

American Postal Workers Union, AFL-CIO

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Greg Bell, Director
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July 22, 2009

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Via Facsimile & First-class Mail

Mr. Alan S. Moore, Manager
Labor Relations Policy and Programs
United States Postal Service
475 L'Enfant Plaza SW, Room 9318
Washington DC 20260-4110

Re: Family and Medical Leave (FMLA) Certification Format

Dear Mr. Moore:

I am writing in response to your letter of June 9, 2009, in regard to the above-referenced subject. In your letter, you state that you have determined that there are "omissions that render the union's forms not equivalent to the Department of Labor (DOL) forms." Attached to your letter is a line-by-line comparison of the APWU forms with the DOL forms, including such minuscule items as the failure of the APWU forms to include language found in the "Paperwork Reduction Act Notice and Public Burden Statement".

As you know, the DOL WH-380 forms are *optional* forms. While the DOL created the WH-380 forms as a sample format, the law expressly allows employees to submit their medical certifications in any format, provided it contains the same basic information required under 29 C.F.R. 825.306. Although the APWU forms do not mirror the WH-380 forms word-for-word, the APWU forms do reflect the same basic FMLA medical certification requirements so as to permit the health care provider to furnish appropriate medical information in accordance with the law. Even a note from the health care provider in narrative format would suffice as acceptable medical certification under the law if it contains the same basic required information.

Enclosed for your review are the following sample documents: (1) a sample completed APWU Form 1 - certification for an employee's own serious health condition; (2) a sample completed APWU Form 2 - certification for a family member's serious health condition; (3) a sample certification for an employee's own serious health condition in narrative format; and (4) a sample certification for a family member's serious health condition in narrative format. Each of these completed sample documents constitutes a complete and sufficient

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medical certification that is fully acceptable under the law. If upon your review, you decide that you disagree with our position, please specify for each enclosed sample document what additional information is required pursuant to the FMLA.

Additionally, regardless of what format an employee uses for medical certification, if a medical certification is incomplete or insufficient, the Postal Service is required to explain to the employee in writing what additional information is necessary to make the certification complete and sufficient, and give the employee an opportunity to submit the additional required information.

Moreover, once an employee has submitted an APWU form for FML documentation, or a certification in any other format, there is no need or requirement to use a different form/format to submit any additional required information. The employee may, for example, have their health care provider write the additional required information on their original certification, or have the health care provider attach a note containing the additional required information.

Thank you for your cooperation in this matter. Should you have any questions concerning this matter, please contact me at (202) 842-4273.

Sincerely,


Greg Bell, Director
Industrial Relations

Enclosures

cc: William Burrus
John W. Dockins

GB/PH:jm
OPEIU #2
AFL-CIO

CERTIFICATION BY EMPLOYEE'S HEALTH CARE PROVIDER FOR EMPLOYEE'S SERIOUS ILLNESS - FMLA

This form is to be completed by employee's Health Care Provider when employee is requesting FMLA and medical documentation is required pursuant to 512.41, 513.36 and 515.5 of the ELM. Form PS 3971 must be completed by employee.

Employee's name JOHN SMITH

Description of serious health condition (On the back of this form is the description of a "serious health condition" under FMLA. Does the patient's condition qualify under any of the categories described? If so, please check the applicable category. In all instances the information on the form must relate only to the serious health condition for which the current need for leave exists.

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

Describe the medical facts and/or treatment that meet the criteria of the serious health condition checked above (Medical diagnosis/prognosis is not required): THE PATIENT IS BEING TREATED FOR A CHRONIC PULMONARY CONDITION WITH RX MEDS AND VISITS EVERY 3 MONTHS

Date condition commenced: 2005
Probable duration of condition: LIFETIME
Probable duration of present incapacity (if different): APRIL 1 - APRIL 3

Will the employee require leave on an intermittent or reduced schedule basis for planned medical treatment (e.g. follow-up treatment) of the employee's serious health condition, including pregnancy? Yes _____ No

If so, please provide an estimate of the dates and duration of such treatment and any period(s) of recovery:

Dates: JULY 17, 2009 AND OCT. 9, 2009

Duration: 2-4 hour(s) or _____ day(s) per episode.

Period of Recovery: IMMEDIATE

Will the employee require leave on an intermittent or reduced schedule basis for the employee's serious health condition, including pregnancy, that may result in unforeseeable episodes of incapacity (e.g. flare ups)? Yes _____ No

If so, please provide an estimate of the frequency and duration of such episodes of incapacity (e.g. 3 times per 1 month lasting 1-2 days):

Frequency: 1 times per 4 week(s) 6 month(s):

Duration: 8-40 hour(s) or 1-5 day(s) per episode.

Is the employee able to perform the essential functions of employee's position? YES If no, describe the physical restrictions placed on the employee, including the duration of such restrictions.

