RECORDS

Applicant/Plaintiff	**Darlene Walls**
Case No.	ADJ11859979, ADJ11864576
Defendant	Kaiser Permanente
Date of Injury	07/01/2018 to 12/31/2018
File/Claim Num	
Date Published	9/4/2019
Records of	**Kaiser Permanente**
Location Copied	1451 Harbor Bay Pkwy ALAMEDA, CA 94502
Type of Records	Personnel

Records delivered to:

Control Num 19-25123-8 (279) C1

1 Customer

Natalia Foley, Esq
Law Offices of Natalia Foley
5753 E Santa Ana Cyn Rd Ste G #616
Anaheim, CA 92807
Attn: Natalia Foley, Esq.

Med-Legal, LLC
955 Overland Ct, Suite 200, San Dimas, CA 91773 (800) 244-3495

These records were produced under U.S. Patent No. 8,301,611

Copy Service Paperwork

Important Notice!

❒**The facility failed to provide a Declaration**
The facility did not include a declaration with the records and has not responded to our request for one. If they provide one in the future we will forward it. If you would like an affidavit describing our efforts please contact us at (800) 244-3495.

☒**We received the pages by mail**
The records were not copied by our representative at the facility's address. The pages were received either by mail or delivery, then scanned into our system for numbering, storage, and CD publishing.

❒**The attached records were copied at a third party location**
The facility insisted that we copy the records at the following location
Name of third party: ____
Address of third party:____

❒**Received Objection or Motion to Quash**
The opposing attorney sent us a written objection; therefore, it is probable that some records were withheld.

❒**Declaration may not have been signed by the Custodian of Records**
We have reason to doubt the party who signed the attached Declaration is the actual Custodian of Records. The person signing does not appear to be an employee or representative of the original facility.

❒**Copies of the records were provided by a third party**
The only way the facility would provide access to these records was through a third-party, such as another copy services. If you would like us to prepare a petition to compel the facility to provide the original records to us for copying please call our office.

❒**Out-of-State facility**
The attached records were sent to our office from an out-of-state facility; therefore, the facility is not required to sign the Affidavit of Custodian of Records normally required by California's Evidence Code 1560, 1561.

❒**Microfiche**
The following records are of poor quality due to the fact that they were made from microfiche. We have done all we can to improve their quality. We apologize for any inconvenience this may cause.

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

WORKERS' COMPENSATION APPEALS BOARD

Darlene Walls
DOB: 03/23/67
AKA:
File:

Claimant/Applicant,

vs.

Kaiser Permanente

Employer/Insurance Carrier/Defendant.

Case No. ADJ11859979, ADJ11864576
(IF APPLICATION HAS BEEN FILED, CASE NUMBER MUST BE INDICATED REGARDLESS OF DATE OF INJURY)

SUBPOENA DUCES TECUM

(When records are mailed, identify them by using above case number or attaching a copy of subpoena)

Where no application has been filed for injuries on or after January 1, 1990 and before January 1, 1994, subpoena will be valid without a case number, but subpoena must be served on claimant and employer and/or insurance carrier.

See instructions below.*

The People of the State of California Send Greetings to: Kaiser Permanente

WE COMMAND YOU to appear before A Deposition Officer – Med-Legal, LLC

at 1837 Whipple Road, Hayward, CA 94544,Phone 800-244-3495

on the 08/26/19 day of ________, at 10:00 o'clock AM., to testify in the above-entitled matter and to bring with you and produce the following described documents, papers, books and records.

See Attachment for a list of records to be produced subject to this subpoena, to make available for inspection and copying or transmit/transfer electronically.

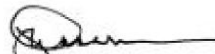
(Do not produce X-rays unless specifically mentioned above.)

For failure to attend as required, you may be deemed guilty of a contempt and liable to pay to the parties aggrieved all losses and damages sustained thereby and forfeit one hundred dollars in addition thereto.

This subpoena is issued at the request of the person making the declaration on the reverse hereof, or on the copy which is served herewith.

Date 08/05/19

WORKERS' COMPENSATION APPEALS BOARD
OF THE STATE OF CALIFORNIA



Secretary, Assistant Secretary, Workers' Compensation Judge

***FOR INJURIES OCCURING ON OR AFTER JANUARY 1, 1990, AND BEFORE JANUARY 1, 1994**

If no Application for Adjudication of Claim has been filed, a declaration under penalty of perjury that the Employee's Claim for Workers' Compensation Benefits (Form DWC-1) has been filed pursuant to Labor Code Section 5401 must be executed properly.

SEE REVERSE SIDE
[SUBPOENA INVALID WITHOUT DECLARATION]

You may fully comply with this subpoena by mailing the records described (or authenticated copies, Evid. Code 1561) to the person and place stated above within ten (10) days of the date of service of this subpoena.

This subpoena does not apply to any member of the Highway Patrol, Sheriff's Office or city Police Department unless accompanied by notice from this Board that deposit of the witness fee has been made in accordance with Government Code 68097.2, et seq.

DWC WCAB 32 (Side 1) (REV. 06/18)

HIPAA Compliant Request Control #: **19-25123-5**

Do not appear! Simply call (800) 244-3495 and somebody will copy the records for you at your office.

DECLARATION FOR SUBPOENA DUCES TECUM

Case No. ADJ11859979, ADJ11864576

STATE OF CALIFORNIA, County of Los Angeles

The undersigned states: That Med-Legal, LLC has been authorized to obtain records by

Natalia Foley, Esq Law Offices of Natalia Foley
That he /she is (one of) the attorney(s) of record / representative(s) for the applicant/defendant in the action captioned on the reverse hereof. That Kaiser Permanente
has in his/her possession or under his/her control the documents described on the reverse hereof. That said documents are material to the issues involved in the case for the following reasons:
Based on the information and belief to resolve any dispute in the above referenced case.

Declaration for Injuries on or After January 1, 1990 and Before January 1, 1994

[X] That an Employee's Claim for Workers' Compensation Benefits (DWC Form 1) has been filed in accordance with Labor Code Section 5401 by the alleged injured worker whose records are sought, or if the worker is deceased, by the dependent(s) of the decedent, and that a true copy of the form filed is attached hereto. *(Check box if applicable and part of declaration below. See instructions on front of subpoena.)*

I declare under penalty of perjury that the foregoing is true and correct

Executed on 08/05/19 , at San Dimas, California.

[signature]	955 Overland Court, Suite 200, San Dimas, CA 91773	(626) 653-5160
Signature	Address	Telephone

Victor Landero, Operations

DECLARATION OF SERVICE

STATE OF CALIFORNIA, County of Los Angeles

I, the undersigned, state that I served the foregoing subpoena by showing the original and delivering a true copy thereof, together with a copy of the Declaration in support thereof, to each of the following named persons, personally, at the date and place set forth opposite each name.

Name of Person Served	Date	Place

I declare under penalty of perjury that the foregoing is true and correct

Executed on__________, at__________, California.

____
Signature

Control #: **19-25123-5**

DWC WCAB 32 (Side 2) (REV. 06/18)

Attachment

Re:

Patient/Applicant: Darlene Walls Social Security #: 558-37-5679

AKA: D.O.B.: 03/23/67

Ordered By:

Natalia Foley, Esq
Law Offices of Natalia Foley
5753 E Santa Ana Cyn Rd Ste G #616
Anaheim, CA 92807

Records to produce:

Deponent's file #:

Exclusions (if any):

Date Range (if any):

For each injury alleged by the Applicant named on the Subpoena, produce the following:

A signed "Declaration of Custodian of Records" must accompany the records.

Request for: Employment file, Personnel file, and Employer's Claim file

This demand to produce is not limited to the dates of injuries that are the subject of the case numbers listed on the attached Notice but includes all dates of occurrences and all periods of time for the specific documents demanded:

1. All documents contained in any file however designated in any location under your possession or control or under the possession or control of any employee or agent of the employer wherein Applicant is the subject including but not limited to any and all employment files, personnel files, claim files, injury files, medical files, investigation files, disciplinary files, and workers' compensation files.
2. Applicant's application for employment or contract for services and all employment documents regarding services performed by Applicant for or on behalf of employer.
3. All written (or printouts of electronically stored) evaluations and documents of employment, title, service position, duties, disciplines, reprimands and changes of title, duties or rate of compensation.
4. All investigation reports, correspondence or memoranda regarding any claims alleged by Applicant, including printouts of electronically stored files of this category.
5. Any and all subrosa video and related billings and logs.
6. All documentation, writings, and memoranda, including but not limited to printouts of all electronically stored data, email and computer notes, pertaining to any injuries or claims made by the Applicant.
7. All correspondence, memoranda, forms and notices transmitted to or received from Applicant, including printouts of electronically stored data, memos, emails and notes.
8. Copy of all correspondence sent to or received from any physicians regarding any claim or injury alleged by the Applicant, including but not limited to printouts of all electronically stored notes, email, reports or documents.

Notice: For Subpoenas of claim files, you are to send the claim file directly to Med-Legal only. Sending the claim file to other than Med-Legal will be considered to be in non-compliance of the subpoena.

If any of the documents described above that are in your possession or control are <u>not</u> being produced then a detailed list of each withheld document must be included with the records production or listed on your declaration.

Where used, the terms "writing", "record", "document" and other words of similar meaning include (but are not limited to) electronically maintained image files, documents, notes, faxes, emails and other similar types of electronically held information. <u>If the subpoenaed records exist in paper they are to be provided for inspection and copying. If the subpoenaed records exist electronically then they are to be provided either electronically through our Internet portal at upload.getrecords.com or on CD.</u>

9. Copy of all written or recorded statements made by the Applicant.
10. Copy of telephone log, and all written and electronic or computer notes (including Email) of any conversation, if any, by any employer's representative with the Applicant, any physician or physician's office personnel, or insurance company representative regarding the Applicant.
11. Any and all medical or dispensary records.
12. A copy of all Employee Notification documents required per Regulation 9767.12 (Medical Provider Network notification). If the notice is posted as an over-sized poster a legible photo may be submitted, or you may contact the copy service who served you with this request and they will come and take a photo/copy of the poster.
13. All documentation and evidence that you have complied with Labor Code Section 3550. If the notice is posted as an over-sized poster a legible photo may be submitted, or you may contact the copy service who served you with this request and they will come and take a photo/copy of the poster.
14. All documentation and evidence that you have complied with Regulation 9782, Notice of Employee Right to Choose Physician. If the notice is posted as an over-sized poster a legible photo may be submitted, or you may contact the copy service who served you with this request and they will come and take a photo/copy of the poster.

