Family and Medical Leave Act

Leave for Employee's Own Serious Health Condition
or
Leave for Birth, Adoption, or Foster Care Placement of a Child

Acknowledgement of Receipt of Family and Medical Leave Act (FMLA) Employee Information Packet

By my signature below, I acknowledge receipt of the FMLA Employee Information Packet on the Family and Medical Leave Act (FMLA).

SIGNATURE

DATE

PRINT NAME

Signed form should be placed in the Employee's Personnel File

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What is FMLA Leave?

FMLA stands for the Family and Medical Leave Act. This act (or law) allows eligible employees an unpaid leave of absence from their job for specified medical or family purposes for up to 12 weeks within a rolling twelve-month period (beginning from the first day of the leave). The FMLA also allows for Military Family Leave for certain qualifying reasons (see below).

Please complete and submit this packet even if you believe you are not eligible for FMLA leave, but will be unable to work due to a reason listed below. The Benefits Department will use the information provided in this paperwork to determine if you are eligible for any other type of leave.

Am I eligible?

To be eligible for leave, you must have a total of 12 months of service with KinderCare Education (KCE) (within the past 7 years). You must have worked 1,250 hours over the 12 months prior to your leave. Eligibility will be determined by the Benefits Department after review of service and hours worked at all KinderCare Education companies. KCE must employ at least 50 employees within 75 miles of your work location.

What types of family or medical matters qualify under the FMLA?

- Incapacity due to pregnancy, prenatal medical care or child birth
- Care for your child after birth, adoption, foster care placement
- Care for a family member (parent, spouse, or child under 18) with a serious health condition
- Your own serious health condition that makes you unable to perform your job

What rights or benefits do I receive under this type of leave?

- You will be reinstated to your pre-leave position or an equivalent position provided that you return to work on your Family Medical Leave return date, that you are medically authorized to resume the duties of your pre-leave position or an equivalent position, and that your return date is not beyond the 12 (or 26) weeks authorized by law.
- KCE will continue to cover you and your dependents under your group health benefits while you are on Family Medical Leave provided you mail timely payments (within 30 days of due date) of the employee portion of the insurance premiums to the Benefits Department. Your failure to make timely payments (within 30 days of due date) may result in the loss of insurance coverage. Please see the Employee Notice of Responsibilities for Group Health Benefits, enclosed, for more information.
- Your eligibility for employment benefits will not change while you are on Family Medical Leave; however, you will not accrue benefits while you are on leave (e.g., vacation and personal leave will not accrue while you are on leave). Taking leave under the FMLA will not result in the loss of any employment benefits that you accrued prior to the start of your leave.

What obligations do I have under the FMLA?

- You will be required to give 30 day notice to the Benefits Department of your intention to take FMLA leave before your leave will be granted. In an emergency situation, when your leave is unforeseeable, you will be required to give notice as soon as practicable.
- You will be required to provide the Benefits Department with a medical certification from your treating physician (or your family member's physician for family leave) to verify the basis of your leave request before you go out on FMLA leave.
- You will be required to provide the Benefits Department with documentation of birth, adoption, or foster placement for FMLA leave for baby-bonding time.
- You must be able to perform the essential functions of your pre-leave position or an equivalent position upon return from your FMLA leave.

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- You will be required to provide the Benefits Department and your supervisor with a return to work medical certification from your health care provider if your leave is for your own serious health condition (including pregnancy-related conditions).
- You may not take or work another job while you are on FMLA leave. If you do, your employment with KCE will be terminated.
- If the circumstances of your leave change and you are able to return to work earlier than your approved return to work date, you must notify your supervisor and the Benefits Department at least two workdays prior to the date you intend to return to work.

What else should I know about leave under the FMLA?

- A serious health condition is defined by the US Department of Labor as an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.
- If you are requesting leave due to adoption or foster care placement, please complete the Family and Medical Leave Request form in this packet and submit it to the Benefits Department along with official documentation showing the date of placement.
- You will be required to use available paid time off for the first five business days of your approved leave. After that you may choose to use as much or as little as you would like (not to exceed 8 hours per day).
- If you are sick for 3 or more consecutive days and under the care of a physician, you must inform your supervisor as soon as possible that you are sick and under the care of a physician. This leave may qualify as FMLA leave.
- If you and your spouse both work for KCE, you are entitled to a total of 12 weeks of parental leave (care for a newborn, adopted or foster child) between the two of you.
- As of January 2013, employees on leave are eligible to use the child care discount.
- With proper medical certification, leave under the FMLA may be taken intermittently or on a reduced schedule when medically necessary for yourself or to care for a qualified family member. Pregnancy-related conditions qualify as a serious health condition. You must make reasonable efforts to schedule leave for planned medical treatment so as not to disrupt the needs of the business. If leave is on an intermittent basis, we may need to transfer you to another position temporarily to better accommodate the leave.
- If your supervisor or the Benefits Department has any reason to doubt the medical certification concerning your serious health condition, you may be required to report to a medical provider of KCE's choice and at KCE's expense for a second opinion.
- For more information, see the KCE Benefits Handbook on www.KUBenefits.com.
- In addition to the FMLA, the state in which you work may have leave laws with different eligibility requirements and/or which allow for longer periods of leave. Contact the Benefits Department at benefit@kc-education.com or 1-888-525-2472, option 3, for more information regarding state specific leave laws.

