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The Adjutant General

DEPARTMENTAL DIRECTIVE NUMBER 230.44* **18 June 2025**

TIME AND ATTENDANCE REPORTING FOR STATE EMPLOYEES

TABLE OF CONTENTS

**** - This Departmental Directive supersedes Departmental Directive 230.44, Time Attendance, and Leave Reporting for State Employees, dated 22 February 2017.***

1. **PURPOSE:** Establishes the policies and procedures governing time and attendance for State employees.

2. **APPLICABILITY.** This directive applies to all State employees (full-time, part-time, seasonal and temp) of the NJ Department of Military and Veterans Affairs (DMAVA).

3. **REFERENCE:** Refer to Appendix A

4. **OBJECTIVES**: This Directive ensures that standardized procedures are in place for DMAVA employees' work schedules, leaves, and time and attendance records/reports

a. **Hours of Work**: DMAVA State employees are required to work the number of hours per week which are specified in the State of New Jersey Compensation Compendium and the Federal Fair Standards Labor Act, as prescribed by the New Jersey Civil Service Commission (CSC), in accordance with the applicable negotiated agreements and contracts, and pursuant to Departmental Directive 230.50. Work schedules will be consistent with current contractual language and the operational requirements of the Department. When and where appropriate, supervisors will publish changes to work schedules in accordance with the applicable negotiated agreements and contracts. Additionally, work schedules will be posted in accordance with the appropriate union contract(s).

b. **Overtime**: Employees may be required to work overtime. Advance notice, to the extent practical, will be given to the employee if overtime is required. All requests for prescheduled overtime must be submitted in advance for supervisor approval. If on occasion, based on operational needs, an employee may find it necessary to work beyond their regularly scheduled hours, the employee should notify the supervisor as soon as possible.

(1) In the Central Office, requesting supervisor must submit overtime requests to their Division Director for approval prior to overtime being worked. The Division Director must notify HRERD immediately of overtime approval. Armorers must follow overtime procedures outlined in Departmental Directives 600.1 and 680.41.

(2) In the New Jersey Veterans Memorial Homes, scheduled overtime must be submitted to the designated individual 48 hours in advance. Emergency overtime powers will be granted to the designated supervisory personnel when a staffing shortage arises that requires immediate action to maintain Department of Health standards. Overtime must be scheduled in accordance with the applicable contractual negotiated agreements.

(3) Employees are limited to the amount of compensatory time they can accumulate and is expressed in applicable Union contracts. If an employee accumulates more than allowed by contract, provisions must be made to allow the employee to use the excess time immediately. If the employee refuses to schedule compensatory time off, their supervisor may schedule the employee's time off down to the amount permitted in the negotiated agreement and the Fair Labor Standards Act (FLSA). Overtime payments will be paid in accordance with the negotiated agreements.

(4) Employees in non-limited titles (NL & N4) who meet unusual work time requirements **may at the discretion of The Adjutant General (TAG) and in accordance with Figure 1** be compensated by either a provision for flexible work patterns such as assigning the employee a comparable amount of time off in the week the compensable time was earned or grant comparable amounts of time off to a maximum of one hour for each hour of unusual work time and may "bank" this time up to a total of 240 hours. *Note: employees engaged in specific law enforcement or fire fighter titles, emergency response or seasonal titles may accrue up to a maximum of 480 hours of compensatory time off.*

(5) **IN NO EVENT SHALL EMPLOYEES IN NON-LIMITED TITLES (NL, N4) HAVE ANY ENTITLEMENT TO CASH OVERTIME COMPENSATION.**

(6) The Adjutant General (TAG), Deputy Adjutant General (DAG), Deputy Commissioners, Division Directors or equivalent, and employees in exempt non limited titles (NL & N4) positions, regardless of their bargaining unit, with established salary ranges at or above the range 32 shall not have any entitlement to additional compensation for additional hours worked beyond their normal work schedule.

(7) Employees serving in 35, 40, NE and 4E work weeks covered by the Fair Labor Standards Act shall have work credited for overtime/compensatory time in one-tenth hour units (six [6] minutes) of continuous work beyond each regular workday.

(8) Employees serving in non-limited work weeks (NL and N4) who are eligible to accrue compensatory time will accrue time in increments of one half of an hour.

(9) The following records shall be kept and maintained by the Human Resources and Employee Relations Department (HRERD):

(a) Name of employee in full.

(b) Home address, including zip code.

(c) Date of birth, if under 19.

(d) Sex and occupation.

(e) Time of day and day of week on which the employee's workweek begins.

(f) Regular hourly rate of pay in any workweek in which overtime premium is due, or other basis of wage payment (such as "$5.00 hr.," "$40.00 day," "$200.00 wk.").

(g) Daily and weekly hours of work.

(h) Total daily or weekly straight time earnings.

(i) Total overtime compensation for the workweek.

(j) Total additions to or deductions from wages paid, e.g. as appropriate meals, housing, etc.

(k) Total wages paid each pay period.

(l) Date of payment and the pay period covered by payment; and

(m) Approved overtime requests and a summary of work accomplished, and number of hours compensated.

(n) The names, titles, and salary ranges of employees receiving compensatory time off (CTO) or comparable time off.

c. **Holidays**:

(1) The following thirteen (13) days have been designated as legal holidays by the State of New Jersey:

New Years' Day	Memorial Day	Election Day
Martin Luther King's Birthday	Juneteenth Day	Veterans' Day
President's Day	Independence Day	Thanksgiving Day
Columbus Day	Labor Day	Christmas Day
Good Friday		

(2) When an authorized holiday falls on a Sunday, the following Monday shall be observed as the holiday. Holidays falling on a Saturday will be observed on a Friday.

(3) When a designated holiday falls on an employee's regular day off and if coverage allows, then, if possible, an additional day should be scheduled off for the employee within the same workweek.

(4) An employee must be in pay status (or on approved furlough provided they are in pay status during the pay period in which the holiday falls) the day before the holiday to receive payment for the holiday.

(5) Religious holidays: Any holiday not designated as a legal holiday or declared a special day off by the Governor may be granted to an employee as a religious holiday but must be charged to either vacation or other accumulated leave (sick time excepted) or leave without pay. Such time must be approved by the supervisor in advance.

WORKWEEK OVERTIME ELIGIBILITY AND COMPENSATION CHART

Eligibility Status (workweek)	Comp Plan	In excess of 35 but not more than 40 hours per workweek	In excess of 40 hours per workweek as prescribed by FLSA
35 (covered)	35	Cash compensation at one and one-half times the hourly proration of the base salary or compensatory time off (CTO) at one and one-half times the hours worked.	Cash compensation at one and one-half times the regular rate[1] or CTO at one and one-half times the hours worked providing the employee has not accrued more than 240 hours of CTO[1].
35 (exempt)	3E	Cash compensation at one and one-half times the hourly proration of the base salary or CTO at one and one-half times the hours worked.	Cash compensation at one and one-half times the hourly proration of the base salary or CTO at the one and one-half times the hours worked.
40 (Covered)	40	Not applicable.	Cash compensation at one and one-half times the regular rate[1] or CTO at one and one-half times the hours worked providing the employee has not accrued more than 240 hours of CTO[2].
40 (exempt)	4E	Not applicable.	Cash compensation at one and one-half times the regular rate or CTO at one and one-half times the hours worked.
NL (covered)	NE	No cash compensation. CTO for **unusual work** to a maximum of hour for hour (discretionary).[4]	Cash compensation at one and one-half times the regular rate[1] or CTO at one and one-half times the hours worked providing the employee has not accrued more than 240 hours of CTO[2].
NL (exempt)	NL	No cash compensation CTO for **unusual work** to a maximum of hour for hour (discretionary).[4]	**No Cash compensation[3]. CTO for unusual work time to a maximum of hour for hour (discretionary).**
NL4 (exempt)	N4	Not applicable.	**No cash compensation[3]. CTO for unusual work time to a maximum of hour for hour (discretionary)[5].**

[1] Regular rate is the hourly proration of the employee's annual base salary plus the fair market value of goods and facilities received as part of the wages. Employees who work at different pay rates in a single workweek shall have their hourly proration based on a weighted average of the different rates.

[2] Employees engaged in a public safety activity, an emergency response activity, or a seasonal activity title may accrue not more than 480 hours of CTO.

[3] Except as provided in N.J.A.C. 4A:3-5.7(d) (Exceptional Emergencies)

[4] Except as provided in N.J.A.C. 4A:3-5.3(d)2.

[5] Except as provided in N.J.A.C. 4a:3-5.6(b)2.

Figure 1

d. **Excessive Absenteeism**:

(1) In accordance with the (N.J.A.C.) 4A:6-1.4(d), an appointing authority may require proof of illness or injury when there is a reason to believe that an employee is abusing sick leave; an employee has been absent on sick leave for five or more consecutive work days; or an employee has been absent on sick leave for an aggregate of more than 15 days in a 12-month period.

