Office of GME at a cost of $40.00 each. Checks should be made payable to UB Foundation and payment must be made in advance.

H. Lab Coats
   1. All new residents will receive two (2) white lab coats with University insignia free of charge at the start of their residency. Replacement and laundering of the coats are at the owner's expense. Lab coats will be distributed during resident orientations, or as soon thereafter as practical.
   2. Residents may purchase additional lab coats at a cost of $25.00 each at any time during the year from the Office of GME. Checks should be made payable to UB Foundation and payment must be made in advance.

I. University Privileges
   Upon receipt of all necessary paperwork, by the Office of GME, each resident will receive the faculty title of Clinical Assistant Instructor. Appointment as a Clinical Assistant Instructor at the State University of New York, University at Buffalo Jacobs School of Medicine and Biomedical Sciences or School of Dental Medicine permits resident use of all campus facilities, such as libraries, gymnasium and parking according to University faculty guidelines. Residents may also attend University at Buffalo events at the faculty rate. After all employment requirements have been met, the resident can obtain a faculty ID card.

J. Certificates of Completion
   At the end of each resident's training, the program director will recommend the resident for a University Certificate of Residency Completion. Duplicate certificates will be provided to the resident at a cost of $15.00 each upon request from the relevant program coordinator. Checks should be made payable to UB Foundation and payment must be made in advance.
Appendix A

Resident Request for Family or Medical Leave
(Family and Medical Leave Act of 1993)

Employees should refer to the Employee Benefits & Leave Policy or contact the Office of Graduate Medical Education (GME) for information on eligibility for leave under the FMLA. The request for leave should be in writing to the Program Director with a copy to the Office of GME. This form may be used as the written request for leave.

Resident Name: __________________________________________

Program: _________________________________________________

Reason for Leave: _________________________________________

Date Last Worked: _________________________________________

Anticipated Length of Leave: _______________________________

Explanation:

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Program Director Approval: ______________________________________

GME Approval: _____________________________________________

All FMLA leaves must commence on the first day following the last day worked as a resident.
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 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(e)(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:

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 name:

First ___________________________ Middle ___________________________ Last ___________________________

SECTION 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: (_________) ___________________________
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):

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Page 2  CONTINUED ON NEXT PAGE  Form WH-380-E Revised May 2015
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:

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Page 3

CONTINUED ON NEXT PAGE

Form WH-380-E Revised May 2015
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.
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 to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. 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’ family members, 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: ________________________________

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your family member or his/her 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 to care for a covered family member with a 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 to your employer. 29 C.F.R. § 825.305.

Your name: 

First       Middle       Last

Name of family member for whom you will provide care: ________________________________

Relationship of family member to you: ________________________________

       First       Middle       Last

       If family member is your son or daughter, date of birth: ________________________________

Describe care you will provide to your family member and estimate leave needed to provide care:

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

Employee Signature ________________________________ Date ________________________________

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CONTINUED ON NEXT PAGE

Form WH-380-F Revised May 2015
SECTION III: For Completion by the HEALTH CARE PROVIDER
INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. 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 patient needs leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e). Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider’s name and business address:

Type of practice / Medical specialty:

Telephone: (_______) Fax: (_______)

PART A: MEDICAL FACTS
1. Approximate date condition commenced: __________________________________________

Probable duration of condition: __________________________________________

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: __________________________________________

Was medication, other than over-the-counter medication, prescribed? ___ No ___ Yes.

Will the patient need to have treatment visits at least twice per year due to the condition? ___ 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. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________
PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient’s need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care.

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ___ No ___ Yes.
   Estimate the beginning and ending dates for the period of incapacity: __________________________
   During this time, will the patient need care? ___ No ___ Yes.
   Explain the care needed by the patient and why such care is medically necessary:
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

5. Will the patient require follow-up treatments, including any time for recovery? ___ 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:
   ____________________________________________________________
   Explain the care needed by the patient, and why such care is medically necessary: __________________________
   ____________________________________________________________
   ____________________________________________________________

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? ___ No ___ Yes.
   Estimate the hours the patient needs care on an intermittent basis, if any:
   ________ hour(s) per day; _________ days per week from __________________ through __________________
   Explain the care needed by the patient, and why such care is medically necessary:
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities?  ____No  ____Yes.

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

Does the patient need care during these flare-ups?  ____No  ____Yes.

Explain the care needed by the patient, and why such care is medically necessary: ____________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER:

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

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.