GRCC Memorandum

TO: GRCC Employee
FROM: Human Resources
SUBJECT: Family Medical Leave Act (FMLA) Information

Attached is information on the **Family and Medical Leave Act of 1993**. Employees are eligible if they have worked for Grand Rapids Community College at least 12 months, and have worked at least 1,250 hours over the past 12 months. Various medical conditions are appropriate for Family and Medical Leave, such as continuing treatment for chronic or long-term medical conditions.

If FMLA leave is appropriate for you, please complete the **Family and Medical Leave Request** form before you begin your leave. This form needs to be complete with your signature and the signature of your supervisor. Return to the Human Resources FMLA Coordinator.

Also, complete the top portion of the front page of the **Certification of Health Care Provider** form. Include the employee's name and department, or if applicable, the patient's name and relationship to the employee. The attending physician must complete the remainder of the form. Once this form is completed by your physician, please return to the Human Resources FMLA Coordinator.

If you have any questions regarding payroll deductions while on FMLA, please call (616) 234-4038.

Human Resources
Phone: (616) 234-3972
Fax: (616) 234-3907
hr@grcc.edu

GRCC Family Medical Leave (FMLA) Policy

FAMILY MEDICAL LEAVE POLICY (FMLA)

I. Policy Section
6.0 Personnel

II. Policy Subsection
6.14 Family Medical Leave Policy

III. Policy Statement
Grand Rapids Community College will abide by all regulations set forth under the Family Medical Leave Act and will grant up to 12 weeks of job-protected leave in a 12 month period for qualified medical reasons.

IV. Reason for Policy
FMLA requires covered employers (employers with 50 or more employees) to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:
A. Incapacity due to pregnancy, prenatal medical care, or childbirth
B. To care for the employee's child after birth, or placement for adoption or foster care
C. To care for the employee's spouse*, domestic partner**, son, daughter or parent, who has a serious health condition or
D. A serious health condition that makes the employee unable to perform the employee's job
E. Qualifying exigency leave for military service
F. Military caregiver leave to care for an injured or ill service member or veteran

*Note: As of March 27, 2015, workers in legal, same-sex marriages, regardless of where they live, have the same rights as those in opposite-sex marriages to federal job-protected leave under the FMLA to care for a spouse with a serious health condition.

**Note: Effective January 1, 2016, the domestic partner program expands eligibility criteria for enrollment in specific Grand Rapids Community College's benefit plans. Under the Family Medical Leave Act (FMLA) domestic partners will be treated the same as spouse.

V. Entities Affected by this Policy
All eligible GRCC Employees that have worked 1250 hours during the past 365 days.

VI. Who Should Read this Policy?
All GRCC Staff and Faculty.

VII. Related Documents
grcc.edu/FMLA

VIII. Contacts
Policy Owner: Human Resources Payroll and FMLA Coordinator
Executive Director of Human Resources
Human Resources Generalists
Director of Equal Opportunity Compliance

IX. Definitions
A. FMLA: Family and Medical Leave Act is a Federal law that provides "eligible" employees of a covered employer the right to take up to 12 workweeks of unpaid, job-protected leave, during any fiscal year. Eligible employees must have worked at least 1,250 hours over the previous 12 months.
B. Serious Health Condition(s): Serious health condition means an illness, injury, impairment or physical or mental condition that involves either:
1. Inpatient care (i.e., an overnight stay) in a hospital.
2. Continuing treatment by a health care provider.
i. Any period of incapacity related to pregnancy or for prenatal care. A visit to the health care provider is not necessary for each absence.
ii. Any period of incapacity or treatment for a chronic serious health condition, which continues over an extended period of time, requires periodic visits (at least twice a year) to a health care provider, and may involve occasional episodes of incapacity. A visit to a health care provider is not necessary for each absence.
iii. A period of incapacity that is permanent or long-term due to a condition for which treatment may not be effective. Only supervision by a health care provider is required, rather than active treatment.

iv. Any absences to receive multiple treatments for restorative surgery or for a condition that would likely result in a period of incapacity of more than three days if not treated.
v. Any continuing treatment by a health care provider, which includes a period of incapacity of more than three consecutive calendar days that results in a regimen of continuing treatment under the supervision of a healthcare provider (e.g., a course of prescription drugs, physical therapy). Unless complications arise, the common cold, flu, upset stomach, headaches, routine dental problems and cosmetic treatments do not meet the definition of a "serious health condition."

