



Family and Medical Leave Employee Information Pack

Table of Contents

I. FMLA LEAVE APPLICATION INSTRUCTIONS	3
II. FMLA LEAVE OF ABSENCE APPLICATION	4
III. FMLA LEAVE OF ABSENCE REQUIREMENTS.....	5
IV. MEDICAL CERTIFICATION FOR FMLA.....	6
V. MEDICAL CERTIFICATION DEFINITIONS	7

I. FMLA LEAVE APPLICATION INSTRUCTIONS

- Provide 30 days advance notice when need for leave is foreseeable
- Complete the FMLA Leave of Absence Application contained in this packet. Then forward it to your Human Resources FMLA Administrator at Greens Creek, who will “provisionally” approve your leave for 15 calendar days based on eligibility requirements (have at least one year of service and have worked 1250 hours in the previous 12 months). If Medical Certification is not returned or the Leave does not meet requirements any absences “provisionally” approved will be changed to non-FMLA absences and may result in a chargeable absence.
- Take the Medical Certification for FMLA form to your or your family member’s Health Care Provider to complete. The Greens Creek FMLA Administrator must receive this Medical Certification for FMLA form within the 15 calendar days or your FMLA leave may be denied. If leave is needed for the adoption of a child, please provide a letter from an authorized adoption agency on their company letterhead.
- Return the completed Medical Certification for FMLA form within 15 calendar days to the FMLA Administrator:

By mail –

Human Resources Department, PO Box 32199, Juneau, AK 99803

By Fax –

907-789-8128, Attn: HR

In person –

Greens Creek HR Department

- Read the information contained in this packet to fully understand your rights and obligations under the FMLA. Contact the Human Resources FMLA Administrator at (907) 789-8114 if you have any questions.
- Respond promptly to all requests from the Greens Creek FMLA Administrator for further medical certification or documentation. Failure to do so may result in the loss of your FMLA leave.

II. FMLA LEAVE OF ABSENCE APPLICATION

Please Do Not List Confidential Medical Information On This Form

I. Employee Information			
a. Personal Information			
Employee Name:		Employee ID:	
Home Phone:		Mobile Phone:	
Mailing Address:	City:	State:	Zip Code:
b. Work Information			
Work Phone:		Work Location	
Supervisor's Name:		Supervisor's Phone:	
II. Application for Leave			
a. Reason for Leave (check one):			
Medical <input type="checkbox"/> Employee's serious health condition <input type="checkbox"/> Pregnancy Family: <input type="checkbox"/> Parent's care of child following birth <input type="checkbox"/> Placement of child with employee for adoption or foster care <input type="checkbox"/> Serious health condition of an employees (select one): <input type="checkbox"/> Child (under 18 years of age (or older if child is disabled), <input type="checkbox"/> Spouse <input type="checkbox"/> Parent			
b. Type of Leave (check one)			
<input type="checkbox"/> Single Block of Time <input type="checkbox"/> Intermittent			
Amount of leave needed:			
Leave Start Date:		Anticipated Return to Work Date (full duty):	
If less than 30-days notice is given requesting FMLA Leave, state the reason below:			
By signing this form, I hereby certify that the information on this form is true and correct. I understand that falsifying information on this form will lead to the termination of my employment with Hecla Greens Creek Mining Company.			
Employee Signature:		Date	
FMLA Administrator Signature:		Date	

After completion of this form forward it to the FMLA Administrator located at Greens Creek. You will have 15 days from the date that the FMLA Administrator signs this form to return the completed Medical Certification from your health care provider. Your leave will be "provisionally" approved for the 15 days. If medical certification is not returned or the leave does not meet requirements, any absences provisionally approved will be changed to non-FMLA absences and may result in a chargeable absence.

III. FMLA LEAVE OF ABSENCE REQUIREMENTS

I agree to provide 30 days advance notice when the need for the leave is foreseeable.

I understand to be eligible for FMLA Leave I must have completed one (1) year of service and have worked 1250 hours in the past 12 months.

I authorize the Greens Creek FMLA Administrator to contact my health care provider(s) about my condition related to this application. I authorize my health care provider(s) to release information about my medical condition related to this application to the Greens Creek FMLA Administrator or another health care provider, as needed.

I understand that it is my responsibility to notify my supervisor of my status every week during an extended leave, or every day I am off for an approved intermittent leave.

I understand that the Company may, from time to time, require updated certification and/or second opinions regarding my condition. I understand that if I fail to keep these appointments, or fail to submit updated for recertification, my FMLA leave may be denied.

I understand that FMLA Leave and Short Term disability run concurrently when the leave is related to my own illness resulting in an inability to perform the essential functions of the job. I also understand that FMLA will run concurrently with Worker's Compensation when leave is due to a work related injury.

I have reviewed and understand the information contained in the document "Your rights under the Family and Medical Leave Act of 1993" and agree to comply with the requirements.