Form E2 (9/2006)

Notice: For Subpoenas of claim files, you are to send the claim file directly to Med-Legal only. Sending the claim file to other than Med-Legal will be considered to be in non-compliance of the subpoena.

If any of the documents described above that are in your possession or control are <u>not</u> being produced then a detailed list of each withheld document must be included with the records production or listed on your declaration.

Where used, the terms "writing", "record", "document" and other words of similar meaning include (but are not limited to) electronically maintained image files, documents, notes, faxes, emails and other similar types of electronically held information. <u>If the subpoenaed records exist in paper they are to be provided for inspection and copying. If the subpoenaed records exist electronically then they are to be provided either electronically through our Internet portal at upload.getrecords.com or on CD.</u>

Case Name: Darlene Walls v. Kaiser Permanente

Case Number: ADJ11859979, ADJ11864576

PROOF OF SERVICE BY MAIL

Deposition Notice

I declare that I am employed in the County of Los Angeles, over the age of 18 years and not a party to this action. My business address is: 955 Overland Court, Ste. 200 San Dimas, California 91773.

On 8/6/2019 I caused to be served, at my direction and following ordinary business practices, true copies of the document(s) referenced above for collection and mailing in a sealed envelope and addressed to the parties listed below. I am readily familiar with the business practices of Med-Legal LLC for collection and processing of correspondence for mailing. The document was set for same day mail processing and collection, with postage fully paid, for delivery by the United States Postal Service or private delivery service following ordinary business practices.

GUARD INSURANCE/BERKSHIRE HATHAWAY
PO BOX 1368 WILKES-BARRE PA 18703

I declare under penalty under the penalty of perjury under the laws of the State of California, the foregoing is a true and correct statement. Executed on 8/6/2019 at San Dimas, California.

/s/ Roderic B. Davis
Business Document Manager
Med Legal, LLC

APPLICANT/PLAINTIFF/PETITIONER: Darlene Walls DEFENDANT/RESPONDENT: Kaiser Permanente	CASE NUMBER: ADJ11859979

PROOF OF SERVICE

1. I served this Notice of Deposition by delivering a copy to the person served as follows:

   ☑ Personal Delivery ☐ Certified Mail ☐ Regular Mail ☐ Via Facsimile

   a. Person served (name): Jana G.

   b. Address where served: 1451 Harbor Bay Pkwy, ALAMEDA,CA, 94502

   c. Date of delivery: 08/07/2019 Time of delivery: 03:04 PM

   d. Deposition date is: 08/26/2019

   e. (1) ☑ Witness fees were paid.
   Amount: ________ $________ Check Number: ________

   (2) ☐ Copying fees were paid.
   Amount: ________ $________

   f. Fee for service: _________ $________

2. I received this subpoena for service on (date): 08/07/2019
3. Person serving:

   a. ☐ Not a registered California process server.

   b. ☐ California sheriff or marshal

   c. ☐ Registered California process server.

   d. ☑ Employee or independent contractor of a registered California process server.

   e. ☐ Exempt from registration under Business and Professions Code Section 22350(b).

   f. ☐ Registered professional photocopier.

   g. ☐ Exempt from registration under Business and Professions Code section 22451.

4. Name, address, telephone number, and, if applicable, county of registration and number:

   Mark Gonzales , LA – 7235

   955 Overland Ct, Suite 200, San Dimas, CA, 91773

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date: 08/07/2019

/S/ Mark Gonzales

►________________________

(SIGNATURE)

(**For California sheriff or marshal use only**)
I **certify** that the foregoing is true and correct.

Date:________________________

►________________________

(SIGNATURE)

Control Number: 19-25123-5

Records Order Form

08/05/19

Notice of Copying to:

GUARD INSURANCE/BERKSHIRE
HATHAWAY
PO BOX 1368
WILKES-BARRE, PA 18703

Case Information

Applicant: Darlene Walls
Employer: Kaiser Permanente
Case #: ADJ11859979, ADJ11864576
DOI: 07/01/18 TO 12/31/18 SS#: 558-37-5679
Claim #: Not Supplied by Carrier
Ordering party: Natalia Foley, Esq

Record Location: Kaiser Permanente

Records of the Injured Worker are being produced at the above record location and delivered to the opposing party. You may receive copies of the records by selecting one of the following;

Title 8, CCR § 9982 Allowable Services. (A)... services for records relevant to an injured worker's claim, except services under a contract between the employer and the copy service provider.

☐ Electronic Set per Billing Codes WC026 or WC027
Fees set by § 9983 *Fees for Copy and Related Services (f)(2)*
Number of Sets ____

☐ CD Set per Billing Codes WC026 or WC027
Fees set by § 9983 *Fees for Copy and Related Services (f)(2)*
Number of Sets ____

Send records:

☐ Same as above

E-mail addresses required for the electronic sets:
____________________@______________
____________________@______________

☐ **Bill to My Office** (*Invoice will be sent to the address on this notice.*)

☐ **Bill to the Insurance Carrier**

______________________________ (Print your name)

______________________________ (Sign your name) **Control #: 19-25123-5**
(Signature required)

Med-Legal, LLC
Photocopy Reg #/County x-423/Los Angeles
Tax ID # 45-4424177
955 Overland Court, Suite 200, San Dimas, CA 91773, (800) 244-3495 FAX (800) 962-4896

There was no violation of California Labor Code Section 139.32 with respect to the services described herein.

KAISER PERMANENTE®
National HR Service Center

August 12, 2019 | Case Number: 4922130

Certification of Records:

RE: Darlene Walls

Court Case Name: Darlene Walls vs Kaiser Permanente

Court Case Number: ADJ11859979, ADJ11864576

Requestor's Reference: 19-25123-5

I, the undersigned, being the duly authorized Custodian of Personnel Records for Kaiser Permanente's National HR Service Center and having the authority to certify the records declare the following:

☒ I am qualified to testify as to the preparation and maintenance of the records, and have the authority to certify the personnel records sought by the Subpoena Duces Tecum. The records accompanying the subpoena were prepared by the personnel of Kaiser Permanente in the ordinary and regular course of business at or near the act, condition or event reflected in such records.

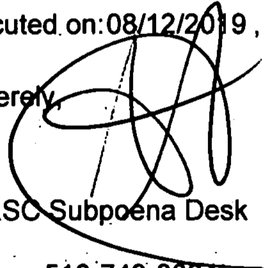
☒ I certify that the records prepared and released to the requester are identified as the personnel records sought by the subpoena and are what they purport to be.

☒ I further certify that the sources of the information produced and the mode, method and time of preparation were such as to indicate the trustworthiness of said records.

I declare under penalty of perjury and under the laws of the State of California that the foregoing is true and correct.

Executed on: 08/12/2019 , at Alameda, California.

Sincerely,



NHRSC Subpoena Desk

Hotline: 510-749-3034

KAISER PERMANENTE®
National HR Service Center

Certification of Records:

RE: Darlene Walls

Dear Requestor of Records,

Kaiser Permanente does not have a single Custodian of Records who has custody of all the corporation's records. There are several Custodians who have custody, respectively, of various types of records. For instance, all medical records of members are kept at the facility where their primary care physician practices, each chart room having its own Custodian.

I am the Custodian of all personnel records excluding payroll and retirement/QDROS. I have included with this letter certified copies of all the records I have lodged with the Court along with a copy of the certification of said records.

Please be advised that Kaiser Permanente does not routinely produce certain types of records pursuant to subpoenas for employment records. Documents in the following categories may have been removed from the file produced.

- Pre-employment reference checks
- Documents relating to credit checks
- Documents relating to labor or employment disputes and wage garnishments
- Third party documents, such as children's birth certificates, marriage certificates.
- Any document containing medical information (Protected Health Information or PHI, as defined by HIPAA), including workers compensation documents

Kaiser Permanente makes no representation that any such documents have been withheld from this production. Rather, this letter is to inform you of the organization's general practice.

Documents in these categories will not be produced without a separate subpoena clearly specifying the documents requested. Please note that documents protected from disclosure by statute or other legal privilege will not be produced without a Court Order enforcing the subpoena

Thank you for your cooperation.

Sincerely,

NHRSC Subpoena Desk

AFFIDAVIT OF PROFESSIONAL PHOTOCOPY SERVICE

I, the undersigned, declare the following:

a) I am an employed in the County of Los Angeles, State of California. I am over the age of 18, and not a Party to the within action. My business address: Med-Legal, LLC, 955 Overland Court, Suite 200, San Dimas, California 91773.

b) Our business is a registered Professional Photocopier in the County of Los Angeles, California. Photocopier Registration Number (PRN): X-423.

c) The attached copy of the records were transmitted or distributed to the authorized persons or entities and are true copies thereof.

d) The records shall be transmitted or distributed to the authorized persons or entities.

e) These records were transmitted or distributed to us by mail directly from the facility. We are including all documents that were received but we did not witness the actual copying.

I declare under penalty under the laws of the State of California that the foregoing is true and correct.

Executed On: 08/29/2019 at San Dimas, California

SS: ____________________

Victor Landero
Director of Operations

Start of Records

KP000013

LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

Instructions: 1. To ensure efficient and effective service please, submit form online.
2. Items marked with an asterisk (*) are required fields.
3. Immediate confirmation will be sent to you upon receipt of your online submittal.
4. **Supervisor/Manager:** Complete Leave of Absence Form for employee. Review Attestations; include applicable notations in the Comments Section on the Request. Be sure to print a copy of Leave of Absence Form before submitting.

* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(213) 401-8827	09/02/2017
* First Name	Middle Name	* Last Name
Darlene		Walls

1. LEAVE INFORMATION

Employee E-mail Address	Alternate Employee Phone Number (###) ###-####	New or Revised Request
		☐ New ☐ Revised

*** Leave Type:**

☒ Medical	☐ Union	☐ Care for Eligible Family Member
☐ Maternity	☐ Personal	☐ Family Military Leave
☐ Workers' Comp/Industrial	☐ Military Service	☐ Bonding

Last Day Worked (mm/dd/yyyy)	* First Day of Leave (mm/dd/yyyy)	Expected Return Date (mm/dd/yyyy)
	09/02/2017	

Is this an intermittent or reduced work schedule Leave? ☒ Intermittent ☐ Reduced Work Schedule ☐ Not Applicable

Is this a Donor Leave? ☐ Yes ☒ No ☐ Unknown

Estimated frequency and duration of absences
Freq 2 times per month
Duration 1 day per episode

If absence is for Care of Eligible Family Member or Bonding:

Name of Eligible Family Member	Relationship to Employee
Is Family Member age 18 or under? If Yes, enter age ☐ Yes ☐ No	Delivery/Adoption/Foster Care Placement Date (mm/dd/yyyy) ☐ Actual Date ☐ Expected Date
Is the child's other parent employed by Kaiser Permanente? ☐ Yes ☐ No	If Yes, full name of other parent

If absence is due to Family Member's Military Service please select the reason(s) that apply:

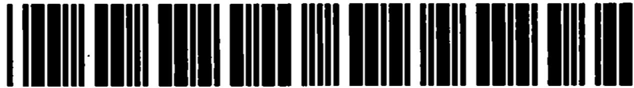
Name of Eligible Family Member	Relationship to Employee

☐ **Qualifying Exigency,** (matters related to deployment such as Child Care issues, Financial Planning, and Family Support Sessions, Seeing off leaving or returning Service Members.)

☐ **Care for qualified Service Member who incurred injury or illness in the line of duty**

National HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist

Next Page >



* First Name	Middle Name	* Last Name
Darlene		Walls
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(213) 401-8827	09/02/2017

1. LEAVE INFORMATION - (Continued)

If absence is for Employee's own health condition (Medical, Maternity or Workers' Comp/Industrial)

Date of illness or injury (mm/dd/yyyy)	Was hospitalization required?	Date Hospitalized (mm/dd/yyyy)
09/02/2017	☐ Yes ☐ No ☒ Unknown	

Estimated/Actual hours worked on last day	If Leave is due to maternity	Delivery Date (mm/dd/yyyy)
8	☐ Actual Delivery Date ☐ Expected Delivery Date	

If absence is pregnancy related, does the employee plan to take Bonding time immediately after the pregnancy related absence is complete?

☐ Yes ☐ No

If absence is for Union Leave

Type of Union Leave:

☐ Short Term (30 days or less) ☐ Long Term (greater than 30 days) ☐ Elected Official

Name of Union

If absence is for Military Leave

Is this absence for Military Training or Active Duty?

☐ Military Training ☐ Active Duty

*** If for Personal Leave, indicate reason**

Temporary Agency or Military Service (asked for FMLA eligibility)

Has the Employee worked for Kaiser Permanente less than one year?

☐ Yes ☒ No

Has the Employee been on active Military Duty in the past 12 months?	Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)
☐ Yes ☒ No		

Did the Employee work for Kaiser Permanente with a Temporary Agency in the year before they were hired?

☐ Yes ☐ No

LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

* First Name	Middle Name	* Last Name
Dar l ene		Wa l l s
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(213) 401-8827	09/02/2017

1. LEAVE INFORMATION - (Continued)

Name of Agency		
Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)	Agency Phone Number (###) ###-####

2. COMMENTS

3. EMPLOYEE SCHEDULE

This information is essential for the NHRSC to prepare a worksheet to assist with TIME coding. This is required for employees absent for their own disability. Please use a 24 hr clock: 00:00 thru 24:00.

NOTE: This section is not applicable for the KRONOS regions.

Week 1

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start Time: (hh:mm)							
Hours:							

Week 2 (Only needed if schedule changes week to week)

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start Time: (hh:mm)							
Hours:							

4. REQUEST PAID TIME-OFF

Review your Collective Bargaining Agreement and/or Summary Plan Description Booklet before completing this section. Selections made here will not supersede conditions set in Collective Bargaining Agreements, Summary Plan Descriptions, KP and HR Policies, or applicable State and Federal Laws.

Did employee request EarnedTime Off (ETO)/Paid Time Off (PTO)/Vacation? ☐ Yes ☐ No	☐ Use all available hours ☐ Use selected hours	Number of hours
Did employee request to use Extended Sick Leave (ESL)/Sick Leave? ☐ Yes ☐ No	☐ Use all available hours ☐ Use selected hours	Number of hours
Did employee request to use Float Holidays? ☐ Yes ☐ No	Only available Float Holidays will be applied.	Number of days

National HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist

* First Name	Middle Name	* Last Name
Darlene		Walls
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(213) 401-8827	09/02/2017

4. REQUEST PAID TIME-OFF - (Continued)

Did employee request to use Flexible Personal Days? ☐ Yes ☐ No	Number of days	OR	Number of hours
Note: Flexible Personal Days can only be used in full day or two hour increments. Only available Flexible Personal Days will be applied.			
Did employee request Military Make-up Pay? ☐ Yes ☐ No			

5. SUBMITTED BY

* Name (First, MI, Last)		
Danny P Jimenez		
* Employee ID	* Title	
00685629		
* E-mail Address		* Work Phone Number (###) ###-####
danny.p.Jimenez@kp.org		(562) 657-8527

6. MANAGER INFORMATION DETAIL

* Name (First, MI, Last)		
Danny Jimenez		
Supervisor ID	* Title	
* E-mail Address		* Work Phone Number (###) ###-####
danny.p.jimenez@kp.org		(562) 657-8527

7. ALTERNATE CONTACT INFORMATION - Someone, in addition to the Manager, who should receive leave communication (i.e. time coding, fmla status, etc)

* Name (First, MI, Last)	
* E-mail Address	* Work Phone Number (###) ###-####

LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

* First Name	Middle Name	* Last Name
Darlene		Walls
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(213) 401-8827	09/02/2017

8. MANAGER ATTESTATION

* Checking these items acknowledges that you have read and understand each item.

☒ I agree to direct the employee requesting Leave to submit any and all supporting documentation to me or the National HR Service Center.

☒ I agree to submit form 1500 - Extend Leave and any supporting documentation at the time I learn that the employee intends to extend his or her leave beyond their expected return date or fails to return on their expected date, fails to respond, and is not terminated.

☒ I agree to submit form 1510 - Return from Leave when the employee returns to work.

☒ TIME must be coded for all paid and unpaid leave taken by the employee.

9. MANAGER SIGNATURE - (Required if not submitted online.)

* Manager Signature	* Date (mm/dd/yyyy)

3510

NEW HIRE DATASHEET

Instructions:
1. To insure efficient and effective service please submit form on-line.
2. Items marked with asterisk (*) are required fields.
3. Immediate notification will be sent to you upon receipt of your on-line submittal.

* **Action** ☒ Hire ☐ Rehire ☐ Add Non-Employee (SCAL only) ☐ Inter-Regional Transfer	* Effective Date (mm/dd/yyyy) 02-25-2008	Requisition Number (If applicable.) SB.0701352
If Rehire, provide last Region worked	If Transfer, provide Sending Region	

1. PRIMARY NAME - (Legal Name)

Prefix ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms.

* First Name	Middle Name	* Last Name
Darlene		Walls

Suffix ☐ Jr ☐ Sr ☐ I ☐ II ☐ III ☐ IV ☐ V

2. PREFERRED NAME

First Name	Middle Name	Last Name
Darlene		Walls

Suffix ☐ Jr ☐ Sr ☐ I ☐ II ☐ III ☐ IV ☐ V

3. ADDRESS - (P.O. Box not accepted as Home Address.)

* **Home**			**Mailing**		
* Address 1: 15545 1/2 Eucalyptus Ave.			Address 1		
Address 2			Address 2		
* City: Bellflower	State: CA	* Zip Code: 90706	City	State	Zip Code

4. TELEPHONE NUMBERS

* Home Number (###) ###-####	Business Number (###) ###-####	Other Number (###) ###-####
+1 (562) 925-5950		

5. E-MAIL ADDRESS

Home

National HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772

KAISER PERMANENTE

NEW HIRE DATASHEET

Name (First, Middle, Last)	Effective Date (mm/dd/yyyy)
Darlene Walls	02-25-2008

11. PAYROLL

*** Employee Type**

☒ Hourly ☐ Salaried

*** Pay Group and Description**

☐ AH1-NCAL Hospital	☐ BC1-SCAL KP On Call	☐ TS1-Texas CSC
☐ AM1-NCAL Medical Group	☐ BM1-SCAL Medical Group	☐ WH1-Northwest Hospital
☐ AP1-NCAL Health Plan	☐ BP1-SCAL Health Plan	☐ WP1-Northwest Health Plan
☒ BH1-SCAL Hospital		

12. SALARY PLAN AND COMPENSATION

* Plan	* Grade	* Step	* Compensation Rate (Provide Hourly Compensation Rate in $00.00)
D2	10	01	13.0820

Red-Circled/Green-Circled	If Red or Green Circled - Enter Comp Rate End Date
☐ Red-Circled ☐ Green-Circled	

13. LICENSE AND CERTIFICATION

Nat'l Provider ID	Taxonomy Code 1
Taxonomy Code 2	**Taxonomy Code 3**
Taxonomy Code 4	**Taxonomy Code 5**

License/Certification Type	License Number	Expiration Date (mm/dd/yyyy)
License/Certification Type 1: CRT / CA-CNA	License Number 1: 00211001	Expiration Date 1 (mm/dd/yyyy): 03-23-2009
License/Certification Type 2: COC / US-BLS	License Number 2:	Expiration Date 2 (mm/dd/yyyy): 07-01-2008
License/Certification Type 3	License Number 3	Expiration Date 3 (mm/dd/yyyy)
License/Certification Type 4	License Number 4	Expiration Date 4 (mm/dd/yyyy)
License/Certification Type 5	License Number 5	Expiration Date 5 (mm/dd/yyyy)
License/Certification Type 6	License Number 6	Expiration Date 6 (mm/dd/yyyy)

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Telephone: (877) 457-4772

KAISER PERMANENTE®

3510 NEW HIRE DATASHEET

Name (First, Middle, Last)	Effective Date (mm/dd/yyyy)
Darlene Walls	02-25-2008

14. NEW HIRE NEGOTIATION

If offering additional PTO please state the number of hours. - (00.00)

15. COMMENTS

16. PREPARED BY

* Employee ID	* Name (First, Middle, Last)
00260609	Joy A Kaiser

* Title	* Work Phone Number (###) ###-####
Recruitment Assistant	(562) 461-6646

* Recruiter E-mail Address
Joy.A.Kaiser@kp.org

17. MANAGER INFORMATION DETAIL

* Name (First, Middle, Last)	* Title
Renato Razonable	Department Nurse Manager

* Work Phone Number (###) ###-####	* Manager E-mail Address
(310) 517-3042	Renato.L.Razonable@kp.org

Submit

After completing the form:
1. Print form to keep a copy for your records.
2. Press the Submit buttion.
3. Wait for a pop-up screen to confirm the form has been submitted. (This may take a few minutes.)

