



# City of Westfield, Massachusetts

## Personnel Department

### CITY OF WESTFIELD FAMILY MEDICAL LEAVE ACT POLICY (FMLA)

#### POLICY

It is the policy of the City of Westfield to implement and administer the provisions of the Family and Medical Leave Act of 1993. This law entitles eligible workers to 12 workweeks of unpaid leave during a 12-month period and is intended to balance the demands of the workplace with the needs of families, to promote the stability and economic security of families, to promote national interests in preserving family integrity and to entitle employees to take reasonable leave for qualifying reasons.

#### DEFINITIONS

Eligible Employee – An employee that has been employed for at least 12 months and has worked at least 1,250 hours during the previous 12 months.

The 12-month period - The eligible period for leave shall be measured by rolling backward from the date an employee uses FMLA leave.

Substitution – paid leave (vacation, sick, personal time) runs concurrently with FMLA leave and the normal terms and conditions of paid leave policies apply.

Qualifying events - The law provides for four circumstances under which an eligible employee is entitled to family leave.

1. Birth of a son or daughter and to be with the healthy child after the birth; leave must be completed by the end of the 12-month period beginning on the date of the birth.
2. Placement of a son or daughter with the employee for adoption or foster care; leave must be completed by the end of the 12-month period beginning on the date of the placement.
3. In order to care for the employee's spouse, son, daughter or parent with a "serious health condition"; or,
4. Because of the employee's own "serious health condition" that makes the employee unable to perform the functions of the employee's job.

### Qualifying Family Members –

1. Parent – a biological, adoptive, step or foster father or mother, or someone who stood “in loco parentis” to the employee when the employee was a son or daughter. Parent for FMLA purposes does not include in-laws.
2. Spouse – a husband or wife as defined or recognized under state law for purposes of marriage in the state where the employee resides, including common law marriage and same-sex marriage.
3. Son or Daughter – for leave other than military family leave, a biological, adopted, or foster child, a stepchild, a legal ward, or a child of a person standing “in loco parentis” who is either under 18 years of age, or 18 or other and incapable of self-care because of a mental or physical disability. An employee’s “child” is one for whom the employee has responsibility for the actual day-to-day care and includes a biological, adopted, foster or step-child.

Limitation - Entitlement to leave for the birth or placement of a child (1) and (2) above, expires at the end of the 12-month period beginning on the date of such birth or placement.

Serious Health Condition - An illness, injury, impairment, or physical or mental condition that involves either:

1. An overnight stay in a medical care facility; or
2. Continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee’s job or prevents the qualified family member from participating in school or other daily activities.

Continuing Treatment – May be met by:

1. A period of incapacity of more than three (3) consecutive calendar days combined with at least two (2) visits to a health care provider or one visit and a regimen of continuing treatment; or
2. Incapacity due to pregnancy; or
3. Incapacity due to a chronic condition.
4. Other permanent/long-term conditions
5. Absence to receive multiple treatments; restorative surgery after an accident/injury; for conditions that, if left untreated, would likely result in incapacity of more than three consecutive, full calendar days.

### Intermittent or Reduced Leave –

- A. An employee may take leave intermittently (a few days or a few hours at a time) or on a reduced leave schedule (1) to care for an immediate family member with a serious health condition or because of a serious health condition of the employee when “medically necessary”. (2) Covered service member’s serious injury or illness when the leave is medically necessary. Or (3) a qualifying exigency arising out of a military member’s covered active duty status.
  - 1. “Medically necessary” means there must be a medical need for the leave and that the leave can best be accomplished through an intermittent or reduced leave schedule.
  - 2. The employee may be required to transfer temporarily to a position with equivalent pay and benefits that better accommodates recurring periods of leave when the leave is planned based on scheduled medical treatment.
- B. For part-time employees and those who work variable hours, the family and medical leave entitlement is calculated on a pro rata basis. A weekly average of the hours worked over the 12 weeks prior to the beginning of the leave should be used for calculating the employee’s normal work week.
- C. Family Medical Leave and leave for identical purposes must be concurrent.
- D. An employee granted a Family Medical Leave for the purpose of giving birth to a child or for his/her own serious health condition must first use available sick leave followed by vacation leave. For the purpose of paternity leave, the placement of a child for adoption, foster care, or to care for his/her spouse, son, daughter, or parent with “a serious health condition” an employee must use any and all available vacation leave. The employee may reserve personal time for later use.
- E. Leave to bond with a child after the birth or placement must be taken as a continuous block of leave.

### Procedures:

#### Notice Requirement

- A. An employee must provide sufficient information to make the City aware of the need for FMLA-qualifying leave, specifically referencing the qualifying reason or need for FMLA leave. An employee is required to give 30 days’ notice in the event of a foreseeable leave. A “Request for Family/Medical Leave” form (see Attachment A) should be completed by the employee and returned to the Personnel Department. In unexpected or unforeseeable situations, an employee should provide as much notice as is practicable, usually verbal notice within one or two business days of when need for leave becomes known, followed by a completed “Request for Family/Medical Leave” form.