(2) When it is determined that an employee's absences meet the standards outlined in N.J.A.C. 4A:6-1.4(d), they will be required to provide medical documentation as proof of illness to support their sick leave absences, paid and/or unpaid for no less than 6 months. Employees will be advised in writing of the medical documentation requirement. Management will review the employee's sick leave usage each (6) months following the issuance of the memo and will advise the employee if the documentation requirement will be lifted or extended.

(a) Failure to provide the required medical documentation for sick leave absences will result in the absence being recorded as an unauthorized absence.

(b) Without pay absences, authorized and/or unauthorized are not an entitlement and constitute chronic and excessive absenteeism and are subject to disciplinary action.

(c) Employees who are approved for intermittent leave, which may or may not be covered by FMLA or SFLA, are not required to provide medical documentation to support absences related to their approved intermittent leave.

(3) Employees are required to provide the required medical documentation for all sick absences until they are formally notified that the documentation requirement has been lifted. This includes when employees received new time balances at the beginning of a calendar year.

e. **Injury Reporting and Appeal Procedures**. The following provisions concerning on the job injury benefits apply to full and part-time State employees in the career, unclassified service, and Temporary Employee Services (Hourly) employees who become disabled because of occupational injury or disease resulting from employment during normal working hours.

(1) When an accident on the job occurs, the accident must be reported immediately by the employee to their immediate Supervisor or other designated individual. The party who was notified of the accident or injury must then forward the information to the appropriate HRERD immediately. Employee accidents at the New Jersey Veterans Memorial Homes should be reported to the HR offices in those facilities. All other Division, Units or Offices in DMAVA must report any accidents to Central Office HRERD.

(a) Form RM-2 (see Figure 2) must be completed by the injured State employee and/or their Supervisor within 24 hours of the accident in the following cases:

i. Accidental injury causing an absence from work beyond the day of injury;

ii. Medical treatment by a doctor or hospital; or

iii. Occurrence of an occupational disease due to working conditions whether or not time is lost.

(b) Form RM-2 must be forwarded to the Human Resources and Employee Relations Division immediately. Supervisor and Employees should retain a copy of the completed Form RM-2 for your records.

(c) In case of fatal or serious injury (hospital admission), immediately notify the Human Resources and Employee Relations Division by telephone.

(d) If the employee is too severely injured to complete the report, the employee's Supervisor will complete the report on the employee's behalf within 24 hours after the incident/accident and submit it to the Human Resources and Employee Relations Division.

(2) The HR Office will contact the Department of the Treasury, Bureau of Risk Management (Risk) to advise of the accident/injury and will direct the employee to a State Approved Medical Center for treatment and will provide all necessary information to receive treatment.

(3) Risk Management will determine if the accident/injury is eligible for Temporary Workers Compensation (TWC) and the amount that the employee will be paid under TWC. (minimum of 70% of wages up to a maximum as specified annually by the Department of Labor and Workforce Development). Employees who are unable to work due to a work-related injury/illness, will have all medical bills, related to the TWC claim, paid by the State.

(4) When an employee is on leave for TWC they are considered to be on a Leave Without Pay from DMAVA. This is due to the employee receiving TWC benefits from Risk Management, not DMAVA. Furthermore, because the employee is on a leave of absence without pay, employees are required to pay the employee's portion for health benefits coverage, dental, and contributory life Insurance. The employee's pension contributions will be paid by the State and will continue throughout duration of the TWC leave with no interruption.

(5) In accordance with N.J.A.C. 4A:6-1.10(a) employees may be granted a leave of absence without pay for a period not to exceed one (1) year unless otherwise provided by statute. An employee who can return to work on a part-time basis shall be compensated for the hours actually worked and may receive TWC benefits for the hours missed due to the disability. Light Duty assignments may be allowed, but only with the approval of the Director of Human Resources and Employee Relations Division.

(a) After one (1) consecutive year of leave of absence without pay, an employee will be contacted by HRERD and the employee will be given three (3) options

i. Return to work full duty by a specific date;

ii. Resign from their position; or

iii. Retire from their position.

(b) If the employee chooses to resign from their position, that does not mean that their TWC benefits will cease. TWC benefits may continue after separation from the State.

6. **RESPONSIBILITIES:**

a. **Time and Attendance Reporting** will be accomplished as follows:

(1) All supervisors are responsible for knowing your employees work and leave schedules. As a Supervisor you will be required to certify each leave request and timesheet. Employees will request their leave in advance from their supervisor.

(2) DMAVA employees primarily use eCATS as their time keeping system of record. Employee will enter a leave request in eCATS and once it is approved by the Supervisor in the system it will automatically populate onto the employee's timesheet.

(3) New Jersey Veterans Memorial Homes use UKG/Timekeeping system, employees must physically punch in and out at time clocks for record time and attendance. Paper leave request, (NJDMAVA 101) will be used to document the type of leave and hours requested. Supervisor will account for employee's time when processing payroll.

(4) Supervisors must promptly review and approve leave requests.

(5) Supervisors or employees are required to notify their HRO of any leave without pay as soon as it comes to their attention, but no later than 10:00 a.m., Friday of the closing day of the pay period.

(6) Failure to complete and/or approve leave requests and timesheets could result in a delayed, or incorrect paycheck and subject the individual to disciplinary action. The mere request should not be construed as an automatic approval. Supervisory approval must be received prior to the utilization of leave time.

(7) Individual sections are authorized to use a locally produced timesheet for their work location.

STATE OF NEW JERSEY
EMPLOYER'S FIRST REPORT OF ACCIDENTAL INJURY OR OCCUPATIONAL DISEASE
REPORTING INSTRUCTIONS

Print Form

This form must be completed by the injured employee and the supervisor within 24 hours of the accident in the following cases: (1) accidental injury causing an absence from work beyond the day of injury, or (2) medical treatment by a doctor or hospital, or (3) occurrence of an occupational disease due to working conditions whether or not time is lost. Mail promptly to your Human Resource office. in case of fatal or serious injury, (hospital admission), immediately notify the Human Resource office by telephone. Retain a copy for your records and forward all other copies to your Human Resource office per your departmental procedures.

The Human Resource office shall review the report for completeness and accuracy and file the original no later than three days after the injury occurred with the Division of Risk Management Department of the Treasury.

NOTE: If the employee is too severely injured to complete the report, the employee's supervisor will complete the report within the 24 hour time span and submit it to Human Resources.

ORIGINAL TO: **DEPARTMENT OF THE TREASURY**
DIVISION OF RISK MANAGEMENT
PO BOX 620
TRENTON NJ 08625-0620

INCIDENT CODE DEFINITIONS

0 - First aid or other Non-recordable cases: Indicates that treatment by a licensed physician and time off work were not necessary.
1 - Medical treatment case: Indicates that treatment by a licensed physician was required, but no time off work other than day of injury for recovery.
5 - Lost work day case: Indicates that time off work, beyond day of injury, for recovery was necessary.
9 - Fatality case: Employee died from injuries received.

FOR EMPLOYEE'S SUPERVISOR USE

TABLE C - Unsafe Act or Hazardous Condition Classification

B1 – Failure to use available personal protective equipment
C1 -- Failure to wear safe personal attire (wearing high heels, loose hair, long sleeves, loose clothing, etc.)
D – Failure to secure or warn
E1 -- Horseplay (distracting, teasing, abusing, starting, quarrelling, practical joking, throwing material, showing off, etc.)
E2 -- Under the influence of alcohol, drugs or medication
F1 – Assault from fight, hold-up, robbery, client, inmate
G – Improper use of equipment
H – Improper use of hand or body parts
J – Inattention to footing or surroundings
K – Making safety devices inoperative
L -- Operating or working at unsafe speed
M – Taking unsafe position or posture
N – Driving errors (by vehicle operator or public roadways.)
P – Unsafe placing, mixing, combining, etc. (e.g. box improperly placed, piled in proper area falling on an employee).
Q -- Using unsafe equipment (e.g. equipment tagged as defective or or obviously defective).
R -- Defects of equipment, tools, materials, or work area. (Generally the opposite of the desirable and proper characteristic such as being dull when it should be sharp)
V – Placement hazards (materials, equipment, telephone wires, etc., placed in wrong areas, aisles, etc.)
W – Inadequately guarded
X – Hazards of outside work environments other than public hazards (encountered while working in or on premises not controlled by the employer and not arising from the activities of the injured or his co-employees or from the tools, materials, or equipment used in those activities).
Y – Public hazards (encountered in public places away from employer's premises including public transportation).