03/05/08

SEIU UNITED HEALTHCARE WORKERS - WEST
MEMBERSHIP APPLICATION/PAYROLL DEDUCTION AUTHORIZATION/COPE CHECK-OFF AUTHORIZATION

MEMBERSHIP APPLICATION

(PLEASE PRINT CLEARLY)

First Name: Darlene M.I.: Last Name: Wallis

Gender (please check appropriately): ☐ Male ☑ Female Birthdate (month/day/year): 03 23 67 Social Security Number: 558 37 5679

Street Address: 15545 1/2 Eucalyptus Apt. No.:

City: Bellflower CA Zip: 90706

Home Email:

Home Phone: 562925 5950 Personal Cell Phone: 310 346 8626 Personal Pager:

Employer Facility: Kaiser Permanente

Work Location/Campus: South Bay Date of Hire: 02,25,08

Department: 3000 Job Classification: Nursing attd

Shift: ☐ AM ☐ PM ☑ Night Job Status: ☐ Full Time ☑ Part Time ☐ Per Diem ☐ Short Hour ☐ Casual/OnCall

Work Phone: Ext.: Work Cell Phone: Work Pager:

Work Email:

I hereby request and accept membership in SEIU United Healthcare Workers - West, and authorize SEIU United Healthcare Workers - West as my Union and exclusive representative with my Employer(s) concerning wages, hours and other terms and conditions of employment. I agree to abide by the Constitution and Bylaws and all amendments thereto, and by any contracts that may be in existence at the time of this application or that may be negotiated by the Union.

I hereby authorize my employer to deduct from my wages and to pay to SEIU United Healthcare Workers - West the designated $100.00 initiation and monthly dues necessary to secure and maintain Union membership as required by the Constitution and Bylaws of the Union and any applicable contracts. I understand that my Union dues rate will periodically increase or otherwise change in accordance with the Union's Constitution and Bylaws.

Employee Signature: Darlene Walls Date Signed: 1/29/08

COPE CHECK-OFF AUTHORIZATION

In order to build political power for health care workers and make health care a priority for public officials, I hereby authorize SEIU United Healthcare Workers - West to file this payroll deduction with my employer and for my employer to forward the amount specified as a voluntary contribution to SEIU COPE and to transfer such funds to SEIU United Healthcare Workers - West:

☒ $5 per month ☐ $10 per month ☐ $________ per month

This authorization shall remain in full force and effect until revoked in writing by me. This authorization is voluntarily made on my specific understanding that:

- I am not required to sign this form or to make COPE contributions as a condition of my employment by my employer or membership in the Union;
- I may refuse to contribute without any reprisal;
- Only Union members and executive/administrative staff of the Union who are U.S. citizens are eligible to contribute to SEIU COPE;
- The amounts on this form are merely a suggestion, and I may contribute more or less by this or some other means without fear of favor or disadvantage from the Union or my employer;
- SEIU COPE uses the money it receives for political purposes, including but not limited to addressing political issues of public importance and contributing to and spending money in connection with federal, state and local elections;
- Contributions to SEIU COPE are not tax deductible for federal income tax purposes.

Member Signature: Darlene Walls Date Signed: 1/30/08

Original Copy: Employer Yellow Copy: SEIU UHW - West Membership Dept Pink Copy: Employee

2870 **CONFIDENTIALITY AGREEMENT**

Instructions:

1. All Employees : To ensure efficient and effective service please, submit form online. Immediate confirmation will be sent to you upon receipt of your online submittal.
2. Residents/Fellows/Interns: Please fax your form to National HR Service Center 877) 477-2329 or interoffice mail to National HR Service Center, Alameda
3. Volunteers, Students and Temporary Employees: Provide completed form to your Kaiser Permanente Manager.
4. SCPMG Physicians ONLY: To be administered and retained as part of credentialing process
5. Remember to print copy of form before submitting.

Note: Applies to all employees (including administrators, managers, supervisors, applicable physicians), volunteers, agency temporary/registry personnel, students and interns.

* Employee / Physician ID	* Work Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
Darlene Walls	310) 517-3000	2/25/08
* Employee / Physican First Name	Employee / Physician Middle Name	* Employee / Physician Last Name

* Job Title	* Location
CNA	South Bay MED/SURG

1. AGREEMENT

In my job, I may see or hear confidential information in any form (oral, written, or electronic) regarding:

- HEALTH PLAN MEMBERS AND PATIENTS AND/OR THEIR FAMILY MEMBERS (such as patient records, test results, conversations, financial information)
- EMPLOYEES, PHYSICIANS, VOLUNTEERS, CONTRACTORS (such as employment records, corrective actions/disciplinary actions)

I will protect the confidentiality of this information. Access to this information is allowed only if I need to know it to do my job.

I AGREE THAT:

1. I will protect the confidentiality of our patients, members, employees and physicians.
2. I will not misuse confidential information and I will only access information I have been instructed or authorized to access to do my job. With respect to Medical Information, I will only access or use such information as it is necessary to provide medical care to the member and/or patient or as necessary for billing and payment or health plan operations.
3. I will not share, change or destroy and confidential information unless it is part of my job to do so. If any of these tasks are part of my job, I will follow the correct department procedure or the instructions of my supervisor/chief of service (such as shredding confidential paper). If a demand is made upon me from outside Kaiser Permanente to disclose confidential information, I will give written notice to my supervisor before disclosing such information.
4. I know that confidential information I learn on the job does not belong to me and that Kaiser Permanente may take away my access to confidential information at any time.
5. If I have access to electronic equipment and/or records, I will keep my computer password secret and I will not share it with any unauthorized individual. I am responsible if I fail to protect my password or other access to confidential information.
6. I will not use anyone else's password to access any Kaiser Permanente system unless I am authorized to do so. If I am authorized to do so (e.g., in order to perform computer systems maintenance), I will follow procedures to ensure the password is changed and that confidential information is not at risk.
7. If I have access to electronic equipment and/or records, I will not make unauthorized copies of Kaiser Permanente's software or software of other companies licensed for use by Kaiser Permanente and I will use software in compliance with the terms of any applicable software license agreements.
8. I will not share and confidential information even if I no longer work for Kaiser Permanente.
9. On termination of my employment, I will return to Kaiser Permanente all copies of documents containing Kaiser Permanente's Confidential Information or data in my possession or control.

National HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772

2870 **CONFIDENTIALITY AGREEMENT**

* First Name	Middle Name	* Last Name
Darlene		Walls
*** Employee ID**	*** Work Phone Number (###)###-####**	*** Effective Date (mm/dd/yyyy)**
530105	310)517-3000	2/28/08

Examples of Breaches of Confidentiality (What you should NOT do.)

These are examples only and do not include all possible breaches of confidentiality.

- Unauthorized reading of patient account information.
- Unauthorized reading of a patient's chart (except your own if you have access to electronic records).
- Unauthorized access to information on friends or co-workers.
- Accessing medical information of a family member without written authorization.
- Discussing confidential information in a public area such as a waiting room or elevator.

Examples of Breaches of Confidentiality related to electronic information (What you should NOT do.)

These are examples only and do not include all possible examples of breaches of confidentiality.

- Telling a co-worker your password so that he or she can login to your work.
- Telling an unauthorized person the access codes for employee files or patient accounts.
- Being away from your workstation while you are logged into an application, without locking your system to protect confidential information.
- Unauthorized use of a co-worker's password to logon to a Kaiser Permanente information system
- Unauthorized use of a user ID to access employee files or patient accounts.
- Allowing a co-worker to use your *secured application for which he/she does not have access after you have logged in.

NOTE: * secured application = any computer program that allows access to confidential information. A secured application usually requires a user name and password to log in.

I understand that I am responsible for my use or misuse of confidential information and know that my access to confidential information may be audited. I understand that my supervisor/chief of service or other managers and/or the Compliance Hot Line are available if I think someone is misusing confidential information or is misusing my password. I further understand that Kaiser Permanente will not tolerate any retaliation because I make such a report.

I understand that failure to comply with this agreement may result in disciplinary action up to and including termination of employment or other relationship with Kaiser Permanente. I understand that I may also be subject to other remedies allowed by law. I understand that I must also comply with any laws, regulations, and other Kaiser Permanente policies, including the Principles of Responsibility that address confidentiality. By signing this Confidentiality Agreement, I agree that I have read, understand and will comply with it.

2. SIGNATURE (Required if not submitted online)

Darlene Walls	3/3/08
* Employee / Physician Signature	* Date (mm/dd/yyyy)

After completing the form:
1. Print form to keep a copy for your records.
2. Press the Submit button.
3. Wait for a pop-up screen to confirm the form has been submitted. (This may take a few minutes.)
4. ALL Employees: Please submit online or fax your form to National HR Service Center (877) 477-2329 or interoffice mail to National HR Service Center, Alameda.
5. Residents/Fellows/Interns: Please fax your form to National HR Service Center (877) 477-2329 or interoffice mail to National HR Service Center, Alameda.
6. Volunteers, Students and Temporary Employees: Provide completed form to your Kaiser Permanente Manager.
7. SCPMG Physicians ONLY: To be administered and retained as part of credentialing process.

National HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772

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2860 CHILD ABUSE REPORTING REQUIREMENTS

Instructions: 1. To ensure efficient and effective service please, submit form online.
2. Items marked with an asterisk (*) are required fields.
3. Remember to print copy of form before submitting.
4. Immediate confirmation will be sent to you upon receipt of your online submittal.