Health Care Provider's Name (Please print): JEFF JONES

Health Care Provider's Signature: S/ JEFF JONES

Date: 4/5/09

Address: 123 MAIN STREET, DALLAS TX 78220

Phone number: 123-456-7890

Fax number: 456-789-1234

Specialty/Type of Practice: INTERNAL MEDICINE

HEALTH CARE PROVIDER CERTIFICATION OF EMPLOYEE'S FAMILY MEMBER SERIOUS ILLNESS – FMLA

Employee's name DAVID STARK

Patient's name MARY STARK

Relationship to employee Spouse Parent Child (under age 18 or if older and incapable of self care due to a mental or physical disability)

Description of serious health condition (On the back of this form is the description of a "serious health condition" under FMLA. Does the patient's condition qualify under any of the categories described? If so, please check the applicable category. In all instances the information on the form must relate only to the serious health condition for which the current need for leave exists.

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

Describe the medical facts and/or treatment that meet the criteria of the category checked above (Medical diagnosis/prognosis is not required). THE PATIENT WAS SEEN BY ME TODAY AND TREATED FOR A LEG FRACTURE. SHE WILL BE ON PRESCRIBED MEDICATION FOR 10 DAYS. FOLLOW UP VISIT IN 6 WEEKS.

Date condition commenced: MAY 3, 2009 Probable duration of condition: 6-8 WEEKS

Probable duration of present incapacity (if different): MAY 3-8, 2009

Does the patient require assistance for basic medical, hygiene, nutritional needs, safety, or transportation? Yes No
If no, would the employee's presence to provide psychological comfort be beneficial to the patient's recovery?

Note the probable duration of the need. _____

Will the employee require leave on an intermittent or reduced schedule basis for planned medical treatment of the family member's serious health condition (e.g. follow-up treatment)? Yes No

If so, please provide an estimate of the dates and duration of such treatment and any period(s) of recovery:

Dates: JULY 19, 2009

Duration: 4-8 hour(s) or 1 day(s) per episode.

Period of Recovery: 1 DAY

Will the employee require leave on an intermittent or reduced schedule basis for the family member's serious health condition, that may result in unforeseeable episodes of incapacity (e.g. flare ups)? Yes No

If so, please provide an estimate of the frequency and duration of such episodes of incapacity (e.g. 3 times per 1 month lasting 1-2 days):

Frequency: 1-2 times per 4 week(s) 2 month(s):

Duration: 4-8 hour(s) or _____ day(s) per episode.

If the employee requires leave on an intermittent or reduced schedule basis to care for a covered family member with a serious health condition, briefly explain why such care is medically necessary (this can include assisting in the family member's recovery).

MR. STARK WILL NEED TO STAY HOME WITH HIS WIFE FOR THE FIRST WEEK AS SHE WILL NOT BE VERY MOBILE AND WILL NEED HIS ASSISTANCE.

Health Care Provider's Name (Please print): JEFFREY MARTIN, MD

Health Care Provider's Signature: S/ JEFFREY MARTIN, MD

Date: MAY 3, 2009

Address: 65 WASHINGTON AVE CAMBRIDGE, MA 02138

Phone number: 772-999-9999

Fax number: 772-999-8888

Specialty/Type of Practice: ORTHOPEDIST

Joe Jones, M.D.
Internal Medicine
29 Main Street
Dalas, TX 78220
Office # 235-555-1111
Fax # 235-555-1112

April 5, 2009


FMLA Supervisor USPS
Postal Facility
Anywhere, USA 01230

To Whom It May Concern:

Please be advised that today I treated your employee John Smith. I have been treating John since 2005 for a chronic pulmonary condition that he will have for the rest of his life. I am currently treating him with prescription meds and follow up visits every 3 months. Accordingly, John will need to be off from work for 2-4 hours on 7/17/09 and 10/9/09 to receive these treatments.

While he is expected to recover from this latest episode within the next three days, John's condition is prone to cause periodic episodes of incapacity. These flare ups can last 1-5 days each time they occur. Based on his history, these incidents may occur on a monthly basis over the next 6 months. Despite these occasional periods of incapacity, John can fully perform his job duties. Thank you for your understanding.

Very truly yours,



Joe Jones, MD

Joe Jones, MD

Jeffrey Martin, M.D.
Orthopedist
65 Washington Ave.
Cambridge, MA 02138
Office # 772-999-9999
Fax # 772-999-8888

May 3, 2009

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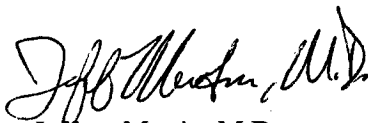
To Whom It May Concern:

Please be advised that today I treated Mary Stark, the wife of your employee David Stark. Mary was seen by me today and treated for a leg fracture. She will be on prescribed medication for 10 days and she will return to my office for a follow-up visit in 6 weeks.

Mary's leg fracture occurred this morning and it will take a total of 6-8 weeks to heal. Mary requires complete bed rest for the next 5 days. She will require assistance from her husband during that time for basic medical, hygiene, nutritional needs, etc.

David will also need to be off from work for 4-8 hours on July 19, 2009 to take Mary to her follow up visit. He will also require intermittent leave 1-2 times per month over the next 2 months to further assist with her recovery as her leg fracture may cause flare ups of pain lasting 4-8 hours per episode. Thank you for your understanding.

Very truly yours,


Jeffrey Martin, M.D.