employee relations BULLETIN

October 29, 2002
(Replacing Bulletin dated November 1, 1993)

To: **Heads of All Departments**
Departmental Personnel Directors

Subject: **UPDATED FAMILY AND MEDICAL LEAVE PROVISIONS**

During recent negotiations with civilian employee organizations over successor Memoranda of Understanding (MOU), the Family and Medical Leave article was updated to ensure compliance with applicable State and Federal statutes, as well as to clarify certain provisions. Los Angeles Administrative Code (LAAC) Section 4.129, which pertains to Family and Medical Leave for non-represented employees, will be similarly amended. The Police and Fire MOUs have not yet been updated, as their MOU terms are on a different cycle. Revised MOU language will be submitted to those employee organizations during the next round of contract negotiations. The key language changes to the Family and Medical Leave provisions contained in both the civilian MOUs and the proposed amendment to LAAC Section 4.129 are described below, including any significant differences among bargaining units.

Management's Right to Designate Family or Medical Leave

Language has been added to the Family and Medical Leave article in the MOUs ("Notice Requirements" section) and will be added to LAAC Section 4.129 to reflect that, in accordance with the Family and Medical Leave Act (FMLA), Management has the obligation and right to designate Family or Medical Leave regardless of an employee requesting such leave. Management's role in designating Family or Medical Leave is as follows:

Once Management has sufficient information from an employee, or an employee's spokesperson, to know that the employee's leave is FMLA qualifying (see "Conditions" section under the Family and Medical Leave article), it shall count such leave (paid or unpaid) against an employee's annual Family/Medical Leave entitlement. Consistent with the City's sick leave policy, if an employee is off sick for more than three consecutive days, the employee's leave should be designated as Family/Medical Leave. Typically, colds and flus are not considered as serious health conditions under FMLA, and thus would not be designated as Family/Medical Leave. However, if a cold or flu develops into a more serious condition, then at that time such leave should be counted

against an employee's annual Family/Medical Leave entitlement. Please note that the designation of Family/Medical Leave cannot be made retroactively if Management had knowledge that the leave was FMLA qualifying but failed to act on it. (See also "Accrued Compensatory Time Off" below.)

In accordance with the U.S. Department of Labor (DOL) regulations, regardless of whether or not the employee initiates a request for Family/Medical Leave, Management's notice to the employee that his/her leave has been designated as Family/Medical Leave may be given orally or in writing, but shall be within two business days absent extenuating circumstances. If the notice is oral, it shall be confirmed in writing no later than the following payday (unless the payday is less than one week after the oral notice, in which case the notice must be no later than the subsequent payday).

When an employee requests Family/Medical Leave, he/she must give Management 30 days' notice when the leave is foreseeable. When not foreseeable, the employee must provide advance notice as soon as practicable. The U.S. DOL regulations governing FMLA interpret "as soon as practicable" to mean no more than within one to two business days of learning of the need to take leave, except in extraordinary circumstances. Management may require that an employee's request for Family/Medical Leave be supported by medical certification (of the employee's own serious health condition or of a family member's).

Exception: For AFSCME bargaining units only, a Letter of Intent has been entered into that allows AFSCME members to request that Family/Medical Leave begin after the exhaustion of compensated time for the purpose of extending the City health insurance subsidy, when it is for the employee's own catastrophic illness or injury. This Letter of Intent expires June 30, 2004 (end of term for current AFSCME MOUs), or when the Joint Labor-Management Benefits Committee provides an alternative method to continue the health insurance subsidy for employees with catastrophic illnesses or injuries, whichever occurs sooner.

Use of Accrued Compensatory Time Off

Language has been added to the MOUs, and will be added to LAAC 4.129, to clarify that for all types of leave (childbirth, family leave, serious health condition of employee or family member), employees may use their accrued compensatory time off after exhaustion of 100% sick leave. However, pursuant to U.S. DOL regulations governing FMLA such use of compensatory time off shall not be counted against an employee's annual four-month (nine pay period) Family/Medical Leave entitlement. Therefore, any use of compensatory time off for this purpose shall extend an employee's Family/Medical Leave by the total amount of compensatory time off used.

Clarification of Pregnancy/Child Birth Leave

There are three pieces of legislation governing leave for the birth or adoption of a child: (1) the California Fair Employment and Housing Act (FEHA) - Pregnancy Disability Leave provisions, (2) the California Family Rights Act, and (3) the Family and Medical Leave Act (Federal). As described below, the City of Los Angeles uses a combination of

all three Acts to provide up to nine pay periods of pregnancy-related disability leave and up to nine pay periods of family leave, commonly referred to as "bonding" leave.