* Employee ID	* Home Phone (###) ###-####	* Work Phone (###) ###-####	* Effective Date (mm/dd/yyyy)
530105	562) 925-5950	310) 517-3000	2/28/08

* First Name	Middle Name	* Last Name
Darlene		Walls

1. REQUIREMENTS

Section 11166 of the Penal Code requires any child care custodian, health practitioner, or employee of a child protective agency who has knowledge of or observes a child in his or her professional capacity or within the scope of his or her employment who he or she knows or reasonably suspects has been the victim of child abuse or who he or she knows or reasonably suspects that a child is suffering serious emotional damage or is at substantial risk of suffering serious emotional damage to report the known or suspected instance of child abuse to a child protective agency immediately or as soon as practically possible by telephone and to prepare and send a written report thereof within 36 hours of receiving the information concerning the incident.

The identity of all persons who report shall be confidential and disclosed among agencies receiving or investigating mandated reports, to the district attorney in a criminal prosecution, or in an action initiated under Section 602 of the Welfare and Institutions Code arising from alleged child abuse, or to counsel appointed pursuant to subdivision (c) of Section 317 of the Welfare and Institutions Code, or to the county counsel or district attorney in a proceeding under Part 4 (commencing with Section 7800) of Division 12 of the Family Code or Section 300 of the Welfare and Institutions Code, or to a licensing agency when abuse or neglect in out-of-home care is reasonably suspected, or when those persons waive confidentiality, or by court order.

Health practitioner includes physicians and surgeons, psychiatrists, psychologists, dentists, residents, interns, podiatrists, chiropractors, licensed nurses, dental hygienists, optometrists, or any other person who is licensed under Division 2 (commencing with Section 500) of the Business and Professions Code; marriage, family and child counselors, emergency medical technicians I or II, paramedics, or other person certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code; psychological assistants registered pursuant to Section 2913 of the Business and Professions Code, marriage, family and child counselor trainees as defined in subdivision (c) of Section 4980.44 of the Business and Professions Code; state or county public health employees who treat minors for venereal disease or any other condition; coroners; paramedics; and religious practitioners who diagnose, examine, or treat children.

Volunteers whose duties include direct contact with and supervision of children are not mandated reporters, but are encouraged to report instances of child abuse and neglect.

Your department chief or supervisor should be notified whenever you believe you may be required to report suspected child abuse.

I understand and agree, if in a Child Care Custodian or Health Practitioner classification, as defined above, to comply fully with the above-cited provisions of the California Penal Code, in accord with procedures established by my Employer/Medical Center.

2. EMPLOYEE SIGNATURE Darlene Walls

Signature - (Required if not submitted online).

Darlene Walls
* Employee Signature

3/3/08
* Date (mm/dd/yyyy)

Facility / Department
South Bay / MED SURG

After completing the form:
1. Print form to keep a copy for your records.
2. Press the Submit button.
3. Wait for a pop-up screen to confirm the form has been submitted. (This may take a few minutes.)

National HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772

2790

LANGUAGE PROFICIENCY

Instructions: 1. To ensure efficient and effective service please submit form on-line.
2. Items marked with asterisk (*) are required fields.
3. Immediate notification will be sent to you upon receipt of your on-line submittal.

* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
530105	310)346-8620	2/28/08
* First Name	Middle Name	* Last Name
Darlene		Walls

1. LANGUAGE INFORMATION

Foreign Language			Foreign Language		
A. How well can you perform the following in this language:			A. How well can you perform the following in this language:		
Speak	Read	Write	Speak	Read	Write
☐ Fluently	☐ Fluently	☐ Fluently	☐ Fluently	☐ Fluently	☐ Fluently
☐ Adequately	☐ Adequately	☐ Adequately	☐ Adequately	☐ Adequately	☐ Adequately
☐ Minimally	☐ Minimally	☐ Minimally	☐ Minimally	☐ Minimally	☐ Minimally
B. Is this your native language?		☐ Yes ☐ No	B. Is this your native language?		☐ Yes ☐ No
C. Are you able to translate this language?		☐ Yes ☐ No	C. Are you able to translate this language?		☐ Yes ☐ No
D. Are you able to teach in this language?		☐ Yes ☐ No	D. Are you able to teach in this language?		☐ Yes ☐ No
Foreign Language			Foreign Language		
A. How well can you perform the following in this language:			A. How well can you perform the following in this language:		
Speak	Read	Write	Speak	Read	Write
☐ Fluently	☐ Fluently	☐ Fluently	☐ Fluently	☐ Fluently	☐ Fluently
☐ Adequately	☐ Adequately	☐ Adequately	☐ Adequately	☐ Adequately	☐ Adequately
☐ Minimally	☐ Minimally	☐ Minimally	☐ Minimally	☐ Minimally	☐ Minimally
B. Is this your native language?		☐ Yes ☐ No	B. Is this your native language?		☐ Yes ☐ No
C. Are you able to translate this language?		☐ Yes ☐ No	C. Are you able to translate this language?		☐ Yes ☐ No
D. Are you able to teach in this language?		☐ Yes ☐ No	D. Are you able to teach in this language?		☐ Yes ☐ No

After completing the form:
1. Print form to keep a copy for your records.
2. Press the Submit button.
3. Wait for a pop-up screen to confirm the form has been submitted. (This may take a few minutes.)

National HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772

1920

STANDARDS OF ATTENDANCE

Instructions: 1. This form cannot be submitted online.
2. Either: a) complete online and print or b) print and complete by printing clearly using blue or black ink.
3. Items marked with an asterisk (*) are required fields.
4. When complete, fax to the number below. Be sure to retain original and the fax receipt for your records.
5. Upon receipt, your form will be processed within 3 days.

* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
530105	310) 346-8620	2/28/08
*** First Name**	**Middle Name**	*** Last Name**
Darlene		Walls

1. ACKNOWLEDGEMENT

The Kaiser Permanente Medical Program is committed to providing high quality health care and service to our members. You are part of the overall team which provides this quality, caring service. When you are absent or late, the team is incomplete and our ability to provide service to our members is diminished. Because reporting to work as scheduled is a most important job requirement, the Employer has established Regional Standards of Attendance. Your supervisor will explain these to you.

It is understood that eligible benefited employees will be absent from time to time as a result of an illness or injury. Kaiser Permanente currently provides two (2) different programs to protect your earnings during such absences: Earned Time Off (ETO) and Extended Sick Leave (ESL). In cases of extended absences, State Disability Insurance or Workers' Compensation Insurance payments are integrated with ESL or ETO to provide you with income for as long as possible.

Kaiser Permanente places great importance in the Regional Standards and Attendance Program and expects each employee to adhere to its standards in the interests of providing quality service to our members and as a consideration to all other employees.

The Regional Standards of Attendance Program has been reviewed with me and I understand my responsibility to maintain an acceptable attendance record.

Darlene Walls
* Employee Signature

3/3/08
* Date (mm/dd/yyyy)

National HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772

2950 ELDER AND DEPENDENT ADULT ABUSE REPORTING REQUIREMENTS

Instructions: 1. To ensure efficient and effective service please, submit form online.
2. Items marked with an asterisk (*) are required fields.
3. Remember to print copy of form before submitting.
4. Immediate confirmation will be sent to you upon receipt of your online submittal.

* Employee ID	* Home Phone (###) ###-####	* Work Phone (###) ###-####	* Effective Date (mm/dd/yyyy)
530125	562) 925-5950	310)517-3000	2/28/08

* First Name	Middle Name	* Last Name
Darlene		Walls

1. ELDER AND DEPENDENT ADULT ABUSE REPORTING REQUIREMENTS

California Welfare and Institutions (W&I) Code Section 15659 requires Kaiser Permanente Medical Program to provide all "health professionals" and "care custodians information concerning their responsibility to report incidents of observed, known, or suspected elder and dependent abuse. All health practitioners or care custodians must sign a statement acknowledging receipt and understand of the mandatory elder and dependent abuse reporting requirements. Kaiser Permanente must retain the signed statement.

Elders are persons 65 years of age or older. **Dependent adults** are persons between the ages of 18 and 64 with physical or mental limitations such as physical or developmental disabilities or age-diminished physical or mental abilities. The law also expressly includes any person between the ages of 18 and 64 who is admitted as an inpatient to an acute care hospital or other 24-hour facility as a dependent adult. (W&I Code Sections 15610.23, 15610.27 and 15701.2)

Abuse of and elder or dependent adult means either of the following:
(a) Physical abuse, including lewd or lascivious acts, neglect, financial abuse, abandonment, isolation, abduction, or other treatment with resulting physical harm or pain or mental suffering; or
(b) The deprivation by a care custodian of goods or services that are necessary to avoid physical harm or mental suffering. (W&I Code Section 15610.07)

At Kaiser Permanente, a physician, nurse, and licensed or unlicensed health care professional, including administrative and support staff, who, in his or her professional capacity, or within the scope of his or her employment, has observed or has knowledge of elder and/or dependent abuse, or reasonably suspects elder and/or dependent abuse, **shall report by telephone immediately or as soon as practically possible and by written report within two (2) working days** as follows:
(a) to the long-term care ombudsmen or the local law enforcement agency when the abuse is alleged to have occurred in a long-term care facility;
(b) to the State Department of Mental Health, the State Department of Developmental Services, or the local law enforcement agency if the abuse is alleged to have occurred in a state mental health hospital or state developmental center; or,
(c) to the adult protective services agency or the local law enforcement agency when the abuse is alleged to have occurred anywhere else. (W&I Code Section 15630)
All incidents should be documented and forwarded to the appropriate agency in accordance with local medical center procedures.

I certify that I have read and understand this statement and will comply with the requirements of the Elder and Dependent Abuse Reporting Law.

2. SIGNATURE

Darlene Walls

Darlene Walls
* Employee Signature

3/3/05
* Date (mm-dd-yyyy)

Facility / Department
South Bay / MED/SURG

After completing the form:
1. Print form to keep a copy for your records.
2. Press the Submit button.
3. Wait for a pop-up screen to confirm the form has been submitted. (This may take a few minutes.)

National HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772

05/04/2008

Darlene Williams C.N.A
15545 ½ Eucalyptus Ave.
Bellflower, CA 90706
(310)346-8620

OBJECTIVE:
To use, build, and to add to my current skills base in a C.N.A. position with a progressive company that recognizes top performance and encourages professional growth and advancement based on professionalism, work performance, ethics, integrity, and trust.