- B. If an employee fails to give 30 days' notice for a foreseeable leave with no reasonable excuse for the delay, the leave will be denied until 30 days after the employee provides notice.
- C. Within five (5) business days of a leave request or knowledge that leave may be FMLA-qualifying, employer must notify employee of eligibility. If employee is not eligible, employer must provide a reason for denial.

#### Medical Certification

- A. For leaves taken because of the employee's or a covered family member's serious health condition, the employee must submit a completed "Certification of Health Care Provider" form (see Attachment B) to support the need for leave and return the certification to the Personnel Department. Medical certification must be provided by the employee within 15 days after requested, unless it is not practicable to do so under the circumstances despite the employee's good faith efforts and diligence.
- B. The City of Westfield may require a second or third opinion (at employer's expense), periodic reports on the employee's status and intent to return to work, and a fitness-for-duty report to return to work.
- C. All documentation related to the employee's or family member's medical condition will be held in strict confidence and maintained in the employee's medical records file.
- D. The City of Westfield may deny FMLA until certification is received.

#### EFFECT OF BENEFITS

- A. An employee granted a leave under this policy will continue to be covered under the City of Westfield's group health insurance plan and life insurance plans under the same conditions as coverage would have been provided if they had been continuously employed during the leave period.
- B. Employee contributions will be required either through payroll deduction or by direct payment to the Benefit's Office. The employee will be advised in writing at the beginning of the leave period as to the amount and method of payment. Employee contribution amounts are subject to change in rates that occur while the employee is on leave.
- C. If an employee's contribution is more than 30 days late, the Personnel Department may terminate the employee's insurance coverage.
- D. If the City of Westfield pays the employee contributions missed by the employee while on leave, the employee will be required to reimburse the Employer for delinquent payments (on a payroll deduction schedule) upon return from leave. The employee will be required to sign a written statement at the beginning of the leave period authorizing the payroll deduction for delinquent payments.

- E. If the employee fails to return from the unpaid family/medical leave for reasons other than (1) the continuation, reoccurrence or onset of a serious health condition of the employee or a covered family member that would otherwise entitle the employee to leave under the FMLA or (2) circumstances beyond the employee's control (certification required within 30 days of failure to return for either reason) the City of Westfield may seek reimbursement from the employee for the portion of the premiums paid by the same on behalf of that employee (also known as the employer contribution) for the period following the 12 week leave.
- F. An employee is not entitled to seniority or benefit accrual during periods of unpaid leave but will not lose anything accrued prior to leave.

V. JOB PROTECTION

- A. If the employee returns to work within the 12 weeks of the family/medical leave, he/she will be reinstated, to his/her former position or an equivalent position with equivalent pay, benefits, status and authority.
- B. The employee's restoration rights are the same as they would have been had the employee not been on leave. Thus, if the employee's position would have been eliminated or the employee would have been terminated but for the leave, the employee would not have the right to be reinstated upon return from leave.
- C. If the employee fails to return after 12 weeks of a family/medical leave, the employee will be terminated, unless reinstated to his/her same or similar position in accordance with applicable laws, other leave-related policies, Civil Service rules and/or appropriate bargaining unit contract language.



Brian P. Sullivan

Dated: 4-30-18

# Employee FMLA Leave Request

(Family/Medical Leave Request Form)

Eligible employees are entitled under the Family and Medical Leave Act (FMLA) to take up to 12 or 26 weeks of job-protected leave for certain family and medical reasons. Submit this request form to your human resources manager at least 30 days before the leave is to begin, when possible. When 30 days' advance submission of the request form is not possible, submit the request as soon as possible. Our Company reserves the right to deny or postpone leave if you do not give adequate notice when permitted under federal and/or state law.

## **Employee Information**

Please print.

Name: \_\_\_\_\_ Employee ID #: \_\_\_\_\_

Department: \_\_\_\_\_ Job Title: \_\_\_\_\_

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Hire Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Supervisor: \_\_\_\_\_

Status:  Full-Time  Part-Time  Temporary

## **Reason for Requesting Leave**

I am requesting family/medical leave for the following reasons: (check all that apply)

- Birth of my child; to care for my newborn child
- Placement of a child with me for  adoption  foster care
- Leave to care for a family member with a serious health condition

Relationship of family member to you: \_\_\_\_\_

- My own serious health condition
- Qualifying exigency because a family member is on or has been called to covered active duty in the Regular Armed Forces (including the National Guard and Reserves) to a foreign country