Figure 2 – RM-2 (page 1)

STATE OF NEW JERSEY

EMPLOYER'S FIRST REPORT OF ACCIDENTAL INJURY OR OCCUPATIONAL DISEASE

INFORMATION BELOW MUST BE COMPLETED BY THE EMPLOYEE AND THE EMPLOYEE'S SUPERVISOR IN ACCORDANCE WITH THE ATTACHED INSTRUCTIONS

Claim Number	Injured Employee Last Name	First Name	M.I.	SS#/EIN#	Date of Birth	Sex

Address	City	County	Zip Code	Gross Biweekly Wage	Daily Wage

Acc. Date (mm/dd/yy)	Date Employee Stopped Work	Official Workstation	Phone No. Home

Day of Week	Time	AM / PM	Date employee returned to Work	Estimate / Actual	Department	Phone No. Work
		☐ AM ☐ PM		☐ Estimate ☐ Actual		

Lost work days	Estimate / Actual	Occupation or Job Title	Division	Emergency Contact
	☐ Estimate ☐ Actual			

Place of accident or exposure	Agency	HR Name & Phone number

☐ Check if additional pages are attached

Describe how the accident occurred in detail

Describe the injury or illness and part of body affected

Identify witnesses on the second page

☐ Witnesses ☐ No witnesses

Was employee referred to authorized physician? If no, explain on other side.

☐ Yes ☐ No

Name of Treating Physician

Did this accident happen because of the action of others who are not co-employees or because of defective equipment? If so, complete responsible party information on other side.

☐ Yes ☐ No

Did the accident happen under normal workplace conditions?

☐ Yes ☐ No

34:15-57.4. Workers' compensation fraud: criminal and civil penalties.
A person shall be guilty of a crime of the fourth degree if the person purposely or knowingly makes, when making a claim for benefits pursuant to R.S. 34:15-1 et seq., a false or misleading statement, representation or submission concerning any fact that is material to that claim for the purpose of wrongfully obtaining benefits.

Are you or your spouse currently eligible for Medicare or Medicaid benefits? ☐ Yes ☐ No

Employee's Signature Date

Information in this area to be provided by the employee's supervisor

Type of incident:
0 - First aid or other non-recordable event
1 - Medical treatment but not lost time
5 - Medical treatment and lost time
9 - Fatality case

Enter number that best describes the incident.

Fatality date if applicable:

Supervisor - Did you witness the accident? ☐ Yes ☐ No

If yes, please describe:

Do you agree with the employee's description? ☐ Yes ☐ No

Supervisor Signature and Phone No. Date
PRINT NAME

RM-2 (Revised 3/11)

Figure 2 (continued) – RM-2 (page 2)

Explanation for using unauthorized Physician

Staff Physician's/Nurses's remarks (for agency medical staff use)

Diagnosis

Is the injury related to the accident or work exposure? ☐ Accident ☐ Work Exposure

What further treatment is needed?

Date the employee is medically able to return to work (mm/dd/yyyy)

Are outside medical/pharmacy bills etc. anticipated? ☐ Yes ☐ No

Remarks

Date

Signature of Physician

Witnesses to Accident

Name	Address

Add Witness | Delete Witness

Responsible Party Information

Name of person(s)

Identify object, machine, substance or premise

If accident caused by a vehicle, complete the following or attach copy of the RM-1 or other vehicle accident report

	EMPLOYEE'S VEHICLE	OTHER VEHICLE
Year and make of car		
License plate no.		
Owner's name		
Owner's address		
Name of Insurance co. and policy no.		
Driver's name		
Driver's address		

Was a State Vehicle Accident Report RM-1 completed and filed? ☐ Yes ☐ No

If no, explain

Seat Belt ☐ Yes ☐ No

Cellphone ☐ Yes ☐ No

RM-2 (Revised 3/11)

Figure 2 (continued) – RM-2 (page 3)

6. RESPONSIBILITIES (continued):

(8) Supervisor must complete timesheets by 10:00 am on the Pay Close Date. All leave requests and timesheets need to be approved by the 12:00 pm on the Pay Close Date.

(9) Questions or issues can be referred to the eCATS Helpdesk email: eCatsHelpdesk@dmava.nj.gov

b. **Request for Leave**: Leave is requested in advance from the employee's supervisor or in an emergency situation, as soon as possible.

(1) Personnel using eCATS will submit leave request for Vacation, Sick and Administrative leave online to the employee's immediate supervisor. Central Office employees must notify their supervisor prior to each time leave is requested, except for emergency situations.

(2) Employees cannot create an eCATS leave request for Jury Duty, School Volunteer, Convention, Union Activity, Military, FMLA, FLA or ADA. These types of leaves must be approved by the Human Resources and Employee Relations Division in advance. Requests for military leave will include a copy of the official military orders requiring such leave. Requests for convention leave must include evidence of the individual being a delegate of an authorized organization as listed in N.J.S.A. 38:23-2.

(3) Veterans Memorial Homes Employees will submit the appropriate request for leave utilized at their facility. A paper request will be used for UKG. The supervisor may grant such leave provided it is scheduled in advance or in an emergency situation, as soon as possible.

(4) Continuous Absent: Human Resources and Employee Relations must be notified by the employee or supervisor when an employee is out of work due to an unexpected illness or illness of their immediate family member for five (5) or more consecutive workdays. Contact the Human Resources and Employee Relations Office at 609- 530-6723.

(5) Contact HRERD if you need further clarification.

c. Retention of Records: The following leave and attendance records will be retained as indicated by the State of NJ Records Retention and Disposition Schedule issued by the NJ State Records Committee.

Record	Retaining Agency	Period of Retention
Employee Work Schedule for 24-hour shifts	Preparing Agency	• 3 Years at Central Office • 5-7 years at NJ Veterans Memorial Homes
Medical Evidence	HRERD	Indefinite
NJDMAVA Form 48	HRM	Indefinite
NJDMAVA Form 48-1	HRM	Indefinite
NJDMAVA Form 101	Supervisor	4 Years
NJDMAVA Form 11	HRERD	Indefinite
Request for Employment Disability Leave/Return (Copy)	HRERD	• Original retained by the CSC. • DMAVA Copy – 6 years after termination of employment, then destroy.
Employee Medical Records Microfilming recommended.	HRERD	• 40 years after termination of employment, then destroy. • Retention period prescribed by • Federal law.
Leave of Absence Bi-Weekly Report (Copy)	HRERD	• Original maintained by the CSC. • DMAVA Copy – 3 years, then destroy.

The proponent of this directive is the
Human Resources and Employee Relations Division.
Users are invited to send comments and suggestions
for improvement directly to
NJDMAVA, ATTN: HRERD,
PO Box 340, Trenton, NJ 08625-0340.

YVONNE L. MAYS
Brigadier General, NJARNG
The Adjutant General

REFERENCES

FEDERAL LAWS AND RULES

29 U.S.C. §§ 201 *et seq.*, The Fair Labor Standards Act of 1938, as amended.
29 U.S.C. §§ 2601 *et seq.*, The Family and Medical Leave Act (FMLA) of 1993.
38 U.S.C. §§ 4301 *et seq.*, Employment and Reemployment Rights of Members of the Uniformed Services (commonly known as USERRA).
42 U.S.C. §§ 12101 *et seq.*, Americans with Disabilities Act (ADA).
45 C.F.R. Parts 160 and 164, Subparts A and E, Health Insurance Portability and Accountability Act of 2002 (HIPAA).

NEW JERSEY PUBLIC LAWS (P.L.)

P.L. 1966, Chapter 113, New Jersey State Wage and Hour Law
P.L. 2003, Chapter 246, New Jersey Domestic Partnership Act
P.L. 2006, Chapter 103, New Jersey Civil Union Law
P.L. 2019, Chapter 37, New Jersey Family Leave Act

NEW JERSEY STATUTES ANNOTATED (N.J.S.A. 26:8A-1 *et seq.*,)

N.J.S.A. 11:1.1 *et seq.*, Civil Service.
N.J.S.A. 11A:3-7 - Employee compensation "New Jersey Compensation Plan"
N.J.S.A 34:1-1 *et seq.*, Labor and Workmen's Compensation
N.J.S.A. 34:11-56a *et seq.*, Minimum wage; establishment.
N.J.S.A. 38:23-1, Leave of absence for field training in reserve corps of United States.
N.J.S.A. 38:23-2, Leave of absence to attend state or national conventions.
N.J.S.A. 38:23-4, Leave of absence to employees of state, county, municipality or other political subdivision entering military or naval service.
N.J.S.A. 38A:1-3, Classes of Militia.
N.J.S.A. 38A:2-4, Militia ordered to active duty in certain cases.
N.J.S.A. 38A:4-4, Leave of absence without loss of pay, exceptions.

NEW JERSEY ADMINISTRATIVE CODE (N.J.A.C.)

N.J.A.C. 4A:1.1 *et seq.*, Civil Service.
N.J.A.C. 4A:2-6.2, Resignation Not in Good Standing.
N.J.A.C. 4A:3-5.1 et seq., Overtime Compensation.
N.J.A.C. 4A:4-1.1 *et seq.*, Career Service Appointments.
N.J.A.C. 4A:6-1.1 *et seq.*, Leaves of Absence.
N.J.A.C. 5A:1-1.5, State's Military Forces.
N.J.A.C. 5A:2-2.1 *et seq.*, Military Leave.
N.J.A.C. 8:57-1,1 *et seq.*, Communicable Diseases.
N.J.A.C. 12:56-1.1 *et seq.*, Wage and Hour.