C. Qualifying Exigency Leave: This leave applies to employees that are members of the National Guard or Reserves or of a regular component of the Armed Forces when the covered military member is on covered active duty or called to covered active duty. The qualifying exigency must be one of the following:
1. Short-notice deployment
2. Military events and activities
3. Child care and school activities
4. Financial and legal arrangements
5. Counseling
6. Rest and recuperation
7. Post-deployment activities and
8. Additional activities that arise out of active duty, provided that the employer and employee agree, including agreement on timing and duration of the leave.

D. Covered active duty: A member of the Armed Forces (including a member of the National Guard or Reserves) who is undergoing recuperation for a serious injury or illness; or a veteran who is undergoing recuperation for a serious injury or illness and who was a member of the Armed Forces (including a member of the National Guard or Reserves) at any time during the preceding period of five years.

E. Military Caregiver Leave: MCL, also known as covered service member leave, are leaves to care for an injured or ill service member or veteran. These leaves may extend up to 26 weeks in a 12 month period.

F. Twelve-month Period Method: The College will measure the 12-month period as a fixed 12-month period measured at the beginning of each fiscal year (July 1 through June 30) each time an employee uses any leave under this policy. Eligible employees may take up to twelve (12) weeks of leave during the 12-month Fiscal Year (July 1 through June 30) period for a purpose that qualifies for a leave under the FMLA Policy. For military caregiver leaves, the 12 month period is not defined by the employer under a calendar or fixed or rolling year, but rather is defined as a rolling year beginning on the first day of leave. FMLA leave already taken for other FMLA circumstances will be deducted from the total of 26 weeks available.

X. Procedures

A. All employees requesting FMLA leave must provide verbal or written notice of the need for the leave to Human Resources. When the need for the leave is foreseeable, the employee must provide Human Resources with at least 30 days' notice. When an employee becomes aware of a need for FMLA leave less than 30 days in advance, the employee must provide notice of the need for the leave either the same day or the next business day. When the need for FMLA leave is not foreseeable, the employee must comply with GRCC's usual and customary notice and procedural requirements for requesting leave, absent unusual circumstances.

B. Within five business days after the employee has provided this notice, Human Resources will complete and provide the employee with the appropriate written notice of eligibility. In the event a qualified employee does not comply with GRCC's usual and customary notice and procedural requirements for requesting FMLA, and employer has enough information to determine that a period of incapacity of more than three consecutive days is for an FMLA qualifying reason, Human Resources will complete the appropriate documentation in its HRIS system, to designate leave as FMLA. Within five business days after the employee has submitted the appropriate certification form, the employee will be provided with a written response regarding their request for FMLA leave.

C. Employee Status and Benefits during Leave:
1. While an employee is on leave, the College will continue the employee's health benefits during the leave period at the same level and under the same conditions as if the employee had continued to work.
2. If the employee chooses not to return to work for reasons other than a continued serious health condition of the employee or the employee's family member or a circumstance beyond the employee's control, the College will require the employee to reimburse the amount it paid for the employee's health insurance premium during the leave period.
3. Under current College policy, the employee pays a portion of the health care premium. While on paid leave, the employer will continue to make payroll deductions to collect the employee's share of the premium.
4. While on unpaid leave, the employee must continue to make this payment, either in person or by mail. It is the employees' responsibility to submit timely monthly payments directly to the Benefits office in order to continue coverage while on an unpaid leave. If the payment is more than 30 days late, the employee's health care coverage may be dropped for the duration of the leave. The College will provide 15 days notification prior to the employee's loss of coverage.

5. If the employee contributes to a life insurance or disability plan, the employer will continue making payroll deductions while the employee is on paid leave. While the employee is on unpaid leave, the employee may request continuation of such benefits and pay his or her portion of the premiums, or the College may elect to maintain such benefits during the leave and pay the employee's share of the premium payments. If the employee does not continue these payments, the College may discontinue coverage during the leave. If the College maintains coverage, we may recover the costs incurred for paying the employee's share of any premiums, whether or not the employee returns to work.

D. Employee Status After Leave: An employee who takes leave under this policy, for their own serious health condition, will be asked to provide a fitness for duty (FFD) clearance from the health care provider. Notice of this requirement will be included in the employer's response to the FMLA request. Generally, an employee who takes FMLA leave will be able to return to the same position or a position with equivalent status, pay, benefits and other employment terms. GRCC may choose to exempt certain key employees from this requirement and not return them to the same or similar position.