I agree to continue my portions of health and welfare premiums as specified in the *Benefits Continuation Agreement*. In the event my leave is unpaid I acknowledge that I may be required to reimburse the Company for my share of health insurance contributions paid on my behalf during my FMLA leave upon my return to work through four automatic payroll deductions.

FMLA leave is unpaid and I understand that I am required to use any available sick and vacation for the duration of my leave as allowed by federal, state and local laws.

I understand if I engage in other employment while I am on an approved leave at Greens Creek I may be discharged unless the Company has approved special prior provision.

I understand that I am responsible to return required paperwork on time, including medical certification forms from my physician. If I fail to return to work at the end of my approved leave, I may be subject to discipline up to and including discharge and responsible for any health and welfare premiums paid on my behalf.

Employee Signature: _____

Date: _____

IV. MEDICAL CERTIFICATION FOR FMLA

I. Employee Information							
Employee Name:		Employee ID:					
Patients Name (if different than employee):							
If FMLA Leave is to care for a family member, state the care you will provide:							
Care Start Date:		Anticipated End Date:					
I authorize my health care provider to release to Greens Creek or their second opinion doctor, the information requested on this form.							
Employee Signature:		Date:					
II. Health Care Provider Certification							
Is patient currently incapacitated by a chronic condition or pregnancy? <input type="checkbox"/> Yes; <input type="checkbox"/> No							
Please check the category that qualifies the patient as having a "serious health condition", if applicable:							
<input type="checkbox"/> 1 – Hospital Care		<input type="checkbox"/> 2 – Absence from work plus treatment					
<input type="checkbox"/> 3 – Pregnancy		<input type="checkbox"/> 4 – Chronic conditions requiring treatments					
<input type="checkbox"/> 5 – Permanent / long-term condition requiring supervision		<input type="checkbox"/> 6 – Multiple treatments (non-chronic conditions)					
<input type="checkbox"/> 7 – None of these apply							
Describe the Medical Facts which support your certification, including a brief statement as to how the medical facts meet the criteria of one of the categories listed above:							
Treatment Regiment (include length and probably number of treatments):							
What are the restrictions and / or requested accommodations?							
<input type="checkbox"/> Check box if it is necessary for the employee to work intermittently or less than their regularly scheduled hours as a result of the condition.							
If leave is to care for an immediate family member of the employee, does the patient require assistance for basic medical or personal needs for safety or transportation? <input type="checkbox"/> Yes; <input type="checkbox"/> No							
Will the employee be providing psychological comfort or assisting in the patient's recovery or caring for a patient intermittently or on a part-time basis? <input type="checkbox"/> Yes; <input type="checkbox"/> No							
Leave Start Date:		Anticipated Return to Work Date (full duty):					
Name of Health Care Provider:			Phone Number:				
Mailing Address:		City:	State:	Zip Code:			
Signature of Health Care Provider:			Date:				

V. MEDICAL CERTIFICATION DEFINITIONS

As an employer, we have made every effort to make this form easy to use, yet still meet the requirements of the state and federal laws, Greens Creek business needs, and our employee's medical needs. If you have any questions regarding this form, or the leave of absence process, please fax them to the Greens Creek FMLA Administrator at 907-789-8128. We welcome your comments.

- 1) A "**SERIOUS HEALTH CONDITION**" means an illness, injury impairment, or physical or mental condition that involves one of the following:
- **HOSPITAL CARE**
 - a. Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.
 - **ABSENCE PLUS TREATMENT**
 - b. A period of incapacity of more than three consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:
 - i. Treatment two or more times by a health care provider, by a nurse or physician's assistant under the direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or
 - ii. Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider.
 - **PREGNANCY**
 - c. Any period of incapacity due to pregnancy, or for prenatal care.
 - **CHRONIC CONDITIONS REQUIRING TREATMENTS**
 - d. A chronic condition which:
 - i. Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;
 - ii. Continues over an extended period of time (including recurring episodes of a single underlying condition); and
 - iii. May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).
 - **PERMANENT/LONG-TERM CONDITIONS REQUIRING SUPERVISION**
 - e. A period of Incapacity, which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.
 - **MULTIPLE TREATMENTS (NON-CHRONIC CONDITIONS)**
 - f. Any period of absence to receive multiple treatments (including any period of recovery there from) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), and kidney disease (dialysis).
- 2) **INCAPACITY**—The inability to work (including light-duty), attend school or perform other regular duties due to a serious health condition, treatment therefore, or recovery there from.
- 3) **TREATMENT**—Includes: examination to determine if a serious health condition exists and evaluations of the condition. Does not include: routine physical examinations, eye examinations, or dental examinations.
- **REGIMEN OF CONTINUING TREATMENT**—includes: for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or slaves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

****Employee's job description with essential functions is available upon request**