REFERENCES (CONTINUED)

NEW JERSEY DEPARTMENT OF MILITARY AND VETERANS AFFAIRS DIRECTIVES AND POLICIES

Departmental Directive 230.05, State Employee Relations Policies, 28 December 1990, with Changes 1 through 3, dated, 1 July 1991, 1 June 1994 and 24 August 2001, respectively.
Departmental Directive 230.45, Unclassified Personnel Vacation Policy, dated 15 April 2021.
Departmental Directive 230.50, DMAVA Hours of Work, dated 8 March 2006.
Departmental Directive 230.55, Donated Leave Program, dated 11 September 2012.
Departmental Directive 600.1, Installations – Operation, Care and Maintenance of Facilities, dated 30 August 2006.
Departmental Directive 680.41, Building & Grounds – Lease of Armory Facilities to Others, dated 1 July 1999.
TAG Policy Letter 20-1, Scheduled Day Off, dated 20 February 2020.

OTHER

Applicable Union Contracts

APPENDIX B

DEFINITIONS

Abuse of Sick Leave: A pattern of absence or Sick Leave absence without documentation, or the use of Sick Leave for purposes other than those defined in N.J.A.C. 4A:6-1.4

Acceptable Medical Documentation: A Certification of Health Care Provider WH-380-E (Employee) or WH-380-F (Family) that must be completed and signed by a licensed medical practitioner and/or an original written verification of absence from a licensed medical practitioner providing the medical facts surrounding the medical condition and the employee's inability to work.

Administrative Leave: Full-time employees are entitled to annual paid leave credited at the beginning of each calendar year in anticipation of continued employment, for personal business, including emergencies and religious observances.

Appointing Authority: A person or group of persons having power of appointment or removal.

Benefit Time: Earned paid time off: Administrative, Sick, Vacation, Compensatory (XP Time).

Bereavement Leave: Effective July 1, 2024, full-time employees will receive an annual one (1) day bank of time for bereavement leave. Each year thereafter, the one (1) bereavement day per year will be credited at the beginning of each calendar year. The bereavement day will be used before an employee's use of sick leave. The bereavement leave day does not accumulate and unused time will not be carried over or paid out upon separation. Bereavement may be used for immediate family members as defined by N.J.A.C. 4A:1-1.3. Employees may be required to furnished proof of death. Employee may be eligible for up to five (5) days subject to approval of HRERD.

Catastrophic Illness: Either a life-threatening condition or combination of conditions; or a period of disability required by the mental or physical health of an employee, employee's fetus or family member, which required the care of a licensed medical practitioner who provides medical verification of the need for the employee's absence for sixty (60) or more workdays.

Central Office: All DMAVA facilities except the three (3) NJ Veterans Memorial Homes.

Child: The biological, adopted or foster child, stepchild, legal ward or child who is under 18 years of age, or 18 years of age or older but incapable of self-care because of mental or physical impairment.

Civil Union Partner: A person of the same sex with whom the employee has entered into a civil union and received a New Jersey Civil Union license or certificate through application to a local registrar, or a valid certification from another jurisdiction that recognizes same-sex domestic partners, civil unions, or similar same-sex relationships.

APPENDIX B

DEFINITIONS (CONTINUED)

Communicable Disease: An illness due to a specific infectious agent or its toxic products which arises through transmission of that agent or its products from an infected person, animal, or inanimate reservoir to a susceptible host, either directly or indirectly through an intermediate plant or animal host, vector, or the inanimate environment.

Compensatory (XP): Compensatory time off in lieu of cash payment for overtime worked.

Continuous Service: Employment for the same jurisdiction without actual interruption due to resignation, retirement or removal.

1. An employee who has been appointed from a special reemployment list shall be credited with any continuous service prior to the layoff in addition to continuous service subsequent to reemployment.

2. Periods of employment before and after a suspension or leave with pay shall be considered continuous service. However, the period of time on a suspension or leave without pay, except for military leave, shall not be included in calculating years of continuous service.

Domestic Partner: Same-sex couples age 18 years or older and opposite-sex couples age 62 or older that share a common residence in New Jersey, are jointly responsible for each other's common welfare and agree to be jointly responsible for each other's basic living expenses who have met the requirements of the New Jersey Domestic Partnership Act to register a Domestic Partnership.

eCATS: Electronic Cost Accounting and Timesheet System is a web-based electronic biweekly time and leave reporting system of daily activity resulting in the generation of payrolls.

Employee: Under the provisions of this Directive, an employee is defined as full-time, part-time, hourly, or temporary services employee within State Government.

1. State Family Leave Act (SFLA): A person who has been employed for at least twelve (12) months and has worked at least 1,000 hours during the preceding 12-month period.

2. Federal Family and Medical Leave Act (FMLA): A person who has been employed for at least twelve (12) months and has worked at least 1,250 hours during the preceding 12-month period.

APPENDIX B

DEFINITIONS (CONTINUED)

Excessive absenteeism:

1. Paid or unpaid days away from the job for illness or injury which exceeds six (6) days in **any** three (3) month period which does not otherwise require a physician's certificate.

2. Ten (10) paid or unpaid sick days in a twelve (12) month "rolling back" period not otherwise requiring a physician's certificate.

Family Leave: Leave from employment so that the employee may provide care made necessary by reason of:

1. The birth or adoption of a child.

2. The serious health condition of a family member, i.e., child, parent, or spouse.

Family Member:

1. SFLA: Child, parent, parent-in-law, spouse, civil union partner or domestic partner.

2. FMLA: Child, parent, spouse.

Federal Family and Medical Leave Act (FMLA): Employers must grant eligible employees up to a total of twelve (12) weeks leave during any 12-month period for one or more of the following:

1. Birth of the newborn child of the employee.

2. Placement with the employee of a child for adoption or foster care.

3. Care for a family member with a serious health condition.

4. Employee is unable to work because of a serious health condition.

__NOTE__: This leave can be paid or unpaid, depending on the availability of employee's prorated benefit time.

Immediate Family: An employee's spouse, domestic partner, civil union partner, child, legal ward, grandchild, foster child, father, mother, legal guardian, grandfather, grandmother, brother, sister, father-in-law, mother-in-law, and other relatives residing in the employee's household. See definition under FMLA/SFLA for qualified family members.[6]

APPENDIX B

DEFINITIONS (CONTINUED)

Intermittent Leave: Leave taken in separate periods of time for less than five (5) days due to a single illness or injury (employee or family member).

1. SFLA: A non-consecutive leave comprised of intervals, each of which is at least one (1) but less than 12 workweeks within a consecutive 12-month period.

2. FMLA: May last for as little as one (1) hour or for as long as several non-continuous weeks.

Intermittent Titles: Those titles used in the career service where work responsibilities are characterized by unpredictable work schedules and which do not meet the normal criteria for regular, year-round, full-time, or part-time assignments.

UKG/Timekeeping system: Automated time tracking system used in New Jersey Veterans Memorial Homes. Leave is accounted for by coordinating with supervisors in advance.

Leave of Absence: An authorized absence, with or without pay, for a period of ten (10) or more workdays (including holidays) with the approval of the Appointing Authority in accordance with provisions prescribed in N.J.A.C. 4A:6-1.1.

Medical Certification Notice: A notice in writing prepared by a supervisor and given to an employee in cases of chronic and excessive absenteeism of fifteen (15) sick days in a 12-month period, or reasonable suspicion of abuse of benefit time. The supervisor may limit the number of allowable absences for each month/quarter for the remainder of the year, but not less than six (6) months. The Human Resources and Employee Relations Division will notify employees in writing in cases of chronic and excessive absenteeism of 15 sick days in a 12-month "rolling back" period, or reasonable suspicion of abuse of benefit time.

Organized Militia: Consists of the New Jersey Army and Air National Guard, the New Jersey Naval Militia and the State Guard.

Parent:

1. SFLA: The biological parent, adoptive parent, foster parent, stepparent, parent-in-law or legal guardian, "having a parent-child relationship" with a child as defined by law, or having sole or joint custody, or physical custody or guardianship or visitation with a child.

2. FMLA: The biological parent or an individual who stands or stood in *loco parentis* to an employee. This term does not include "parent-in-laws".

Patterned Absence: Any repetition of absence from duty comprised of three (3) or more incidents within the preceding four (4) months.

APPENDIX B

DEFINITIONS (CONTINUED)

Pay Close Date: Date the payroll must be submitted by HR. Normally last Friday in the pay period, but can be changed/modified due to holidays.

Permanent Employee: A career service employee who has acquired the tenure and rights resulting from regular appointment and successful completion of the working test period.

Permanent Part Time Employee: An employee whose hours are less than the normal workweek, excluding hourly employees. Part time employees accrue vacation, sick and administrative leave on a prorated basis based on a percentage of hours worked.

Prorated (earned) Time: An employee who leaves State service or goes on a leave of absence without pay for ten (10) or more workdays before the end of the calendar year will have their benefit time prorated based on the time earned for the year.

Provisional Employees: An employee serving in the competitive division of the career service pending the appointment of a candidate from an eligible list.

Qualifying Exigency Situations: A non-medical, non-routine circumstance that allows eligible employees to take up to twelve (12) weeks in a 12-month period of time.

