Designation Notice (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 5/31/2018

Leave covered under the Family and Medical Leave Act (FMLA) must be designated as FMLA-protected and the employer must inform the employee of the amount of leave that will be counted against the employee's FMLA leave entitlement. In order to determine whether leave is covered under the FMLA, the employer may request that the leave be supported by a certification. If the certification is incomplete or insufficient, the employer must state in writing what additional information is necessary to make the certification complete and sufficient. While use of this form by employers is optional, a fully completed Form WH-382 provides an easy method of providing employees with the written information required by 29 C.F.R. §§ 825.300(c), 825.301, and 825.305(c).

To: Salvatore Ziccarelli- Ex Ops #386581

Date: December 29, 2015

We have reviewed your request for leave under the FMLA and any supporting documentation that you have provided. We received your most recent information on December 24, 2015 and decided:

_X_ **Your FMLA leave request is approved. All leave taken for this reason will be designated as FMLA leave.**

The FMLA requires that you notify us as soon as practicable if dates of scheduled leave change or are extended, or were initially unknown. Based on the information you have provided to date, we are providing the following information about the amount of time that will be counted against your leave entitlement:

_____ Provided there is no deviation from your anticipated leave schedule, the following number of hours, days, or weeks will be counted against your leave entitlement: _

_X_ Because the leave you will need will be unscheduled, it is not possible to provide the hours, days, or weeks that will be counted against your FMLA entitlement at this time. You have the right to request this information once in a 30-day period (if leave was taken in the 30-day period). **Approved: INT/S, January 28, 2016, Up to 7 episodes a month, up to 1 day per episode**

Please be advised (check if applicable):

_____ You have requested to use paid leave during your FMLA leave. Any paid leave taken for this reason will count against your FMLA leave entitlement.

_____ We are requiring you to substitute or use paid leave during your FMLA leave.

____ You will be required to present a fitness-for-duty certificate to be restored to employment. If such certification is not timely received, your return to work may be delayed until certification is provided. A list of the essential functions of your position ___ **is** ___ **is not** attached. If attached, the fitness-for-duty certification must address your ability to perform these functions.

___ **Additional information is needed to determine if your FMLA leave request can be approved:**

___ The certification you have provided is not complete and sufficient to determine whether the FMLA applies to your leave request. You must provide the following information no later than _____, unless it is not
(Provide at least seven calendar days)
practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied.

_____
(Specify information needed to make the certification complete and sufficient)

_____

___ We are exercising our right to have you obtain a second or third opinion medical certification at our expense, and we will provide further details at a later time.

_____ Your FMLA Leave request is Not Approved.

_ The FMLA does not apply to your leave request.

_ You have exhausted your FMLA leave entitlement in the applicable 12-month period.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

It is mandatory for employers to inform employees in writing whether leave requested under the FMLA has been determined to be covered under the FMLA. 29 U.S.C. § 2617; 29 C.F.R. §§ 825.300(d), (e). 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 10 – 30 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.**

Form WH-382 January 2009

2015 DEC 24 AM 9:32

COOK COUNTY
DEPT. OF CORRECTIONS
PERSONNEL

COOK COUNTY SHERIFF'S OFFICE
BUREAU OF HUMAN RESOURCES
3026 South California Avenue, Building 2, First Floor, Room 118
Chicago, IL 60608
PHONE NUMBER: 773-674-8407 FAX NUMBER: 773-674-8168

FAMILY AND MEDICAL LEAVE OF ABSENCE (FMLA) REQUEST

12-21-14/15=1907

INSTRUCTIONS:

1. **Each section must be completed as part of the approval process. Please initial the appropriate FMLA section.**
2. **You have 15 days in which to return the completed forms to HR Employee Services. All incomplete packets will be returned to you and will cause a delay in processing.**
3. **Only original HR/FMLA forms will be accepted.**
4. **Only a Health Care Provider can complete the Certification of Health Care Provider Form.**

SECTION 1 – FMLA Request:

I am requesting a leave of absence under the Cook County Sheriff's Office Family and Medical Leave of Absence Policy (Number 07-3). I am responsible for ensuring the completion of the FMLA forms and providing any other documentation as required under the policy. I understand and agree to the terms set forth I the County's policy. I am requesting the absence for the following reasons (initial your section):

N/A The birth of my child and and/or care of my newborn child. My child was born/is expected to be on N/A (date).

N/A The placement of a child, with me for adoption/foster care. This placement will take place on N/A (date).

N/A To care for my child, spouse, or parent (please circle one) who has a serious health condition. Proof of relationship is required (i.e., copy of marriage license or birth certificate) is required.

X To care for my own serious health condition which makes me unable to perform the essential functions of my job.

N/A To care for a family member who is a service member of the Armed Forces who was injured or ill while on active military duty.

N/A For any qualifying exigency (necessity) that arises out of a covered military member (spouse, son, daughter or parent) beig on active duty or called u to active duty.

SECTION 2 – FMLA leave and duration request:

I am requesting the following type of leave and duration (initial your selection):

___ A single period of absence from _____ (Start Date) to _____ (Expected End Date). A single period of absence is taken I a single period of time not to exceed twelve (12) workweeks in a twelve (12) month period, taken for one occurrence.

✓ An Intermittent Leave: Probable frequency (i.e., 1-2 days a week, month, year) 3-7 days per month 1-8 hrs per episode. An intermittent leave is taken in separate blocks of time due to a single qualifying reason. FMLA leave may be taken whenever medically necessary to care for a family member with a serious health condition or because the employee is unable to work due to their own serious medical condition.