QUALIFICATIONS

Vital signs
Charting
Surgery Pre Op Prep
Surgery Post Op Care
In Home Care

EMPLOYMENT HISTORY:

February 2007 – Present
Mediscan Nursing Staff
Woodland Hills, CA

- Vital signs
- Same Day Surgery Pre op Prep
- Charting
- Surgery Aftercare

September 2006 – January 2007
Accredited Nursing Care

- In Home Health Care
- Meal Preparation
- Light Housekeeping
- Bathing

June 2003 – July 2005
Williams Board Care
Mental Illness Care

- Vital signs
- Charting
- Seclusion observation
- Monitor patient intake
- Assisted with group therapy
- ADLS

KAISER PERMANENTE®

APPLICATION FOR EMPLOYMENT

TEST RESULTS: JAN 25 2008 — FOR OFFICE USE ONLY

TO THE APPLICANT: Kaiser Foundation Health Plan, Inc., Kaiser Foundation Hospitals (together KFHP/H), KFHP/H's subsidiaries, Southern California Permanente Medical Group, and The Permanente Medical Group, Inc. ("Kaiser Permanente") are equal opportunity employers. Kaiser Permanente makes employment decisions based on qualifications only without regard to race, religion, color, national origin, ancestry, sex, age, marital status, disability, medical condition, sexual orientation, veteran status, or other non-job related factors prohibited by applicable federal state or local laws. Kaiser Permanente provides applicants who have disabilities with reasonable accommodation to assist in the interview/hiring process. Applicants requiring accommodation should contact the Human Resources office. Kaiser Permanente is a smoke-free workplace. **This document must be completed in its entirety before an offer of employment can be authorized.**

PERSONAL DATA

NAME (LAST)	(FIRST)	(MIDDLE)	SOCIAL SECURITY NUMBER
Walls	Darlene		558-37-5679

ADDRESS (NUMBER)	(STREET)	APARTMENT #	HOME TELEPHONE	ALTERNATE TELEPHONE
15545 1/2	Eucalyptus Ave		(562) 925-5950	(310) 346-8620

CITY	STATE	ZIP CODE	E-MAIL ADDRESS
Bellflower	CA	90706	

INDICATE ANY OTHER NAMES USED
NAME (LAST) Williams (FIRST) Darlene (MIDDLE) COMPANY/SCHOOL

POSITION(S) FOR WHICH YOU ARE APPLYING
1. Nursing Att
2.

SHIFTS: ☑ DAYS ☐ EVENINGS ☐ NIGHTS
HOURS: ☑ FULL-TIME ☑ PART-TIME ☐ PER DIEM/ON-CALL
TEMPORARY: ☐

LOCATION(S) FOR WHICH YOU ARE APPLYING: Harbor City

HOW WERE YOU REFERRED TO KAISER PERMANENTE?
☐ ADVERTISEMENT ☐ AGENCY ☐ EMPLOYEE REFERRAL (Indicate Name of Employee)
☐ EVENT ☑ WALK-IN ☐ WEBSITE ☐ OTHER

HAVE YOU EVER BEEN EMPLOYED BY KAISER PERMANENTE OR ANY OTHER KAISER ORGANIZATION? ☐ YES ☑ NO
IF YES, NAME OF FACILITY OR ORGANIZATION | WHEN
WHERE | POSITION HELD | NAME USED

DO YOU HAVE RELATIVES WORKING FOR KAISER PERMANENTE? IF YES, INDICATE NAME, RELATIONSHIP, DEPARTMENT, LOCATION
☐ YES ☑ NO

IF HIRED, YOU WILL BE REQUIRED TO FURNISH PROOF THAT YOU ARE LEGALLY AUTHORIZED TO WORK FOR KAISER PERMANENTE IN THE UNITED STATES. CAN YOU FURNISH SUCH PROOF? ☑ YES ☐ NO

EDUCATIONAL HISTORY

If your name on your diploma/degree is different than on this Application, please indicate your previous name here: Williams

HIGH SCHOOL

NAME OF SCHOOL (WHERE YOU RECEIVED YOUR DIPLOMA OR G.E.D.)	CITY AND STATE	MAJOR FIELD	DO YOU HAVE A HIGH SCHOOL DIPLOMA? / DO YOU HAVE A G.E.D.?
Jefferson High	Los Angeles California		Diploma: ☑ YES ☐ NO; G.E.D.: ☐ YES ☐ NO

COLLEGE OR UNIVERSITY (UNDERGRADUATE AND GRADUATE)

NAME OF SCHOOL	CITY AND STATE	FIELD OF STUDY	INDICATE DEGREE RECEIVED
LA Harbor College	Harbor City	Children Development	Cert

OTHER SCHOOLING / VOCATIONAL / TRAINING

NAME OF SCHOOL	CITY AND STATE	FIELD OF STUDY	INDICATE DIPLOMA / CERTIFICATION RECEIVED

LICENSE / CERTIFICATION / REGISTRATION

DO YOU HAVE A CURRENT PROFESSIONAL LICENSE, CERTIFICATE OR REGISTRATION? ☐ YES ☐ NO

IF YES, INDICATE TYPE	NUMBER	EXPIRATION DATE	STATE WHERE ISSUED
Nurse Assistant Certificate	00688083	3/23/09	CA
Home Health Aide Certificate	00211001	3/23/09	CA

ARE THERE ANY CURRENT RESTRICTIONS OF ANY NATURE ON YOUR LICENSE, REGISTRATION, CERTIFICATION OR ON YOUR RIGHT TO PRACTICE YOUR PROFESSION, OCCUPATION OR ABILITY TO PROVIDE HEALTH CARE SERVICES? ☐ YES ☑ NO — IF YES, EXPLAIN

ARE THERE ANY ACTIONS PENDING AT THIS TIME RELATING TO THE RESTRICTION, SUSPENSION, DENIAL OR REVOCATION OF YOUR LICENSE, REGISTRATION OR CERTIFICATION TO PRACTICE YOUR PROFESSION OR OCCUPATION? ☐ YES ☑ NO — IF YES, EXPLAIN

NAME: Walls (LAST) Darlene (FIRST) MIDDLE INITIAL

05/04/2008

LAST NAME Walls FIRST NAME Darlene DATE 1/25/08

EMPLOYMENT / VOLUNTEER WORK / OTHER WORK HISTORY

A resume will not be accepted in place of any information required on this form.

PLEASE ACCOUNT FOR ALL YOUR TIME DURING THE PAST TEN YEARS, INCLUDING JOBS, STUDENT INTERSHIPS, VOLUNTEER WORK, EDUCATION, UNEMPLOYMENT, SELF-EMPLOYMENT, MILITARY SERVICE, ETC. IF YOU NEED ADDITIONAL SPACE, PLEASE REQUEST ADDITIONAL PAGE(S).

CURRENT EMPLOYER

Field	Entry
DATES EMPLOYED FROM (MM/YY)	2/07
DATES EMPLOYED TO (MM/YY)	Preent
RATE OF PAY START	12.00 hrs
RATE OF PAY LAST	13.00 hrs
EMPLOYER NAME (PRESENT OR MOST RECENT POSITION)	Mediscan STAFFING
EMPLOYER ADDRESS	21050 Calisa
CITY	Woodhills
STATE	CA
ZIP CODE	91367
TELEPHONE NUMBER / EXTENSION	(888) 500-4700
MAY WE CONTACT THIS EMPLOYER?	☑ YES ☐ NO
NAME OF SUPERVISOR	Mary
CURRENT TELEPHONE #	( )
YOUR JOB TITLE	CNA
YOUR JOB DUTIES AND RESPONSIBILITIES	Charting I/O, Dicting, Serving breakfast Lunch, Vital Sign
REASON FOR LEAVING	
WORK SCHEDULE	☐ FULL-TIME ☑ PER DIEM / ON-CALL ☐ PART-TIME ☐ TEMPORARY

PREVIOUS EMPLOYERS

Field	Entry
DATES EMPLOYED FROM (MM/YY)	9/06
DATES EMPLOYED TO (MM/YY)	6/07
RATE OF PAY START	9.00 hrs
RATE OF PAY LAST	9.50 hrs
EMPLOYER NAME	ACCREDITED NURSING CARE
EMPLOYER ADDRESS	950 S Coast Drive Suit 215
CITY	Coast Mesa
STATE	CA
ZIP CODE	
TELEPHONE NUMBER / EXTENSION	(714) 430-6804
MAY WE CONTACT THIS EMPLOYER?	☑ YES ☐ NO
NAME OF SUPERVISOR	Darrin Carey
CURRENT TELEPHONE #	(714) 973-1234
YOUR JOB TITLE	CNA Assistant Paitent in The H
YOUR JOB DUTIES AND RESPONSIBILITIES	Assistant Paitent in there Home, Prepare Bathing, Light Housekeeping
REASON FOR LEAVING	Temporary
WORK SCHEDULE	☑ FULL-TIME ☑ PER DIEM / ON-CALL ☑ PART-TIME ☐ TEMPORARY

Field	Entry
DATES EMPLOYED FROM (MM/YY)	9/94
DATES EMPLOYED TO (MM/YY)	7/04
RATE OF PAY START	7.50 hrs
RATE OF PAY LAST	$11 11. hrs
EMPLOYER NAME	L.A.U.S.D
EMPLOYER ADDRESS	
CITY	Harbor City
STATE	CA
ZIP CODE	
TELEPHONE NUMBER / EXTENSION	(310) 326-3344
MAY WE CONTACT THIS EMPLOYER?	☑ YES ☐ NO
NAME OF SUPERVISOR	Susie
CURRENT TELEPHONE #	( )
YOUR JOB TITLE	Teacher AIDE
YOUR JOB DUTIES AND RESPONSIBILITIES	Assit teacher with children, Daily Active, Served Lunch Breakfast, Playground Active, Groups Act, CRAFTS
REASON FOR LEAVING	With to School for nursing
WORK SCHEDULE	☐ FULL-TIME ☐ PER DIEM / ON-CALL ☐ PART-TIME ☐ TEMPORARY

Field	Entry
DATES EMPLOYED FROM (MM/YY)	8/07
DATES EMPLOYED TO (MM/YY)	12/07
RATE OF PAY START	$13.00
RATE OF PAY LAST	$13.00
EMPLOYER NAME	Huntington Hospital
EMPLOYER ADDRESS	100 W. California Blvd
CITY	PO. Box 7013
STATE	
ZIP CODE	
TELEPHONE NUMBER / EXTENSION	(626) 379-0623
MAY WE CONTACT THIS EMPLOYER?	☑ YES ☐ NO
NAME OF SUPERVISOR	Myase Harwthone
CURRENT TELEPHONE #	( )
YOUR JOB TITLE	CNA
YOUR JOB DUTIES AND RESPONSIBILITIES	Vital Sign, Charting, Surgery After Care, Surgery Pre Op prep
REASON FOR LEAVING	Temporary
WORK SCHEDULE	☐ FULL-TIME ☐ PER DIEM / ON-CALL ☐ PART-TIME ☑ TEMPORARY

03/04/2008

LAST NAME Walls FIRST NAME Darlene DATE 1/25/08

EMPLOYMENT / VOLUNTEER WORK / OTHER WORK HISTORY

A resume will not be accepted in place of any information required on this form.