Reduced Leave:

1. SFLA: A non-consecutive leave of up to the equivalent of twelve (12) workweeks which is taken in increments of not less than one (1) workday, but not more than one (1) workweek at a time.

2. FMLA: Reduces the number of employee's hours per workweek or workday.

Serious Health Condition: An illness, injury, impairment, or physical or mental condition which involves:

1. Any period of incapacity requiring absences from work for more than three (3) calendar days, that also involves continuing treatment of by a health care provider.

2. In-patient care in a hospital, hospice, or residential medical care facility.

3. Continuing treatment by a health care provider for a chronic or long-term health condition that is incurable or so serious that, if not treated, would likely result in a period of incapacity of more than three calendar days; or for prenatal care.

APPENDIX B

DEFINITIONS (CONTINUED)

Service Member Caregiver Leave: Employers must grant eligible employees up to a total of 26 weeks leave during any 12-month period to care for a service member who has incurred a serious injury or illness in the line of duty while on active duty.

Sick Leave: Full-time employees are entitled to annual paid leave credited at the beginning of each calendar year in anticipation of continued employment, for absences due to personal illness or injury, exposure to contagious disease, or care, for a reasonable period of time, of a seriously ill member of the employee's immediate family.

Spouse: A person to whom an employee is lawfully married as defined by State law.
leave

State Family Leave Act (SFLA): Employers must grant eligible employees up to a total of twelve (12) weeks leave in any 24-month period for one or more of the following:

1. Birth of the newborn child of the employee.

2. Placement with the employee of a child for adoption or foster care.

3. Care for a family member with a serious health condition.

4. Employee is unable to work because of a serious health condition.

NOTE: This leave can be paid or unpaid, depending on the availability of employee 's prorated benefit time.

Temporary Employment Services (TES) - Hourly: An employee who is limited for a specific time frame defined by project or for a seasonal employment. TES employees earn sick leave based on the number of hours worked as outlined by the New Jersey Earned Sick Leave Law of 2018. TES employees are not entitled to vacation or administrative leave.

Time Without Pay:

1. Authorized Time: Time off from work on a regular scheduled workday with supervisory approval, but without pay.

2. Unauthorized Time: Time off from work on a regular scheduled workday without supervisory approval and without pay.

NOTE: Authorized and unauthorized time without pay may result in disciplinary action.

APPENDIX B

DEFINITIONS (CONTINUED)

Unclassified Service: Those positions and job titles not subject to the tenure provisions of N.J.S.A. 11A-1.1 *et seq.* or N.J.A.C. 4A-1.1 *et seq.*, unless otherwise specified.

Vacation Leave: Full-time employees are entitled to annual paid leave, credited at the beginning of each calendar year in anticipation of continued employment, based on their years of continuous State service.

Workers' Compensation: A wage replacement program (minimum of 70% of wages up to a maximum as specified annually by the Department of Labor and Workforce Development) for employees who are unable to work due to a work-related injury/illness. All medical bills are paid by the State, however, since the employee is on a leave of absence without pay, employees are required to pay the employee's portion for health benefits coverage, dental, and contributory life Insurance.

Workweek: The period beginning at 12:01 a.m. Saturday and ending midnight the following Friday, totaling 35 or 40 hours depending on the job title.

APPENDIX C

ACRONYMS AND ABBREVIATIONS

ADA	Americans with Disabilities Act
AFSCME	American Federation of State, County and Municipal Employees
AL	Administrative Leave
AMVETS	American Veterans
CEO	Chief Executive Office
C.F.R.	Code of Federal Regulations
CSC	Civil Service Commission
CWA	Communication Workers of America
DMAVA	Department of Military and Veterans Affairs
eCATS	Electronic Cost Accounting and Timesheet System
FLI	Family Leave Insurance
FMLA	Federal Family and Medical Leave Act
HIPAA	Health Insurance Portability and Accountability Act of 2002
HRERD	Human Resources and Employee Relations Division
HRM	Human Resource Manager
IBEW	International Brotherhood of Electrical Workers
IFTPE	International Federation of Technical and Professional Engineers
ILOS	In lieu of sick (code used in eCATS)
N.J.A.C.	New Jersey Administrative Code
N.J.S.A.	New Jersey Statutes Annotated
NJDMAVA	New Jersey Department of Military and Veterans Affairs
P.L.	Public Law
RM	Risk Management
SCOR	Supplemental Compensation on Retirement
SDO	Standard Day Off
SES	State Executive Service
SFLA	State Family Leave Act
SOILS	Set-Off Individual Liability System
TAG	The Adjutant General
TDI	Temporary Disability Insurance
TES	Temporary Employment Services
U.S.C.	United States Code
USERRA	Uniformed Services Employment and Reemployment Rights Act
WC	Workers' Compensation
WCMP	Workers' Compensation (code used in eCATS)
XP	Compensatory Time

APPENDIX D

LEAVE OF ABSENCE FOR STATE OR NATIONAL CONVENTIONS

N.J.S.A. 38:23-2. ***The head of every public department and of every court of this State, every superintendent or foreman on the public works of this State, the heads of the county offices of the several counties and the head of every department, bureau, and office in the government of the various municipalities, shall give a leave of absence with pay to every person in the service of the State, county or municipality who is a duly authorized representative of the following:***

Grand Army of the Republic
United Spanish-American War Veterans
Disabled American Veterans
Disabled American Veterans' Auxiliary
Veterans of Foreign Wars
Ladies Auxiliaries of Veterans of Foreign Wars
Ladies Auxiliary, Veterans of World War I of the U.S.A.
American Gold Star Mothers
Indian War Veterans
American Legion
American Legion Auxiliary
Jewish War Veterans of the United States
Ladies Auxiliary, Department of New Jersey, Jewish War Veterans of the U.S.A.
Catholic War Veterans of the United States
Ladies Auxiliary of New Jersey State Department, Catholic War Veterans
The 369th Veterans Association, Incorporated
Women's Overseas Service League
American Veterans (AMVETS) of World War Two, Korea and Vietnam
AMVETS Ladies Auxiliary
Reserve Officers Association of the United States
Marine Corps League of the United States
Army and Navy Legion of Valor
The Twenty-ninth Division Association
Council of State Employees
War Veteran Public Employees Association
New Jersey Civil Service Association
Blind Veterans Association of New Jersey
Army and Air National Guard Association of New Jersey
The National Guard Association of the United States
The United States Coast Guard Auxiliary

APPENDIX D

LEAVE OF ABSENCE FOR STATE OR NATIONAL CONVENTIONS (CONTINUED)

N.J.S.A. 38:23-2. (*continued*)

Navy League
Veterans of World War I of the United States of America
Polish Legion of American Veterans
Polish Legion of American Veterans, Ladies Auxiliary
The Italian American War Veterans of the United States, Incorporated
The Ladies Auxiliary, Italian American War Veterans of the United States, Incorporated
The New Jersey Firemen's Association
The New Jersey State Exempt Firemen's Association
The Tuskegee Airmen, Incorporated

A certificate of attendance to the State convention or encampment shall, upon request, be submitted by the representative so attending.

Leave of absence shall be for a period inclusive of the duration of the convention with a reasonable time allowed for time to travel to and from the convention. No person shall be entitled to a total of more than five days' leave of absence with pay each calendar year for the purpose of attending, as authorized representative, the State or national convention of one or more of the above enumerated organizations. The leaves of absence authorized hereunder shall not be cumulative and any unused leaves shall be canceled at the end of any given year.

APPENDIX D

LEAVE OF ABSENCE FOR STATE OR NATIONAL CONVENTIONS (CONTINUED)

N.J.A.C. 4A:6-1.13(b). ***An employee who is a duly authorized representative of the below organizations shall be granted a leave of absence with pay to attend a State or national convention of one or more of those organizations; provided, however, that:***

1. No more than 10 percent of the employee organization's membership shall be permitted such a leave of absence with pay, except that no less than two and no more than 10 authorized representatives shall be entitled to such leave, unless more than 10 authorized representatives are permitted such leave pursuant to an agreement between the appointing authority and negotiations representatives.

2. For employee organizations as with more than 5,000 members, a maximum of 25 authorized representatives shall be entitled to such leave.

New Jersey Policemen's Benevolent Association, Inc.
Fraternal Order of Police
Firemen's Mutual Benevolent Association, Inc.
Professional Fire Fighters Association of New Jersey

N.J.A.C. 4A:6-1.13(d). ***Persons designated by the Governor shall be granted leaves of absence to attend the convention of the*:**

American Correctional Association (American Prison Association). *See N.J.S.A. 30:4-178.*

APPENDIX E

NJ DEPARTMENT OF MILITARY & VETERANS AFFAIRS
Application for Voluntary Furlough

INSTRUCTIONS FOR FURLOUGH APPLICATIONS

- Furlough requests must be submitted 7 days prior to the pay period in which furlough days are to be taken.
- If you wish to cancel your approved furlough request, cancellations must be received one pay period in advance of the scheduled time off.
- Timekeepers are to notify the payroll clerk on the last Friday of the pay period in which furlough time was taken.
- All furlough requests must be submitted to the Human Resources Division for processing.
- Furlough requests disapproved by a Division Director must be forwarded to the Director of the Human Resources Division, with written documentation stating the reason for denial.
- An employee shall not be permitted to use a voluntary furlough for any of the following purposes: sick leave; a leave without pay due to disability; or to seek or engage in alternate employment.
- Final approval for all furlough requests is to be granted by the Deputy Commissioner.