E. Use of Paid and Unpaid Leave: An employee who is taking FMLA leave is required to use accrued but unused sick days to cover this period of absence. If the employee's FMLA leave continues after they have exhausted their available sick days, the remainder of the leave will be unpaid or they have the option to use accrued but unused vacation, personal business or compensatory time, or any available sick bank, if eligible. Sick leave may be run concurrently with FMLA leave if the reason for the FMLA leave is covered by the applicable contract or handbook provisions. Employees (CEBA, Meet & Confer, APSS, Campus Police) who do not return to work and have used leave banks that are advanced will be responsible for reimbursing the College all unearned leave banks.

F. Intermittent Leave or a Reduced Work Schedule
   1. The employee may take FMLA leave in 12 consecutive weeks, may use the leave intermittently (take a day periodically when needed over the year) or, under certain circumstances, may use the leave to reduce the workweek or workday, resulting in a reduced hour schedule. In all cases, the leave may not exceed a total of 12 workweeks (or 26 workweeks to care for an injured or ill service member over a 12-month period).
   2. The College may temporarily transfer an employee to an available alternative position with equivalent pay and benefits if the alternative position would better accommodate the intermittent or reduced schedule, in instances when leave for the employee or employee's family member is foreseeable and for planned medical treatment, including recovery from a serious health condition or to care for a child after birth, or placement for adoption or foster care.
   3. For the birth, adoption or foster care of a child, the College and the employee must mutually agree to the schedule before the employee may take the leave intermittently or work a reduced hour schedule. Leave for birth, adoption or foster care of a child must be taken within one year of the birth or placement of the child.
   4. If the employee is taking leave for a serious health condition or because of the serious health condition of a family member, the employee should try to reach an agreement with the College before taking intermittent leave or working a reduced hour schedule. If this is not possible, then the employee must prove that the use of the leave is medically necessary.

G. Intent to Return to Work from FMLA Leave: The College may require an employee on FMLA leave to report periodically on the employee's status and intent to return to work.

H. Return to work with accommodations: If an employee needs accommodations to perform the essential functions of their job upon their return to work, they may reach out to their Human Resources Generalist or the Director of Equal Opportunity Compliance to request such accommodations. If the Fitness for Duty clearance letter from a medical provider indicates the need for accommodations, or indicates limitations in an employee's ability to return fully, an HR representative will discuss the accommodation request and GRCC's ability to accommodate that request with the employee, before their return, if possible.

XI. Forms
GRCC FMLA Request Form
Department of Labor Certification of Health Care Provider Form
FMLA Family Form
FMLA Employee Rights and Responsibilities
Department of Labor Employee Guide
Disability Accommodation Request Form

XII. Effective Date: July, 1994

XIII. Policy History
This policy was updated June 2013, May 2015, May 2017, and May 2019, to ensure compliance with state and federal laws related to FMLA.

XIV. Next Review/Revision Date: June 2021

GRCC Family and Medical Leave (FMLA) Request

PERSONAL INFORMATION (Please print.)

Employee's Last Name:_____ First Name:_____ Middle Initial:_____

Street Address:_____

City:_____ State:_____ Zip:_____

Phone: (_____)_____

WORK-RELATED INFORMATION

Department:_____ Employee's ID Number:_____

GRCC Email Address:_____

Date of Hire:_____ Normal Work Hours Per Week:_____

Anticipated Begin Date of Leave:_____ Anticipated Return to Work Date:_____

Supervisor's Name:_____ Phone Number: (_____)_____

Employee Group:

☐ APSS
☐ Adjunct Faculty
☐ Campus Police
☐ CEBA
☐ Faculty
☐ Meet and Confer

REASONS FOR REQUEST

☐ Birth and/or care of a child of the employee
☐ Placement of a child into the employee's family by adoption or by a foster care arrangement
☐ In order to care for the employee's spouse, child or parent who has a serious health condition
☐ Spouse
☐ Child
☐ Parent
☐ A serious health condition which renders the employee unable to perform the functions of the employees position

REQUIRED SIGNATURE

☐ I acknowledge that I have received the policy and/or rules relative to the Family and Medical Leave Act.

Employee's Signature:_____ Date:_____

SUPERVISOR AND HUMAN RESOURCE SECTION

Leave has been:

☐ Approved

☐ Denied

Supervisor's Signature:_____ Date:_____

Human Resource's Signature:_____ Date:_____

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 Hour Division

WAGE AND HOUR DIVISION

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

OMB Control Number: 1235-0003
Expires: 6/30/2023

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: Grand Rapids Community College 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.)

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.

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.