PLEASE ACCOUNT FOR ALL YOUR TIME DURING THE PAST TEN YEARS, INCLUDING JOBS, STUDENT INTERNSHIPS, VOLUNTEER WORK, EDUCATION, UNEMPLOYMENT, SELF-EMPLOYMENT, MILITARY SERVICE, ETC. IF YOU NEED ADDITIONAL SPACE, PLEASE REQUEST ADDITIONAL PAGE(S).

PREVIOUS EMPLOYERS

DATES EMPLOYED — FROM (MM/YY): 8/94 — TO (MM/YY): 9/06

EMPLOYER NAME: "Stay [illegible] mom"

YOUR JOB TITLE:

EMPLOYER ADDRESS: 210 E. 220th St

CITY: Carson STATE: CA ZIP CODE: 90745

YOUR JOB DUTIES AND RESPONSIBILITIES: [illegible]

RATE OF PAY — START: LAST:

TELEPHONE NUMBER / EXTENSION: ( )

MAY WE CONTACT THIS EMPLOYER? ☐ YES ☐ NO

NAME OF SUPERVISOR:

CURRENT TELEPHONE #: ( )

REASON FOR LEAVING: Temporary

WORK SCHEDULE ☐ FULL-TIME ☐ PER DIEM / ON-CALL ☐ PART-TIME ☐ TEMPORARY

DATES EMPLOYED — FROM (MM/YY): TO (MM/YY):

EMPLOYER NAME:

YOUR JOB TITLE:

EMPLOYER ADDRESS:

CITY: Carson STATE: ZIP CODE:

YOUR JOB DUTIES AND RESPONSIBILITIES:

RATE OF PAY — START: LAST:

TELEPHONE NUMBER / EXTENSION: ( )

MAY WE CONTACT THIS EMPLOYER? ☐ YES ☐ NO

NAME OF SUPERVISOR:

CURRENT TELEPHONE #: ( )

REASON FOR LEAVING:

WORK SCHEDULE ☐ FULL-TIME ☐ PER DIEM / ON-CALL ☐ PART-TIME ☐ TEMPORARY

DATES EMPLOYED — FROM (MM/YY): TO (MM/YY):

EMPLOYER NAME:

YOUR JOB TITLE:

EMPLOYER ADDRESS:

CITY: STATE: ZIP CODE:

YOUR JOB DUTIES AND RESPONSIBILITIES:

RATE OF PAY — START: LAST:

TELEPHONE NUMBER / EXTENSION: ( )

MAY WE CONTACT THIS EMPLOYER? ☐ YES ☐ NO

NAME OF SUPERVISOR:

CURRENT TELEPHONE #: ( )

REASON FOR LEAVING:

WORK SCHEDULE ☐ FULL-TIME ☐ PER DIEM / ON-CALL ☐ PART-TIME ☐ TEMPORARY

PROFESSIONAL REFERENCES

PLEASE PROVIDE THE NAMES OF AT LEAST TWO PERSONS (NOT RELATIVES) WHO MAY BE CONTACTED BY US. BOTH SHOULD HAVE SPECIFIC KNOWLEDGE OF YOUR WORK EXPERIENCE.

NAME	ADDRESS	TELEPHONE NUMBER	OCCUPATION	HOW DOES THIS PERSON KNOW YOU?
Chaita Culpepper	412 E Carson St Carson CA 90746	(310) 522-9786	Teacher	Work together
Myane Harwthorne		(626) 379-0633	Nurse	work together

03/04/2008

LAST NAME Walls FIRST NAME Darlene DATE 1/25/08

LANGUAGE PROFICIENCY (OTHER THAN ENGLISH)

LANGUAGE	READS	WRITES	SPEAKS
	English	English	English

AMERICAN SIGN LANGUAGE — SIGN ☐ Yes ☒ No

ADDITIONAL SKILLS (PLEASE INDICATE ANY ADDITIONAL JOB-RELATED SKILLS YOU POSSESS)

TYPING 35. W.P.M.

COMPUTER SOFTWARE/APPLICATIONS PROFICIENCY (PLEASE LIST):

MEDICAL TERMINOLOGY ☐ Yes ☒ No

OTHER:

CRIMINAL PUBLIC RECORD CHECK (PLEASE COMPLETE ALL SECTIONS BELOW)

IN ANSWERING THE FOLLOWING QUESTION, *DO NOT* DISCLOSE (1) MISDEMEANOR MARIJUANA-RELATED CONVICTIONS THAT ARE MORE THAN TWO YEARS OLD; (2) CONVICTIONS THAT HAVE BEEN EXPUNGED, SEALED, OR STATUTORILY ERADICATED; (3) MISDEMEANOR CONVICTION(S) FOR WHICH YOU PETITIONED THE COURT TO EXPUNGE YOUR CONVICTION(S) AND THE COURT ORDERED DISMISSAL OF THE CONVICTION(S); (4) COURT ORDERED DISMISSAL OF CONVICTION(S) AFTER COMPLETION OF A DIVERSION PROGRAM.

HAVE YOU EVER BEEN CONVICTED OF A CRIME? ☐ YES ☒ NO

(*"A CRIME"* MEANS ANY MISDEMEANOR OR FELONY REGARDLESS OF AGE INCLUDING CONVICTIONS FOR MOTOR VEHICLE/DRIVING VIOLATIONS THAT CONSTITUTE A MISDEMEANOR OR FELONY; e.g., DRIVING UNDER THE INFLUENCE OF DRUGS OR ALCOHOL, RECKLESS DRIVING.)

(*"CONVICTED"* MEANS PLEA, VERDICT OR FINDING OF NO CONTEST OR GUILT, REGARDLESS OF WHETHER SENTENCE WAS IMPOSED BY THE COURT)

IF *YES* FOR EACH CONVICTION INDICATE: *(USE REVERSE FOR ADDITIONAL CASES)*

DATE	CRIME	COURT NAME	CITY	COUNTY

CONVICTION OF A CRIME IS NOT AN AUTOMATIC BAR TO EMPLOYMENT. ALL CIRCUMSTANCES WILL BE CONSIDERED. HOWEVER, FAILURE TO FULLY DISCLOSE IS FALSIFICATION AND GROUNDS FOR IMMEDIATE TERMINATION UPON DISCOVERY AT ANY TIME DURING EMPLOYMENT.

ARE YOU PRESENTLY ON PROBATION? ☐ YES ☒ NO

ARE YOU PRESENTLY ON PAROLE? ☐ YES ☒ NO

DO YOU HAVE A CRIMINAL CASE NOW PENDING? THIS INCLUDES CASES PENDING TRIAL, CONTINUED FOR HEARINGS, CASES WHERE WARRANTS ARE OUTSTANDING AND CASES WHERE YOU ARE RELEASED ON BAIL OR YOUR OWN RECOGNIZANCE. ☐ YES ☒ NO

IF THE POSITION YOU APPLIED FOR IS IN A HEALTH FACILITY AND HAS ACCESS TO DRUGS AND MEDICATIONS, HAVE YOU EVER BEEN **ARRESTED** FOR AN OFFENSE INVOLVING CONTROLLED SUBSTANCES? ☐ YES ☒ NO (CAL LABOR CODE 432.7 (I), CAL HEALTH AND SAFETY CODE 11590)

IF THE POSITION YOU APPLIED FOR IS IN A HEALTH FACILITY AND HAS REGULAR ACCESS TO PATIENTS, HAVE YOU EVER BEEN **ARRESTED** FOR A SEX OFFENSE FOR WHICH REGISTRATION AS A SEX OFFENDER WOULD BE REQUIRED UPON CONVICTION? ☐ YES ☒ NO (CAL LABOR CODE 432.7 (I), CAL PENAL CODE 290)

ARE YOU REQUIRED TO REGISTER AS A SEX OFFENDER UNDER CAL PENAL CODE 290? ☐ YES ☒ NO

1/25/08

SANCTION/EXCLUSION LIST

HAVE YOU EVER BEEN SANCTIONED OR OTHERWISE EXCLUDED FROM PARTICIPATION IN MEDICARE, MEDICAID OR ANY OTHER FEDERAL OR STATE HEALTH CARE PROGRAM? ☐ YES ☒ NO

IF YES, WHAT DATE WAS THE SANCTION/EXCLUSION IMPOSED? ____________

ARE ANY SUCH ACTIONS PENDING? ☐ YES ☒ NO

ARE YOU STILL ON THE SANCTION/EXCLUSION LIST? ☐ YES ☒ NO

IF NO, WHAT DATE DID THE SANCTION/EXCLUSION END? ____________ WHEN WERE YOU REINSTATED? ____________

DRIVING RECORD (COMPLETE THIS SECTION ONLY IF YOU ARE APPLYING FOR A POSITION THAT REQUIRES A DRIVER'S LICENSE)

DO YOU HAVE A CURRENT DRIVER'S LICENSE? ☒ YES ☐ NO

IF YES, INDICATE DRIVER'S LICENSE NUMBER: C5118851

STATE WHERE ISSUED: CALIFORNIA

ARE THERE ANY CURRENT RESTRICTIONS ON YOUR DRIVER'S LICENSE? ☐ YES ☒ NO

IF YES, INDICATE RESTRICTIONS:

HAVE YOU BEEN FOUND GUILTY OF A MOVING VIOLATION IN THE PAST 5 YEARS? ☐ YES ☒ NO

IF YES, INDICATE WHEN:

1/08

APPLICATION STATEMENT

THIS APPLICATION IS SUBMITTED WITH THE UNDERSTANDING THAT ALL JOB OFFERS ARE CONDITIONAL AND WILL NOT BE CONFIRMED UNTIL SATISFACTORY COMPLETION OF A PRE-EMPLOYMENT HEALTH SCREENING AND (IF APPLICABLE) URINALYSIS TEST TO DETERMINE THE PRESENCE OF ILLEGAL OR INAPPROPRIATE USE OF LEGAL DRUGS. I HEREBY CONSENT TO SUCH REQUIRED SCREENING AND DRUG TESTING AND TO THE INCLUSION OF A STATEMENT WHETHER I HAVE PASSED OR FAILED THE SCREENING IN MY PERSONNEL FILE.