NAME _____ WORK LOCATION _____ DATE (mm/dd/yy) _____

Please check which type of furlough you want and fill in the dates for the period of time in the blank spaces provided.

1. Shorter Workday: (must be taken in one-hour increments)

☐ Number of hours: _____

I am requesting consideration of the above be given for the period _____ (mm/dd/yy) through _____ (mm/dd/yy)

2. Intermittent days or weeks:

☐ 1 day / pay period ☐ 1 week / pay period

☐ 1 day / week ☐ 1 week / month

☐ 2 days / week ☐ 1 week / year

I am requesting consideration of the above be given for the period _____ (mm/dd/yy) through _____ (mm/dd/yy)

3. Day Options: (Single day or days on a one-time basis)

I am requesting consideration of the above be given for the period _____ SPECIFY DATES (mm/dd/yy)

4. Consecutive Days/Extended Leave Options:

☐ Aggregate of time up to 30 days for any one furlough

☐ May be renewed at appointing authority option, but is treated as a new furlough for days exceeding 30

I am requesting consideration of the above be given for the period _____ (mm/dd/yy) through _____ (mm/dd/yy)

I fully understand that I will not be compensated for furlough leave.

EMPLOYEE _____ SUPERVISOR _____ ☐ Approved ☐ Disapproved DATE _____

HUMAN RESOURCES MANAGER _____ ☐ Approved ☐ Disapproved DATE _____

Ref.: DMAVA Department Directive No. 230.10 dated 27 October 2005

New Jersey Department of Military and Veterans Affairs

Human Resources & Employee Relations Division

ATTENTION

ALL EMPLOYEES COMPLETING AND SUBMITTING LEAVE REQUEST

When submitting FMLA requests to Human Resources, the following must be completed by both the employee and health care provider.

TO BE COMPLETED BY EMPLOYEE:

- Part A - General Information
- Part B - Type of Leave Requested
- Part C - Duration of Leave
- Part D - Leave Expectations/Procedures
- Part E - Medical Information Authorization

For FMLA (WH-380-E)

- Section I: Employer (Form WH-380-E page 1)

For FLA (WH-380-F)

- Section I: Employer (Form WH-380-F page 1)
- Section II: Employee (Form WH-380-F pages 1-2)

TO BE COMPLETED BY HEALTH CARE PROVIDER:

For FMLA (WH-380-E)

- Section II: For Completion by the Health Care Provider (Form WH-380-E, page 2)
- Part A: Medical Information (Form WH-380-E, page 2)
- Part B: Amount of Leave Needed (Form WH-380-E, page 3)
- Signature of Health Care Provider (Form WH-380-E, page 4)

OR

For FMLA (WH-380-F)

- Section III: For Completion by the Health Care Provider (Form WH-380-E, page 2)
- Part A: Medical Information (Form WH-380-E, page 2)
- Part B: Amount of Leave Needed (Form WH-380-E, page 3)
- Signature of Health Care Provider (Form WH-380-E, page 4)

Please note, if the request for leave is not completed thoroughly, it will be returned to you for corrections. This will cause a delay in processing your leave request. Additionally, please see the attached document below, which provides additional information regarding FMLA and FLA leaves.

New Jersey Department of Military and Veterans Affairs

LEAVE OF ABSENCE, FMLA, FLA INFORMATION SHEET

The Federal Family and Medical Leave Act (FMLA) and State Family Leave Act (FLA) requires all public agencies, to provide up to 12 workweeks of paid/unpaid, job-protected leave to eligible employees for certain specified family and medical reasons who meet the established criteria for a serious health condition; to maintain eligible employees' pre-existing group health insurance coverage during periods of FMLA and FLA leave; and to restore eligible employees to their same or an equivalent position at the conclusion of their FMLA and FLA leave.

FMLA - Form WH-380-E	**VS.**	**FLA** - Form WH-380-F
Employees must have 12 months of employment and must have worked 1250 hours.		Employees must have 12 months of employment and must have worked 1000 hours.
Employees are entitled to 12 weeks in a 12-month period. Spouse with the same covered employer may only be entitled to a combined 12 weeks of FMLA for the same purpose.		Employees are entitled to 12 weeks in a 24-month period. There is no leave sharing requirement for spouses under FLA.
Leave under this act may be approved for birth, adoption and foster care; care for parent, child, spouse with a serious health condition; or an employee's own serious health condition.		Leave under this act may be approved for birth or adoption; serious health condition of a parent, parent of spouse, child or spouse (not an employee's own serious health condition).
Employees may be entitled to a leave schedule that reduces the number of hours per workweek or per day with the consent of the Supervisor.		Employees may be entitled to reduce their work schedule to non-consecutive days (not less than 1 day, not more than 1 workweek at a time) with the consent of the Supervisor. Note: Reduced periods shall not exceed 24 consecutive weeks.
Employees may be entitled to intermittent leave taken on an occasional basis: i.e. Chemotherapy or *Chronic Conditions that requires periodic visits for treatment by a health care provider. Intermittent leave may continue over an extended period of time or may cause episodic rather than a continuing period of incapacity (i.e. asthma, diabetes epilepsy. etc.).		Employees may be entitled to intermittent non-consecutive intervals of 1 workweek but less than 12, within a 12-month period. Note: FLA does not permit time to be taken in hours as FMLA does.

Department policy requires utilization of earned paid sick leave prior to receiving a Leave without Pay for FMLA, FLA and LAW absences. Once FMLA / FLA entitlement is exhausted, a leave of absence without pay must be requested and is subject to approval of the appointing authority.

Exception: An employee may use accrued sick, vacation or AL leave for pregnancy disability purposes but shall not be required to exhaust accrued leave before taking a leave without pay.

All foreseeable FMLA / FLA requests must be received at least 30 days in advance. These requests must be forwarded to the Human Resources Office immediately. All non-foreseeable/emergent FMLA / FLA absences require the employee to obtain a Medical Certification from their physician within the prescribed time frames.

*Employees with an established chronic condition must notify Human Resources within two business days of their absence. For more information regarding chronic conditions, please contact HR.

New Jersey Department of Military and Veterans Affairs

REQUEST FOR LEAVE WITH OR WITHOUT PAY

This form must be completed and signed by employee with applicable documentation before forwarding to Human Resources for approval.

PART A GENERAL INFORMATION

FULL NAME: _____ PERSONAL PHONE #: _____

ADDRESS: _____ ZIP CODE: _____

PERSONAL EMAIL ADDRESS: _____

DIVISION/BUREAU/INSTITUTION: _____

SHIFT _____ RDO DAYS _____ TITLE _____

PART B TYPE OF LEAVE REQUESTED

I HEREBY REQUEST A LEAVE OF ABSENCE DUE TO:

☐ FAMILY LEAVE, IF I MEET ELIGIBILITY REQUIREMENTS AS STATED IN C.F.R § 825.305 & DMAVA DD 230.44, FOR THE FOLLOWING QUALIFYING EVENT. COMPLETED CERTIFICATION OF HEALTH CARE PROVIDER MUST BE ATTACHED WITH ALL MEDICAL LEAVE REQUEST.

☐ PERSONAL ILLNESS

☐ PREGNANCY DISABILITY

☐ BIRTH OF CHILD / BONDING (INDICATE DATE OF BIRTH): _____

☐ SERIOUS HEALTH CONDITION OF FAMILY MEMBER RELATIONSHIP: _____

☐ MILITARY FAMILY LEAVE (FMLA)

☐ OTHER _____

☐ MILITARY- ATTACH COPY OF ORDERS

☐ PLACEMENT OF CHILD DUE TO ADOPTION OR FOSTER CARE- DATE _____

☐ VOLUNTARY FURLOUGH- ATTACH A DETAILED SCHEDULE ***(CENTRAL OFFICE APPROVAL ONLY)***

PLEASE SELECT ONE: I HEREBY REQUEST THAT THIS LEAVE BE ☐ **WITH PAY** ☐ **WITHOUT PAY.**

SIGNATURE _____ DATE _____

PART C DURATION OF LEAVE (To be completed for all types of leave request)

FULL TIME LEAVE FROM _____ THROUGH _____

☐ INITIAL REQUEST ☐ EXTENSION REQUEST

☐ REDUCED OR INTERMITTENT LEAVE - ATTACH DETAILED SCHEDULE ☐ CONTINUOUS LEAVE - 10 OR MORE CONSECUTIVE DAYS

DEPARTMENT POLICY REQUIRES THE USE OF ALL EARNED SICK LEAVE PRIOR TO RECEIVING A LEAVE WITHOUT PAY.