In accordance with Pregnancy Disability Leave under the FEHA, pregnant employees are eligible on the first day of employment with the City for six weeks (three pay periods) of leave if not disabled due to pregnancy and up to four months (nine pay periods) of leave if disabled due to pregnancy, inclusive of the six-week, non-disability leave. This is an exception to the eligibility requirements for Family and Medical Leave, which requires employees to be employed by the City for at least 12 months and to have **worked** (as opposed to "compensated" for) 1,040 hours during the 12 months immediately preceding the beginning of the leave.[1] LAAC Section 4.129 will be amended, and most of the civilian MOUs have been amended, to include this provision (under "Eligibility"). Even if this language has not yet been incorporated into an MOU, however, it is still applicable to all employees because it is State law.

Language will be included in LAAC Section 4.129, and has been included in most of the MOUs, to clarify how much and what type of leave is provided for the two types of childbirth leave: the disability portion for the pregnant employee and the "bonding" portion for either parent (including leave for adoption and foster care placement).

> **Disability Portion** – For the pregnant employee, up to four months (nine pay periods) of leave shall be provided for the entire period of disability that a health care provider certifies is necessary (this can be before or after birth). This type of leave is provided in accordance with the Pregnancy Disability Leave provisions of the State FEHA and pregnancy leave under the federal FMLA, which run concurrently. Leave must be concluded within one year of the child's birth. Accrued sick leave (100% and 75%), vacation, unpaid leave, or accrued compensatory time off may be taken for this leave at the employee's discretion.
>
> **Bonding -** For either parent, family leave up to four months (nine pay periods) shall be provided in accordance with the California Family Rights Act. This includes family leave for adoption or foster care placement. Leave must be concluded within one year of the child's birth, adoption, or placement. Parents who both work for the City are only entitled to use an aggregate period of leave that is equal to the amount of leave that is allowed for one employee. Employees must use their vacation time for this leave prior to using sick time (100% and 75%), unpaid leave, or accrued compensatory time off.

Miscellaneous

Definition of 12-Month Period – Leave under the City's Family/Medical Leave provisions is limited to nine pay periods for all incidents (up to 18 pay periods for pregnancy disability and bonding) during a 12-month period.[2] A 12-month period begins on the first day of leave for each individual taking such leave. The succeeding 12-month

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[1] *Please note that the eligibility requirement in the FMLA is 1,250 hours **worked**, but the City has negotiated 1,040 hours **worked**.*

[2] *Previous MOU and LAAC language stated leave in terms of months only and not pay periods. Leave is now expressed both ways (i.e., four months [nine pay periods]). Please note also that the FMLA provides for up to 12 weeks of leave, but the City has negotiated a longer period of leave.*

period begins the first day of leave taken after completion of the previous 12-month period.

Posting Requirements - Attached to this Bulletin are two posters that are required to be posted for Family and Medical Leave: (1) Your Rights Under the Family and Medical Leave Act of 1993, and (2) Your Rights Under the California Family Rights Act. Any future revisions will be distributed by the Personnel Department. Posters can also be obtained through the following websites:

www.dol.gov/esa/regs/compliance/posters/fmla.htm (FMLA)
www.dfeh.ca.gov/posters/Posters.asp (CFRA)

Workers' Compensation – As a reminder, the FMLA provides that when an employee is on temporary disability (Workers' Compensation or State Rate), he/she is automatically considered to be on Family/Medical Leave concurrently. There is existing language in the MOUs and LAAC Section 4.129 to this effect. **Exception:** some AFSCME MOUs deliberately do not include this language as a result of negotiations, and as a consequence, members belonging to those bargaining units are not subject to this requirement.

New Citywide Family and Medical Leave Forms – The following three forms (copies attached), which are accessible on the City's intranet, have been developed for use in administering Family or Medical Leave:

- Employee Request for Family or Medical Leave (Form Gen. 191)
- Employer Response to Employee Request for Family or Medical Leave, and Employer Designation of Family or Medical Leave (Form Gen. 192)
- Certification of Health Care Provider (Form Gen. 193)

An employee does not have to use the "Certification of Health Care Provider" form if he/she has provided adequate proof of medical certification using a different form from a health care provider. If medical certification has not been received, or re-certification is being requested by Management, then the new City Form Gen. 193 should be provided to the employee as an attachment to the form "Employer Response to Employee Request for Family or Medical Leave" (Form Gen. 192).