What qualifies under Military Family Leave?

- **Military Caregiver Leave**: An eligible employee may take up to a total of twenty six (26) workweeks for Military Caregiver Leave during the normal FMLA twelve-month period established by KCE. You may take this leave if you are the spouse, son, daughter, parent, or next of kin of an active member of the Armed Forces, including 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 incurred in the line of duty on active duty or an injury or illness that existed before the beginning of the member's active duty and was aggravated by service in the line of duty on active duty. A serious injury or illness is one that was incurred by a service member in the line of duty on active duty that may render the service member medically unfit to perform the duties of his or her office, grade, rank, or rating. KCE may require certification of the leave completed by an authorized health care provider.

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This leave is also available to the spouse, parents, children, or next of kin of veterans who were members of the Armed Forces (including National Guard or Reserves) who are undergoing treatment for a serious injury or illness incurred in the line of duty on active duty or a prior serious injury or illness aggravated in the line of duty on active duty. The veteran must have been a member of the Armed Forces at any time during the period of 5 years preceding the date on which the veteran undergoes the medical treatment. The injury or illness may manifest itself before or after the member became a veteran.

During a single twelve-month period, an eligible employee shall be entitled to a combined total of twenty six (26) workweeks for Military Caregiver Leave and other leave available under the FMLA. In the event that both a husband and wife are employees of KCE, the aggregate number of workweeks of Military Caregiver Leave available to them is limited to twenty six (26) weeks during a single twelve-month period. This leave may be taken intermittently when medically necessary.

Qualifying Exigency Leave: An eligible employee may take up to a total of 12 workweeks of unpaid leave during the normal FMLA twelve-month period established by KCE for qualifying exigencies arising out of the fact that the employee’s spouse, son, daughter, or parent is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces, National Guard or Reserves in support of a contingency operation. Qualifying exigencies include: short notice deployment; military events and related activities; childcare and school activities; financial or legal arrangements; counseling; rest and recuperation; and post-deployment activities. KCE may require the employee to provide a copy of the covered military member’s active duty orders and certification providing the appropriate facts related to the particular qualifying exigency for which leave is sought.

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Any group health benefits (i.e., medical, dental, vision, life insurance, dependent life insurance, and disability) that you and your family members are enrolled in on the day before your FMLA leave begins will continue while you are on leave. Your benefits are subject to any general changes in coverage or premiums while you are out on leave.

As stated in the FMLA Fact Sheet, and indicated in the Family and Medical Leave policy, you are responsible for the payment of your portion of the insurance premiums while you are on leave.

PAYMENT PROCEDURE:

1. If any part of your leave is paid through the use of paid time off, your paycheck will reflect the normal group health and benefit deductions.
2. If you are receiving pay through the KCE Short Term Disability Plan or a state disability plan, or if your leave is unpaid, premium payments must be made by check payable to:

   KinderCare Education
   Attention: Benefits Department
   P.O. Box 6787
   Portland, OR 97228-6787

   You will owe the amount for each paycheck that you miss during your leave. Payment must be received within thirty (30) days of the missed paycheck date. You can log into the ADP portal (https://portal.adp.com/public/index.htm) to view paycheck dates as well as your premium amounts. You may also view your premium amounts at kcebenefits.com.

   Failure to follow the payment procedure identified above may result in the cancellation of your benefits (to include any enrolled family member) while you are out on leave. Please note: should you wish to cancel your benefits, please see the information regarding voluntarily cancelling your benefits provided below.
3. If you receive a paycheck before your payment is received and applied to your account, the amount that you owe will be deducted from your paycheck. If applicable, any checks received and not processed will be voided and returned to you.

VOLUNTARY CANCELLATION OF BENEFITS:

Being out on FMLA is a qualifying life event that allows you to voluntarily cancel your benefits while you are out on leave. You will also have the option to re-enroll upon returning to work. Should you wish to cancel your benefits while out on leave, please reach out to a Benefit Counselor at 1-844-279-7896.