___ Reduced Schedule Leave: Reduced hours per work day or work week _____. A reduced schedule leave reduces an employee's usual number or working hours per work week or hours per work day. A reduced schedule must be provided. (Note: Flex time is not a reduced schedule leave).

1-27-16

SECTION 3 – Health Insurance Premium:

✓ I agree that I am responsible for my portion of the health premium incurred while on disability leave should I decide to use this leave while on FMLA. The Department of Risk will bill me directly for my portion of the health premium.

✓ I agree that if I do not return to work for at least thirty (30) calendar days after the completion of my leave, except when I cannot return because of a serious health condition, the County will seek to recoup its share of any health insurance premium incurred during my leave. I also agree that, apart from any Federal, State or Local wage payment or other laws limiting the about that can be deducted from paycheck(s); I will owe the County the full amount of any health insurance premium payments that remains unpaid after the paycheck deductions(s).

SECTION 4 – Explanation of Contractual rights under FMLA:

✓ I understand that this Agreement is not intended to create any contractual rights for continued employment.

SECTION 5 – COBRA Benefit Time Period:

✓ I understand that if I fail to return from work at the end of my leave and my employment relationship with Cook County might be subject to termination, the period of time on my leave will be applied towards COBRA benefit period.

SECTION 6 – FMLA Fraud:

✓ I certify that all information in this FMLA Request and on any other documents is true and complete. I understand that if my FMLA request is approved, any false information, omissions, or misrepresentations made on this FMLA request or any other documents I have submitted during the process may result in the denial of my FMLA request and disciplinary action up to and including termination. In consideration of my FMLA request, I agree to follow the department rules and regulations. I acknowledge that I have received a copy of the Family and Medical Leave Policy (Number 07-3) and that I understand I must abide by its provisions,

SECTION 7 – FMLA Re-certification:

✓ I understand that this FMLA request may be approved for one of the leaves in Section 1. Re-certification will be requested after thirty days (30) and after six (6) months if the FMLA is being utilized is for a different type of FMLA leave and/or duration.

SECTION 8 – Approval to contact Health Care Provider:

✓ In order to expedite my FMLA, I understand that it may be necessary to contact the Health Care Provider for clarification or authentication. I am granting authority to do so by signing this FMLA request.

EMPLOYEE NAME (print): SALVATORE ZICCARELLI EMPLOYEE SIGNATURE: [signature]

This signature acknowledges my receipt and understanding of the Family and Medical leave of Absence Request.

DATE OF REQUEST: 12-21-2015	JDE: 386581
DEPARTMENT/ASSIGNMENT: C.C.D.O.C / EXOPS	WORK SHIFT/RDO DETAIL: 2-10 - Group-7
PHONE: 1-708-299-3099	EMAIL: Sal2352@hotmail.com

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

U.S. Department of Labor
Wage and Hour Division

WHD

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

OMB Control Number: 1235-0003
Expires: 5/31/2018

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: _____

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions: _____

_____

Check if job description is attached:

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 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).

Your name: SALVATORE (First) ICCARELLI (Last)

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b). Please be sure to sign the form on the last page.

Provider's name and business address: Asima Doriwala
Loyola Center for Health at North Riverside
1950 S. Harlem Avenue
North Riverside, IL 60546

Type of practice / Medical specialty: Internal Medicine

Telephone: (708) 354-9250 Fax: (708) 354-8765

PART A: MEDICAL FACTS

1. Approximate date condition commenced: 2003

Probable duration of condition: Lifetime

Mark below as applicable:
Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
X No ___ Yes. If so, dates of admission:

Date(s) you treated the patient for condition:
10/13/15

Will the patient need to have treatment visits at least twice per year due to the condition? ___ No X Yes.

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

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
X No ___ Yes. If so, state the nature of such treatments and expected duration of treatment:

2. Is the medical condition pregnancy? ___ No ___ Yes. If so, expected delivery date: ___

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition: X No ___ Yes.

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

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

Right lower extremity DVT causing pain in lower extremity and impeding ability to walk.
Right Shoulder injury preventing repetitive motion with right shoulder and arm
PTSD and anxiety requiring time off from work due to anxiety and flashbacks, lack of concentration

CONTINUED ON NEXT PAGE

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? X No ___ Yes.

   If so, estimate the beginning and ending dates for the period of incapacity: _____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? X No ___ Yes.

   If so, are the treatments or the reduced number of hours of work medically necessary?
   ___ No ___ Yes.

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   _____

   Estimate the part-time or reduced work schedule the employee needs, if any:

   _____ hour(s) per day; _____ days per week from _____ through _____

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

   Is it medically necessary for the employee to be absent from work during the flare-ups?
   ___ No ___ Yes. If so, explain:

   Pain and anxiety impede walking, repetitive use of right arm, and concentration / focus

   Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

   Frequency: 3-7 times per ___ week(s) ___ month(s)

   Duration: 1-8 hours or ___ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

Signature of Health Care Provider

12/23/15
Date

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**

SHERIFF'S OFFICE OF COOK COUNTY, ILLINOIS

HUMAN RESOURCES

EMPLOYEE SERVICES DEPARTMENT

Building 2, Room 118 – South Campus

3026 South California Avenue

Chicago, IL 60608

PHONE NUMBER: 773-674-8407 FAX NUMBER: 773-674-8168

HEALTH CARE PROVIDER INFORMATION

Asima Doriwala
Signature of Health Care Provider

Asima Doriwala
Print Name

[redacted]
City, State, Zip Code

Internal Medicine
Type of Practice

036 134406
Medical License No.

708-354-9250
Telephone Number

12/23/15
Date