The "Employee Request for Family or Medical Leave" form (Form Gen. 191) should be made available to employees who are requesting such leave. The "Employer Response to Employee Request for Family or Medical Leave" form (Form Gen. 192) should be used by Management to respond to an employee's request for such leave and/or to notify an employee that his/her time off will be counted against his/her annual Family/Medical Leave entitlement.

Any questions regarding this bulletin or attached forms may be directed to the Family/Medical Leave Coordinator in the Office of the City Administrative Officer, Employee Relations Division, at (213) 485-5253.

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Attachments

Employee Request for Family or Medical Leave

(Family and Medical Leave Act of 1993)

CITY OF LOS ANGELES

Form Gen. 191 (09/02)

To be submitted to the Personnel Director of the Employee's Department/Bureau

PLEASE PRINT OR TYPE:

Employee's Name	SSN/Employee I.D.
Classification	**Division/Bureau**
Work Phone	**Home Phone**

REQUEST FOR FAMILY OR MEDICAL LEAVE

I am requesting Family or Medical Leave for the following reason:

- ☐ The birth of a child, adoption, or foster care of a child; or
- ☐ My own serious health condition (non-work related); or
- ☐ A serious health condition affecting an immediate member of my family: ☐ spouse/domestic partner, ☐ child, ☐ parent, or ☐ other immediate family member _____ *(relationship);* or
- ☐ On Injury on Duty (IOD)/Workers' Compensation status.

1. Anticipated duration of leave: _____ *(days)* _____ *(months)*

   Start date of leave (mm/dd/yyyy): _____ End date of leave (mm/dd/yyyy): _____

2. Check if requesting: ☐ Intermittent Leave or ☐ Leave on Reduced Schedule

   Explain request for this type of leave here:

3. Medical Certification of a Health Provider is attached: ☐ Yes ☐ No

   I understand that I may be required to furnish Medical Certification before my leave is approved, and/or that additional certification may be necessary.

4. I ☐ do ☐ do not have a spouse/domestic partner, or other parent of my child, also employed by the City of Los Angeles who will be taking a Family/Medical Leave for the same incident/reason.

If applicable, spouse/domestic partner's name, or other parent's name:

Name	Department/Bureau employed

Anticipated duration of leave: _____ *(days)* _____ *(months)*

Start date of leave (mm/dd/yyyy): _____ End date of leave (mm/dd/yyyy): _____

5. For my Family or Medical Leave, I will be using the following paid and/or unpaid leave:

(Indicate 100% sick leave, 75% sick leave, vacation, compensatory time off*, or unpaid leave, and place in order of usage. For pregnancy-related leave, use both columns, if necessary, to indicate time used for pregnancy disability {1st column} and time used for family leave/"bonding" {2nd column}.)

a.		a.	
b.		b.	
c.		c.	
d.		d.	

* *Accrued compensatory time off cannot be counted against an employee's annual FMLA entitlement.*

Note: Please refer to your MOU provision on Family and Medical Leave (for represented employees) or to Los Angeles Administrative Code Section 4.129 (for non-represented employees) for guidance regarding type and order of time off to be used. Your most recent paycheck stub shows available time off balances. If needed, verify balances with a department/bureau representative.

Regarding the continuation of Flex-Benefits (health, dental, life insurance, and disability) during Family or Medical Leave, I understand the following:

- The City will pay Flex-Benefit subsidies up to nine (9) pay periods and I will be responsible for any related payroll deductions.
- If on unpaid leave, I will be billed for any outstanding payroll deductions.
- If on unpaid leave beyond the maximum Family or Medical Leave period, I will be sent a billing letter by the Employee Benefits Division of the Personnel Department requesting payment of monthly premiums for an additional two months. Thereafter, continuation of benefits through COBRA will be offered at full monthly premiums.
- If and when a billing letter is sent, I will have 30 days from the date of the letter to make payment, and if payment is not received, my benefits will be cancelled.