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Family and Medical Leave Request

TOTAL REWARDS   LIFE

PART 1 – To be completed by the employee requesting leave

EMPLOYEE'S NAME		EMPLOYEE NUMBER	TODAY'S DATE
ADDRESS	CITY	STATE	ZIP
CENTER/DEPARTMENT	EMAIL ADDRESS	PHONE NUMBER	WORK STATUS ☐ Full-time ☐ Part-time

I request Family Medical Leave for the following reason: ***(check one box only)***

- ☐ **To care for my child after birth.**
- ☐ **To care for my child after placement by adoption or foster care.**
- ☐ **For my own serious health condition (including pregnancy-related conditions) which prevents me from performing at least one of the essential functions of my job.**

  Describe your condition:

  ____

  ____

  ____

  ____

Expected Dates of Leave*

Start date: ____ / _____ / ____   Return date: _____ / _____ / ____

**You must notify your supervisor and the Benefits Department if the above leave dates change.*

- ☐ I will not be working at all during the above dates.
- ☐ I will be working an intermittent/reduced schedule during the above dates.

______________________________   ______________

EMPLOYEE SIGNATURE   DATE

Employee: Submit this form to the Benefits Department (fax 503-872-1753) and notify your supervisor verbally of the dates requested above.

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PART 2 – Certification of Health Care Provider – Employee's Serious Health Condition

I. Instructions to Employee:

Please provide your name and Employee ID Number below 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. 20 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).

Please submit the completed certification to the Benefits Department. You may take a picture of the form and email them to benefit@kc-education.com, fax the form to 1-503-872-1753, or mail the form to KCE, Attn: Benefits, P.O. Box 6787, Portland, OR 97228.

Employee Name: ______________________ **Employee ID Number:** ______________

II. To be completed by 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. Please be sure to sign the form on the last page.

Provider's Name: ______________________

Business Address: ______________________

Type of Practice/Medical Specialty: ______________________

Telephone: ______________ Fax: ______________

A. Medical Facts

1. Approximate date condition commenced: ______________

   Probable duration of condition: From: __________ To: __________
2. Date(s) you treated the patient for condition: ______________

   ____
3. Is the medical condition pregnancy? ☐ Yes ☐ No

   If yes, expected delivery date: ______________
4. Use the information provided by the employer to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer this question 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? ☐ Yes ☐ No

   If yes, identify the job functions the employee is unable to perform:

   ____

   ____

   ____

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5. Describe relevant medical facts related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, dates of hospitalization, or any regimen of continuing treatment):

____

____

____

B. Amount of Leave Needed

1. 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? ☐ Yes ☐ No

   If yes, anticipated date the employee will become unable to work: _____ / ____ / ____

   Anticipated date the employee will be able to return to work: _____ / ____ / ____

2. Will it be medically necessary for the employee to leave work intermittently or work a reduced schedule as a result of the medical condition (other than for episodic flare-ups which are addressed in questions #3 below)? ☐ Yes ☐ No

   If the employee needs a reduced schedule leave, estimate the part-time or reduced work schedule the employee needs:

   ____ hour(s) per day; ___ days per week, from _____ / ____ / _____ through _____ / _____ / __

   If the employee needs intermittent leave, estimate the frequency of need for intermittent leave and the duration of incapacity (e.g., 1 episode every 3 months lasting 1-2 days):

   Frequency: _____ times per week or month. Duration: _____ hours or _____ days per episode.

   ____

3. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ☐ Yes ☐ No

   Is it medically necessary for the employee to be absent from work during the flare-ups? ☐ Yes ☐ No

   If yes, please explain: ____

   ____

   Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of the 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

   Flare-ups may occur from: ____________ through: ____________

C. Additional Information

Please provide any additional relevant information:

____ ___________________________

SIGNATURE OF HEALTH CARE PROVIDER DATE

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Return to Work Medical Certification

TOTAL REWARDS LIFE

Welcome Back!

If you have been out of work for your own serious health condition you will need to complete the following steps before clocking back into work:

1. **You and your health care provider complete this form.**
2. **Provide a copy of the completed form to your supervisor.**
3. **Send a copy of this form to The Benefits Department by fax 503-872-1753 or email benefit@kc-education.com.**

Part 1 – To be completed by Employee

LAST NAME	FIRST NAME	EMPLOYEE NUMBER	CENTER / DEPARTMENT
EMPLOYEE'S POSITION (JOB TITLE)		EMPLOYEE SIGNATURE	

Part 2 – To be completed by Health Care Provider

HEALTH CARE PROVIDER'S NAME	ADDRESS AND TELEPHONE NUMBER

Have you reviewed the essential functions of the employee's job at KCE with him/her? ☐ Yes or ☐ No

What date is the employee released to return to work?

Are there any restrictions on the employee's schedule? ☐ Yes or ☐ No

If Yes, please clarify:

- ☐ Employee can work from _____ am/pm to _____ am/pm
- ☐ Employee can work up to _____ hours per day.
- ☐ Employee can work up to _____ hours per week.

Does the employee have any other restrictions? ☐ Yes or ☐ No If yes, please list here:

When can the employee return to full duty without restrictions?

- ☐ Employee can return to full duty on _____ - _____ - _____.
- ☐ Employee will be re-evaluated on _____ - _____ - _____ to determine return to full duty.
- ☐ Employee's restrictions are indefinite.

SIGNATURE OF HEALTH CARE PROVIDER

DATE

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