Relationship of family member to you: \_\_\_\_\_

- Leave to care for a family member who is a current member of the Armed Forces (including the National Guard and Reserves) or a covered veteran and who is undergoing medical treatment, recuperation, or therapy, is in outpatient status or on temporary disability retired list for a serious injury or illness

Relationship of family member to you: \_\_\_\_\_

- Other (please explain) \_\_\_\_\_

## **Duration of Leave**

Leave expected to begin: \_\_\_\_/\_\_\_\_/\_\_\_\_ Leave expected to end: \_\_\_\_/\_\_\_\_/\_\_\_\_

If intermittent or reduced-leave schedule is being requested, please explain why it is needed and the proposed leave schedule:

\_\_\_\_\_  
\_\_\_\_\_

## **Employee Certification and Signature**

I certify that the above information is true and correct to the best of my knowledge:

Employee signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

EMPLOYER: This form should be treated as a medical record and must be maintained separately from employee personnel files, in locked cabinets with only designated personnel having access. As an employer, you should retain this original and provide a photocopy of the form to your employee along with the Company Response form within a reasonable period of time.

This product is designed to provide accurate and authoritative information. However, it is not a substitute for legal advice and does not provide legal opinions on any specific facts or services. The information is provided with the understanding that any person or entity involved in creating, producing or distributing this product is not liable for any damages arising out of the use or inability to use this product. You are urged to consult an attorney concerning your particular situation and any specific questions or concerns you may have.

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



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. 29 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: \_\_\_\_\_  
First Middle 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: \_\_\_\_\_

Type of practice / Medical specialty: \_\_\_\_\_

Telephone: (\_\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_

**PART A: MEDICAL FACTS**

1. Approximate date condition commenced: \_\_\_\_\_

Probable duration of condition: \_\_\_\_\_

**Mark below as applicable:**

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

No  Yes. If so, dates of admission:

\_\_\_\_\_

Date(s) you treated the patient for condition:

\_\_\_\_\_

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

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

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?

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:  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):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**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?  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?  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  Yes.

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

\_\_\_\_\_  
\_\_\_\_\_

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 : \_\_\_\_\_ times per \_\_\_\_\_ week(s) \_\_\_\_\_ month(s)

Duration: \_\_\_\_\_ hours or \_\_\_\_\_ day(s) per episode

**ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



Certification of Health Care Provider for  
Family Member's Serious Health Condition  
(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: 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 to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. 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' 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.

Employer name and contact: \_\_\_\_\_

**SECTION II: For Completion by the EMPLOYEE**

**INSTRUCTIONS to the EMPLOYEE:** Please complete Section II before giving this form to your family member or his/her 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 to care for a covered family member with a 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. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Your name: \_\_\_\_\_  
First Middle Last

Name of family member for whom you will provide care: \_\_\_\_\_  
First Middle Last

Relationship of family member to you: \_\_\_\_\_

If family member is your son or daughter, date of birth: \_\_\_\_\_

Describe care you will provide to your family member and estimate leave needed to provide care:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

**SECTION III: For Completion by the HEALTH CARE PROVIDER**

**INSTRUCTIONS to the HEALTH CARE PROVIDER:** The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. 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 patient needs leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e). Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address: \_\_\_\_\_

Type of practice / Medical specialty: \_\_\_\_\_

Telephone: ( \_\_\_\_\_ ) \_\_\_\_\_ Fax: ( \_\_\_\_\_ ) \_\_\_\_\_

**PART A: MEDICAL FACTS**

1. Approximate date condition commenced: \_\_\_\_\_

Probable duration of condition: \_\_\_\_\_

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

No  Yes. If so, dates of admission: \_\_\_\_\_

Date(s) you treated the patient for condition: \_\_\_\_\_

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

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

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PART B: AMOUNT OF CARE NEEDED:** When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care.

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery?  No  Yes.

Estimate the beginning and ending dates for the period of incapacity: \_\_\_\_\_

During this time, will the patient need care?  No  Yes.

Explain the care needed by the patient and why such care is medically necessary:

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5. Will the patient require follow-up treatments, including any time for recovery?  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:

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Explain the care needed by the patient, and why such care is medically necessary: \_\_\_\_\_

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6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery?  No  Yes.

Estimate the hours the patient needs care on an intermittent basis, if any:

\_\_\_\_\_ hour(s) per day; \_\_\_\_\_ days per week from \_\_\_\_\_ through \_\_\_\_\_

Explain the care needed by the patient, and why such care is medically necessary:

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7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? \_\_\_ No \_\_\_ Yes.

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: \_\_\_ times per \_\_\_ week(s) \_\_\_ month(s)

Duration: \_\_\_ hours or \_\_\_ day(s) per episode

Does the patient need care during these flare-ups? \_\_\_ No \_\_\_ Yes.

Explain the care needed by the patient, and why such care is medically necessary: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Signature of Health Care Provider**

\_\_\_\_\_  
**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.**