Employee Signature	Date (mm/dd/yyyy)

Supervisor's Signature	Date (mm/dd/yyyy)

Division Head Signature	Date (mm/dd/yyyy)

Employer Response to Employee Request for Family or Medical Leave, and Employer Designation of Family or Medical Leave
(Family and Medical Leave Act of 1993)

CITY OF LOS ANGELES
Form Gen. 192 (09/02)

Date: _____

To: _____ _____ _____
Employee's Name *SSN/Employee I.D.* *Division/Bureau:*

From: _____
Departmental Personnel Director

Subject: **Employer Response to Employee Request for Family or Medical Leave, and Employer Designation of Family or Medical Leave**

On _____, you notified us of your need to take Family/Medical Leave, **OR** Management has received
Date (mm/dd/yyyy)
sufficient information that your leave qualifies as Family/Medical Leave, due to the following reason:

- ☐ The birth of a child, or the placement of a child with you for adoption or foster care; or
- ☐ A serious health condition that makes you unable to perform the essential functions for your job; or
- ☐ A serious health condition affecting your ☐ spouse/domestic partner, ☐ child, ☐ parent, or ☐ other immediate family member for which you are needed to provide care.
- ☐ Injury on Duty/Workers' Compensation status.

We received information that you need this leave beginning on _____ and that the leave is expected
Date (mm/dd/yyyy)
to continue until _____
Date (mm/dd/yyyy)

For the following, refer to the appropriate MOU (represented employees) or to LAAC Section 4.129 (non-represented employees).

This is to inform you that: *(Check appropriate boxes; explain where indicated)*

1. You are ☐ eligible ☐ not eligible for Family/Medical Leave under the Family Medical Leave Act of 1993 (FMLA), the California Family Rights Act, and/or the Pregnancy Disability Leave provisions of the California Fair Employment and Housing Act.

2. The requested or designated leave ☐ will ☐ will not be counted against your annual Family/Medical Leave entitlement.

3. a. ☐ We have received satisfactory medical certification of a serious health condition affecting you or a member of your immediate family.

   b. ☐ You will be required to furnish medical certification of a serious health condition by _____
   Date (mm/dd/yyyy)
   (must be at least 15 days after you are notified of this requirement), or we may delay the start date of your leave until the certification is submitted, which may result in your time being recorded as unauthorized leave (AW).

   c. ☐ You will not be required to furnish medical certification at this time.

4. a. Family/Medical Leave for personal illness/injury (including IOD), family illness, or pregnancy disability leave:

Time off (100% sick leave, 75% sick leave [1] , vacation, compensatory time off [2] , unpaid leave, or IOD) for your FMLA leave (including Pregnancy Disability Leave under the Fair Employment and Housing Act) will be charged as follows: (fill in type of time off and place in order to be used)

(1) _____

(2) _____

(3) _____

(4) _____

(5) _____

b. Family leave for non-disability childbirth ("bonding"), adoption, or foster care placement:

Time off (100% sick leave, 75% sick leave [1] , vacation, compensatory time off [2] , unpaid leave) for your FMLA leave (including leave pursuant to the California Family Rights Act or non-disability Pregnancy Leave under the Fair Employment and Housing Act) will be charged as follows: (fill in type of time off and place in order to be used)

(1) _____

(2) _____

(3) _____

(4) _____

(5) _____

[1] *You may qualify for Catastrophic Illness Leave or disability benefits upon the exhaustion of sick leave. Please contact the City's Catastrophic Illness Leave Donation Program Coordinator at (213) 978-1617 or the City's Disability Coordinator at (213) 978-1584 or the Employee Benefits Office at (213) 978-1655.*

[2] *Accrued compensatory time off cannot be counted against an employee's annual FMLA entitlement.*

Note: To add a new dependent to your medical coverage, you must call within 30 days the Flex-Benefits by Request Line at (800) 778-2133.

5. a. If your leave is approved as Family/Medical Leave, you may be eligible to have the City continue to pay (up to nine {9} pay periods) the subsidies for your Flex-Benefits (health and/or dental, basic life, and basic disability plan). The employee will be responsible for any related payroll deductions. If you are on unpaid leave, you will be billed for any outstanding payroll deductions. If an employee is on unpaid leave beyond the maximum Family/Medical Leave period, the Employee Benefits Office, Personnel Department, will be sending you a billing letter requesting payment of monthly premiums for an additional two months. Thereafter, you will be offered continuation of benefits through COBRA at full monthly premiums.

b. When a billing letter is sent to the employee, the employee will have 30 days from the date of the letter to make payment. If payment is not received, your benefits will be cancelled.

6. You ☐ will ☐ will not be required to present a Return to Duty certificate (Occupational Health Services Division, Personnel Department) prior to being restored to employment. If such certification is required but not received, your return to work may be delayed until certification is provided.

7. a. You ☐ are ☐ are not a "key employee" as described in Sec. 825.217 of the FMLA regulations.

If you are a "key employee," restoration to employment may be denied following Family/Medical Leave on the grounds that such restoration will cause substantial and grievous economic injury to us as discussed in Sec. 825.218.

b. We ☐ have ☐ have not determined that restoring you to employment at the conclusion of Family/Medical Leave will cause substantial and grievous economic harm to us.