Note: In accordance with the NJ Temporary Disability Benefits Law (N.J. Stat. § 43:21-26), employees that are eligible for Temporary Disability Insurance (TDI) are only required to use two weeks worth of sick time, however, are not required to use their last week of sick time. Family Leave Insurance (FLI) provides the employee the option of using time (Vacation or AL) before claiming FLI, and doing so will not impact their benefits

DO YOU WISH YOUR EARNED VACATION TIME BE USED? ☐ YES ☐ NO

DO YOU WISH YOUR EARNED COMP TIME BE USED? ☐ YES ☐ NO

DO YOU WISH YOUR EARNED AL TIME BE USED? ☐ YES ☐ NO

PART D Leave Expectations / Procedures Ackowledgement Form

This document serves as an official acknowledgment by the employee regarding the expected general leave procedures that must be abided by:

1. I hereby confirm that I will continue to "call off duty" until I receive a written determination letter regarding this request.

2. I will resume my duties on the specified return date. Should circumstances prevent my return as scheduled, I will submit a new Request for Leave of Absence Form to the Human Resources Department no less than seven days prior to my anticipated return date.

3. When returning from personal medical leave, I will provide appropriate medical documentation from my physician confirming my ability to resume full duties without restriction. This documentation must be submitted to the Employee Health Clinic and/or Human Resources Department.

4. I acknowledge that prior to resuming work, I must ensure the Employee Health Clinic and/or Human Resources Department has received and processed my physician's note stating my clearance to return to full duty without restrictions. The Employee Health Clinic and/or Human Resources Department can be contacted at (###) ###-####.

5. I understand that failure to comply with established protocols or instructions provided by Human Resources, the Medical Department, or my Department Head may result in disciplinary measures and/or suspension of health, dental, and prescription benefits.

6. All inquiries and concerns should be directed to the Human Resources Department at (###) ###-####.

I hereby certify that I have read, understood, and agree to abide by the statements above and the Leave of Absence Procedures provided with this form.

SIGNATURE:_____ Date:_____

New Jersey Department of Military and Veterans Affairs

REQUEST FOR LEAVE WITH OR WITHOUT PAY

PART E Authorization to disclose protected health information pursuant to the health insurance portability and accountability act 45 C.F.R. 164.508

_____ DO HEREBY CONSENT AND AUTHORIZE
(EMPLOYEE FULL NAME)

_____ LOCATED AT _____
(I.E. NAME OF TREATING DOCTOR)

TO RELEASE MY PROTECTED HEALTH INFORMATION TO HUMAN RESOURCES REPRESENTING THE STATE OF NJ, DEPARTMENT OF MILITARY & VETERANS AFFAIRS.

DISCLOSURE INCLUDES INFORMATION FROM MY CLINICAL RECORDS PERTAINING TO THE REASONS FOR THIS LEAVE REQUEST, INCLUDING A TREATMENT SUMMARY. I UNDERSTAND THAT THE PURPOSE OF THIS DISCLOSURE IS IN ACCORDANCE WITH MY REQUEST FOR A LEAVE OF ABSENCE AND TO DETERMINE WHETHER I AM CAPABLE OF PERFORMING MY EMPLOYMENT DUTIES. I ALSO UNDERSTAND THAT THIS CONSENT IS REVOCABLE AT ANY TIME UPON WRITTEN REQUEST AND THAT IT WILL REMAIN IN FORCE FOR A PERIOD OF 180 DAYS FROM THE DATE SIGNED, UNLESS I SPECIFY OTHERWISE, IN ORDER TO EFFECTUATE THE PURPOSE FOR WHICH IT IS GIVEN, I UNDERSTAND THAT THERE MAY BE CONDITION ON TREATMENT, PAYMENT, ENROLLMENT OR ELIGIBILITY FOR BENEFITS WHETHER OR NOT I SIGN THIS AUTHORIZATION. I UNDERSTAND THE POTENTIAL FOR INFORMATION DISCLOSED PURSUANT TO THIS AUTHORIZATION TO BE SUBJECT TO REDISCLOSURE BY THE RECIPIENT AND NO LONGER PROTECTED BY 45 C.F.R. 164.508

SIGNATURE: _____ Date: _____

PART F - HR Representative Approval

- ☐ The attached submitted leave request has been APPROVED as signed and dated below
- ☐ The attached submitted leave request has NOT BEEN APPROVED for the following reason(s):
  - ☐ DID NOT MEET THE WORK REQUIREMENT WITHIN THE NECESASARY TIMEFRAME
  - ☐ ALREADY EXHAUSTED ALLOTED LEAVE TIME
  - ☐ MISSING DOCUMENTATION
  - ☐ INADEQUATE EXPLANATION OF HEALTH CONDITION / SITUATION
  - ☐ OTHER: _____

Certification of Health Care Provider for Employee's Serious Health Condition under the Family and Medical Leave Act

U.S. Department of Labor
Wage and Hour Division

WHD
WAGE AND HOUR DIVISION

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR.
RETURN TO THE PATIENT.

OMB Control Number: 1235-0003
Expires: 6/30/2026

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. 29 U.S.C. §§ 2613, 2614(c)(3); 29 C.F.R. § 825.305. The employer must give the employee at least 15 calendar days to provide the certification. If the employee fails to provide complete and sufficient medical certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

SECTION I - EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, this form asks the health care provider for the information necessary for a complete and sufficient medical certification, which is set out at 29 C.F.R. § 825.306. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308.** Additionally, you may not request a certification for FMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care.

Employers must generally maintain records and documents relating to medical information, 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(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.

(1) Employee name: _____ _____ _____
First Middle Last

(2) Employer name: _____ Date: _____ (mm/dd/yyyy)
(List date certification requested)

(3) The medical certification must be returned by _____ (mm/dd/yyyy)
(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee's diligent, good faith efforts.)

(4) Employee's job title: _____ Job description ☐ is / ☐ is not attached.

Employee's regular work schedule: _____

Statement of the employee's essential job functions:

_____

(The essential functions of the employee's position are determined with reference to the position the employee held at the time the employee notified the employer of the need for leave or the leave started, whichever is earlier.)

SECTION II - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form. Your patient has requested leave under the FMLA. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of the employee. For FMLA purposes, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves **inpatient care** or **continuing treatment by a health care provider**. For more information about the definitions of a serious health condition under the FMLA, see the chart on page 4.

You also may, but are **not required** to, provide other appropriate medical facts including symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment. Please note that some state or local laws may not allow disclosure of private medical information about the patient's serious health condition, such as providing the diagnosis and/or course of treatment.

Employee Name: _____

Health Care Provider's name: (Print) _____

Health Care Provider's business address: _____

Type of practice / Medical specialty: _____

Telephone: _____ Fax: _____ E-mail: _____

PART A: Medical Information

Limit your response to the medical condition(s) for which the employee is seeking FMLA leave. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. **After completing Part A, complete Part B to provide information about the amount of leave needed.** Note: For FMLA purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. 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).

(1) State the approximate date the condition started or will start: _____ (mm/dd/yyyy)

(2) Provide your **best estimate** of how long the condition lasted or will last: _____

(3) Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

☐ **Inpatient Care**: The patient (☐ has been / ☐ is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): _____

☐ **Incapacity plus Treatment**: (e.g. outpatient surgery, strep throat)

Due to the condition, the patient (☐ has been / ☐ is expected to be) incapacitated for **more than** three consecutive, full calendar days from: _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy).

The patient (☐ was / ☐ will be) seen on the following date(s): _____

_____

The condition (☐ has / ☐ has not) also resulted in a course of continuing treatment under the supervision of a health care provider (e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment).

☐ **Pregnancy**: The condition is pregnancy. List the expected delivery date: _____ (mm/dd/yyyy).

☐ **Chronic Conditions**: (e.g. asthma, migraine headaches) Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

☐ **Permanent or Long Term Conditions**: (e.g. Alzheimer's, terminal stages of cancer) Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

☐ **Conditions requiring Multiple Treatments**: (e.g. chemotherapy treatments, restorative surgery) Due to the condition, it is medically necessary for the patient to receive multiple treatments.

☐ **None of the above**: If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed. Go to page 4 to sign and date the form.

Employee Name: _____

(4) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. (e.g., use of nebulizer, dialysis)

_____

PART B: Amount of Leave Needed

For the medical condition(s) checked in Part A, complete all that apply. 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.

(5) Due to the condition, the patient (☐ had / ☐ will have) **planned medical treatment(s)** (scheduled medical visits) (e.g.psychotherapy, prenatal appointments) on the following date(s): _____

_____

(6) Due to the condition, the patient (☐ was / ☐ will be) **referred to other health care provider(s)** for evaluation or treatment(s).

State the nature of such treatments: (e.g. cardiologist, physical therapy) _____

Provide your **best estimate** of the beginning date _____ (mm/dd/yyyy) and end date _____ (mm/dd/yyyy). for the treatment(s).

Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery (e.g. 3 days/week)

_____

(7) Due to the condition, it is medically necessary for the employee to work a **reduced schedule**.