(Explain [a] and/or [b] here. See Sec. 825.219 of the FMLA regulations)

8. While on leave, you ☐ will ☐ will not be required to furnish us with periodic reports every _____ *(indicate interval of periodic reports, as appropriate for the particular leave situation)* of your status and intent to return to work *(see Sec. 825.309 of the FMLA regulations).* If the circumstances of your leave change and you are able to return to work earlier than the date indicated on page 1 of this form, you ☐ will ☐ will not be required to notify us at least two work days prior to the date you intend to report to work.

9. You ☐ will ☐ will not be required to furnish re-certification relating to a serious health condition.

(Explain here, if necessary, including the interval between certifications as prescribed in Sec. 825.308 of the FMLA regulations)

If you have any questions regarding this form, please contact _____ at _____
of my staff. *Name* *Phone No.*

_____ _____
Department Representative Signature *Date (mm/dd/yyyy)*

Certification of Health Care Provider

(Family and Medical Leave Act of 1993)

CITY OF LOS ANGELES

Form Gen. 193 (09/02)

When completed, please provide this form directly to the employee, not to the City of Los Angeles

1.a. Employee's Name

b. SSN/Employee I.D.

2. Patient's Name (if different from Employee)

3. Page 4 describes what is meant by a "serious health condition" under the Family and Medical Leave Act. Does the patient's condition (* see below) qualify under any of the categories described? If so, please check the applicable category.

(1) ☐ (2) ☐ (3) ☐ (4) ☐ (5) ☐ (6) ☐ or None of the above ☐

4.a State the approximate date the condition commenced, and the probable duration of the condition (and also the probable duration of the patient's present incapacity {** see below} if different):

b. Will it be necessary for the employee to work only intermittently or to work on a less than full schedule as a result of the condition (including for treatment described in Item 5 below)?

Yes ☐ No ☐

If yes, give the probable schedule of time off required and duration:

c. If the condition is a chronic condition (Condition #4) or pregnancy, state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity (** see below):

* Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking FMLA leave.

** "Incapacity," for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom.

5. a. If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments.

b. If the patient will be absent from work or other daily activities because of treatment on an intermittent or part-time basis, also provide an estimate of the probable number of and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any:

c. If any of these treatments will be provided by another provider of health services (e.g., physical therapist), please state the nature of the treatments:

d. If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment):

6. a. If medical leave is required for the employee's absence from work because of the employee's own condition (including absences due to pregnancy or a chronic condition), is the employee unable to perform work of any kind?

b. If able to perform some work, is the employee unable to perform any one or more of the essential functions of the employee's job (the employee or the employer should supply you with information about the essential job functions)? If yes, please list the essential functions the employee is unable to perform:

c. If neither a nor b applies, is it necessary for the employee to be absent from work for treatment?

Yes ☐ No ☐

7. a. If leave is required to care for a family member of the employee with a serious health condition, does the patient require assistance for basic medical or personal needs or safety, or for transportation?

b. If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery?

c. If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need:

Signature of Health Care Provider

Type of Practice

Address Number

Street

Phone Number

Extension

City

State

Zip Code

Date (mm/dd/yyyy)

To be completed by the employee needing family leave to care for a family member:

State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule:

Employee Signature

Date (mm/dd/yyyy)

A " Serious Health Condition" means an illness, injury, impairment, or physical or mental condition that involves one of the following:

1. Hospital Care

   Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity {** see page 1} or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

   A period of incapacity (** see page 1) of more than three consecutive calendar days (including any subsequent treatment or period of incapacity {** see page 1} relating to the same condition), that also involves:

   (a) Treatment (*** see below) two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or

   (b) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment (**** see below) under the supervision of the health care provider

3. Pregnancy

   Any period of incapacity due to pregnancy, or for prenatal care.

4. Chronic Conditions Requiring Treatments

   A chronic condition which:

   (a) Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;

   (b) Continues over an extended period of time (including recurring episodes of a single underlying condition); and

   (c) May cause episodic rather than a continuing period of incapacity (** see page 1) (e.g., asthma, diabetes, epilepsy, etc.).

5. Permanent/Long-Term Conditions Requiring Supervision

   A period of incapacity (** see page 1) which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

6. Multiple Treatments (Non-Chronic Conditions)

   Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity (** see page 1) of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), and kidney disease (dialysis).

*** Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

**** A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.