Provide your **best estimate** of the reduced schedule the employee is able to work. From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy) the employee is able to work: (e.g., 5 hours/day, up to 25 hours a week)

_____

(8) Due to the condition, the patient (☐ was / ☐ will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.

Provide your **best estimate** of the beginning date _____ (mm/dd/yyyy) and end date _____ (mm/dd/yyyy). for the period of incapacity.

(9) Due to the condition, it (☐ was / ☐ is / ☐ will be) medically necessary for the employee to be absent from work on an intermittent basis (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, episodes of incapacity are estimated to occur _____ times per (☐ day ☐ week ☐ month) and are likely to last approximately _____ (☐ hours ☐ days) per episode.

Employee Name:

PART C: Essential Job Functions

If provided, the information in Section I question #4 may be used to answer this question. If the employer fails to provide a statement of the employee's essential functions or a job description, answer these questions based upon the employee's own description of the essential job functions. An employee who must be absent from work to receive medical treatment(s), such as scheduled medical visits, for a serious health condition is considered to be **not able** to perform the essential job functions of the position during the absence for treatment(s).

(10) Due to the condition, the employee (☐ was not able / ☐ is not able / ☐ will not be able) to perform **one or more** of the essential job function(s). Identify at least one essential job function the employee is not able to perform:

Signature of Health Care Provider _____ Date: _____ (mm/dd/yyyy)

Definitions of a Serious Health Condition (See 29 C.F.R. §§ 825.113-.115)
Inpatient Care
• An overnight stay in a hospital, hospice, or residential medical care facility. • Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.
Continuing Treatment by a Health Care Provider (any one or more of the following)
Incapacity Plus Treatment: A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either: o Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or, o At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.
Pregnancy: Any period of incapacity due to pregnancy or for prenatal care.
Chronic Conditions: Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.
Permanent or Long-term Conditions: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.
Conditions Requiring Multiple Treatments: Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.

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 15 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 Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR. RETURN TO THE PATIENT.

Certification of Health Care Provider for Family Member's Serious Health Condition under the Family and Medical Leave Act

U.S. Department of Labor
Wage and Hour Division

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR. RETURN TO THE PATIENT.

OMB Control Number: 1235-0003
Expires: 6/30/2026

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave to care for a family member with a serious health condition to submit a medical certification issued by the family member's health care provider. 29 U.S.C. §§ 2613, 2614(c)(3); 29 C.F.R. § 825.305. The employer must give the employee **at least 15 calendar days** to provide the certification. If the employee fails to provide complete and sufficient medical certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

SECTION I - EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, this form asks the health care provider for the information necessary for a complete and sufficient medical certification, which is set out at 29 C.F.R. § 825.306. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308.** Additionally, you **may not** request a certification for FMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care.

Employers must generally maintain records and documents relating to medical information, medical certifications, recertifications, or medical histories of employees or 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.

(1) Employee name: _____ _____ _____
First Middle Last

(2) Employer name: _____ Date: _____ (mm/dd/yyyy)
(1st date certification requested)

(3) The medical certification must be returned by _____ (mm/dd/yyyy)
(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee's diligent, good faith efforts.)

SECTION II - EMPLOYEE

Please complete and sign Section II before providing this form to your family member or your family member's health care provider. The FMLA allows an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of your family member. If requested by your employer, your response is required to obtain or retain the benefit of the FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). **You are responsible for making sure the medical certification is provided to your employer within the time frame requested, which must be at least 15 calendar days.** 29 C.F.R. §§ 825.305-825.306. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA leave request. 29 C.F.R. § 825.313.

(1) Name of the family member for whom you will provide care: _____

(2) Select the relationship of the family member to you. The family member is your:

☐ Spouse ☐ Parent ☐ Child, under age 18

☐ Child, age 18 or older and incapable of self-care because of a mental or physical disability

Spouse means a husband or wife as defined or recognized in the state where the individual was married, including in a common law marriage or same-sex marriage. The terms "child" and "parent" include in loco parentis relationships in which a person assumes the obligations of a parent to a child. An employee may take FMLA leave to care for an individual who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave to care for a child for whom the employee has assumed the obligations of a parent. No legal or biological relationship is necessary.

Employee Name: _____

(3) Briefly describe the care you will provide to your family member: **(Check all that apply)**

☐ Assistance with basic medical, hygienic, nutritional, or safety needs ☐ Transportation

☐ Physical Care ☐ Psychological Comfort ☐ Other: _____

(4) Give your **best estimate** of the amount of leave needed to provide the care described:

_____

(5) If a **reduced work schedule** is necessary to provide the care described, give your **best estimate** of the reduced schedule you are able to work. From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy). I am able to work _____ (hours per day) _____ (days per week)

Employee Signature _____ **Date** _____ (mm/dd/yyyy)

SECTION III - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form below. A family member of your patient has requested leave under the FMLA to care for your patient. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a family member with a serious health condition. For FMLA purposes, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves inpatient care or continuing treatment by a health care provider. For more information about the definitions of a serious health condition under the FMLA, see the chart at the end of the form.

You also may, but are **not required** to, provide other appropriate medical facts including symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment. Please note that some state or local laws may not allow disclosure of private medical information about the patient's serious health condition, such as providing the diagnosis and/or course of treatment.

Health Care Provider's name: (Print) _____

Health Care Provider's business address: _____

Type of practice / Medical specialty: _____

Telephone: _____ Fax: _____ E-mail: _____

PART A: Medical Information

Limit your response to the medical condition for which the employee is seeking FMLA leave. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. **After completing Part A, complete Part B to provide information about the amount of leave needed.** Note: For FMLA purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. 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).

(1) Patient's Name: _____

(2) State the approximate date the condition started or will start: _____ (mm/dd/yyyy)

(3) Provide your **best estimate** of how long the condition lasted or will last: _____

(4) For FMLA to apply, care of the patient must be medically necessary. Briefly describe the type of care needed by the patient (e.g., assistance with basic medical, hygienic, nutritional, safety, transportation needs, physical care, or psychological comfort).

_____

Employee Name: _____

(5) Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

☐ **Inpatient Care**: The patient (☐ has been / ☐ is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): _____

☐ **Incapacity plus Treatment**: (e.g. outpatient surgery, strep throat)

Due to the condition, the patient (☐ has been / ☐ is expected to be) incapacitated for more than three consecutive, full calendar days from: _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy).

The patient (☐ was / ☐ will be) seen on the following date(s): _____

The condition (☐ has / ☐ has not) also resulted in a course of continuing treatment under the supervision of a health care provider (e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment)

☐ **Pregnancy**: The condition is pregnancy. List the expected delivery date: _____ (mm/dd/yyyy).

☐ **Chronic Conditions**: (e.g. asthma, migraine headaches) Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

☐ **Permanent or Long Term Conditions**: (e.g. Alzheimer's, terminal stages of cancer) Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

☐ **Conditions requiring Multiple Treatments**: (e.g. chemotherapy treatments, restorative surgery) Due to the condition, it is medically necessary for the patient to receive multiple treatments.

☐ **None of the above**: If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed. Go to page 4 to sign and date the form.

(6) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. (e.g., use of nebulizer, dialysis)

_____

PART B: Amount of Leave Needed

For the medical condition(s) checked in Part A, complete all that apply. 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 if the benefits and protections of the FMLA apply.

(7) Due to the condition, the patient (☐ had / ☐ will have) **planned medical treatment(s)** (scheduled medical visits) (e.g. psychotherapy, prenatal appointments) on the following date(s): _____

(8) Due to the condition, the patient (☐ was / ☐ will be) **referred to other health care provider(s)** for evaluation or treatment(s).

State the nature of such treatments: (e.g. cardiologist, physical therapy) _____

Provide your **best estimate** of the beginning date _____ (mm/dd/yyyy) and end date _____ (mm/dd/yyyy). for the treatment(s).

Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery (e.g. 3 days/week)

_____

Employee Name: _____

(9) Due to the condition, the patient (☐ was / ☐ will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.

Provide your **best estimate** of the beginning date _____ (mm/dd/yyyy) and end date _____ (mm/dd/yyyy) for the period of incapacity.

(10) Due to the condition, it (☐ was / ☐ is / ☐ will be) medically necessary for the employee to be absent from work to provide care for the patient on an **intermittent basis** (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, episodes of incapacity are estimated to occur _____ times per (☐ day ☐ week ☐ month) and are likely to last approximately _____ (☐ hours ☐ days) per episode.

Signature of Health Care Provider _____ Date: _____ (mm/dd/yyyy)

Definitions of a Serious Health Condition (See 29 C.F.R. §§ 825.113-.115)
Inpatient Care
• An overnight stay in a hospital, hospice, or residential medical care facility. • Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.
Continuing Treatment by a Health Care Provider (any one or more of the following)
Incapacity Plus Treatment: A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either: o Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or, o At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.
Pregnancy: Any period of incapacity due to pregnancy or for prenatal care.
Chronic Conditions: Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.
Permanent or Long-term Conditions: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.
Conditions Requiring Multiple Treatments: Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.

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