I HEREBY AUTHORIZE KAISER PERMANENTE TO SOLICIT ALL INFORMATION RELEVANT TO THIS APPLICATION. THIS AUTHORIZATION INCLUDES, BUT IS NOT LIMITED TO, A CRIMINAL RECORDS CHECK, MY ACADEMIC BACKGROUND, EMPLOYMENT HISTORY AND FEDERAL OR STATE SANCTIONS/EXCLUSIONS. I AUTHORIZE AND REQUEST ALL PERSONS, SCHOOLS, COMPANIES, CORPORATIONS, GOVERNMENTAL, LAW ENFORCEMENT AND OTHER AGENCIES TO RELEASE SUCH REQUESTED INFORMATION TO KAISER PERMANENTE.

I ALSO UNDERSTAND THAT ALL JOB OFFERS ARE CONTINGENT UPON RECEIPT OF SATISFACTORY VERIFICATION OF ALL OF THE ABOVE INFORMATION INCLUDING VERIFICATION OF MY ABILITY TO PERFORM THE ESSENTIAL FUNCTIONS OF THE POSITION THAT I HAVE APPLIED FOR.

I CERTIFY THAT THE ANSWERS I HAVE PROVIDED ABOVE ARE TRUE, CORRECT AND COMPLETE AND THAT I HAVE NOT KNOWINGLY WITHHELD ANY FACTS. I UNDERSTAND THAT ANY FALSIFICATION, MISREPRESENTATION OR OMISSION OF FACTS ARE SUFFICIENT REASONS FOR DISQUALIFICATION FROM FURTHER CONSIDERATION FOR EMPLOYMENT OR DISMISSAL AT ANY TIME DURING EMPLOYMENT SHOULD I BECOME EMPLOYED AT KAISER PERMANENTE.

I ALSO UNDERSTAND THAT IF I AM EMPLOYED BY KAISER PERMANENTE, MY EMPLOYMENT CAN BE TERMINATED AT ANY TIME, WITH OR WITHOUT CAUSE AND WITH OR WITHOUT NOTICE, EXCEPT AS MAY BE MODIFIED BY AN APPLICABLE COLLECTIVE BARGAINING AGREEMENT.

FOR POSITIONS REPRESENTED BY BARGAINING GROUPS, I UNDERSTAND THAT THE WAGES ARE BASED UPON CONTRACTUAL BARGAINING GROUP AGREEMENTS AND MAY BE SUBJECT TO CHANGE.

I UNDERSTAND THAT A COPY OF THIS DOCUMENT IS AVAILABLE TO ME IF I SO DESIRE. THIS APPLICATION WILL REMAIN ACTIVE FOR A PERIOD OF SIX MONTHS.

SIGNATURE Darlene Walls DATE 1/25/08

TRI CENTRAL SERVICE AREA
Baldwin Park, Bellflower, South Bay
NEW EMPLOYEE ORIENTATION CHECKLIST
Newly Hired and Transferring Employees

PRINT NAME (LAST)	(FIRST)		DATE OF HIRE
Walls	Darlene		2/25/08
JOB TITLE	**FACILITY (MEDICAL CENTER)**	**DEPARTMENT**	**DATE OF TRANSFER**
Nursing Attendants	South Bay	MeD/Surg	

ORGANIZATIONAL POLICIES

AVAILABILITY OF PERSONNEL FILE
EQUAL EMPLOYMENT OPPORTUNITY
AFFIRMATIVE ACTION PROGRAM
UNION MEMBERSHIP/COLLECTIVE BARGAINING AGREEMENT (IF APPLICABLE)
ATTENDANCE POLICY
CONFIDENTIALITY OF INFORMATION
QUALITY OF SERVICE STANDARDS
EMPLOYEE IDENTIFICATION BADGE REQUIREMENT
PROPERTY REMOVAL RULES
ALCOHOL AND DRUG POLICY
PAYDAY – WHERE, WHEN
CORPORATE COMPLIANCE
HIPAA – PART I
2000 SMOKE FREE

SAFETY AND HEALTH

ANNUAL HEALTH SCREENING
EMPLOYEE HEALTH SERVICES
OCCUPATIONAL SAFETY HEALTH STANDARDS ACT
SECURITY/THREAT MANAGEMENT
EMERGENCY PREPAREDNESS PLAN
RADIATION SAFETY
INFECTION CONTROL/STANDARD UNIVERSAL PRECAUTIONS
BODY MECHANICS
ASBESTOS NOTIFICATION
PATIENT & EMPLOYEE SAFETY

EMPLOYEE SERVICES

WORKER'S COMPENSATION
STATE DISABILITY INSURANCE
EMPLOYEE ASSISTANCE PROGRAM
KAISERIDER
CHILD CARE RESOURCES AND REFERRAL SERVICES
SERVICE EXCELLENCE PROGRAM
KAISER FEDERAL

ADDITIONAL SUBJECTS

PERFORMANCE IMPROVEMENT
RISK MANAGEMENT
CUSTOMER SERVICE
DIVERSITY/CLAS STANDARDS
ADVANCE DIRECTIVES
BIOETHICS
PATIENT RIGHTS
PAI
HIPAA Security

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE NEW EMPLOYEE ORIENTATION HANDBOOK AND THAT IT IS MY RESPONSIBILITY TO READ AND UNDERSTAND ITS CONTENTS.
THE ABOVE INFORMATION HAS BEEN COVERED WITH ME DURING MY NEW EMPLOYEE ORIENTATION.

EMPLOYEE SIGNATURE	DATE
Darlene Walls	2/27/08
STAFF EDUCATION REPRESENTATIVE SIGNATURE	**DATE**
[signature]	2/27/08

03/04/2008

NS-1293 (8-03) WHITE - HUMAN RESOURCES SERVICE CENTER CANARY - MANAGER PINK - EMPLOYEE

558-37-5679

California Technical University High School

This High School Diploma is awarded to

Darlene Williams

Who has been found worthy of Character and Citizenship
and has satisfactorily completed a Course of study
as prescribed by the Board of Trustees.

Given at Los Angeles, California
This Twelfth day of June, of the year Nineteenth Hundred and Eighty Five

Principal

President Board of Trustee

03/04/2008

558-37-5679

KAISER PERMANENTE

Hand Hygiene and Artificial Nail Policy Review and Distribution Documentation

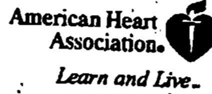
Date: January 30, 2008

I have been informed of the Kaiser Permanente Hand Hygiene Policy and the requirement to eliminate artificial nails effective July 8, 2002, for all persons who provide direct patient care.

Darlene Walls

Employee signature

03/04/2008

American Heart Association.

Learn and Live.

Healthcare Provider

DARLENE WALLS

This card certifies that the above individual has successfully completed the national cognitive and skills evaluations in accordance with the curriculum of the American Heart Association for the BLS for Healthcare Providers (CPR & AED) Program.

07/26/2006 — Issue Date

07/2008 — Recommended Renewal Date

COPIED FROM ORIGINAL

AHA Region: W.S.R. - Los Angeles County

Community Training Center: Little Company of Mary CTC

Training Site: TRINITY VOCATIONAL CENTER

Instructor: ZENAIDA MITU

Holder's Signature: Darlene Walls

©2000 American Heart Association Tampering with this card will alter its appearance. 70-2915

03/04/2008

04-13-2010

Course Completion Form

REGION: SCAL

COURSE TITLE: Annual Compliance Training 2009

COMPLETION DATE: 9/2/09

Instructions: To receive credit for this course, complete the fields below. Print clearly. To complete the I.D. Number and Name fields, use the information as it appears on your paycheck.

Your Information		
EMPLOYEE/PHYSICIAN I.D. NUMBER: 00530105	NUID #, IF KNOWN: X835065	
LAST NAME: WALLS	FIRST NAME: DARLENE	MIDDLE INITIAL
WORK PHONE NUMBER, TIELINE	WORK PHONE NUMBER, OUTSIDE	
DEPARTMENT: MED-SURG	LOCATION/FACILITY NAME: HABOR CITY	

Manager Information		
LAST NAME	FIRST NAME	WORK NUMBER

Course Information	
DELIVERY TYPE: ILT—Instructor-Led Training	COURSE ID: CPL:NACPL ANN 09 ILT

Course Completion Attestation

I understand that required compliance training is an important part of Kaiser Permanente's compliance program. My signature indicates that I, and no one on my behalf, have completed my *Annual Compliance Training 2009* course.

X Darlene Walls — 9/2/09

SIGNATURE — DATE ATTENDED/COMPLETED

Principles of Responsibility Attestation

- I have received a copy of the *Principles of Responsibility*.
- I understand that the principles discussed in Kaiser Permanente's *Principles of Responsibility* apply to me.
- I have read, understood, and have familiarized myself with the *Principles of Responsibility*.
- If I have any questions about the *Principles of Responsibility*, I will seek clarification from the compliance and ethics resources listed in the "Where to Get Help" section.
- I understand that I am expected to conduct myself in an ethical and responsible manner at all times, in accordance with the *Principles of Responsibility*.
- I agree to abide by the *Principles of Responsibility* and acknowledge that the failure to comply with the *Principles of Responsibility* can result in disciplinary action, up to and including termination.
- In addition to complying with the *Principles of Responsibility*, I understand that I am also required to report any suspected compliance or ethics concerns I become aware of. I further understand that I am protected from retaliation for reporting any such concerns.

X Darlene Walls — 9/2/09

SIGNATURE — DATE ATTENDED/COMPLETED

Please check your classification:

☒ KP Employee (Employee, Per Diem, etc.)	☐ PMG Physician (Physician, Per Diem, etc.)

Revision 01/02/09

KAISER PERMANENTE®
HR Service Center

August 23, 2013

Employee ID: 00530105
Case Number: 36209643

Darlene Walls
16323 cortuna ave # 8
Bellflower, CA 90706

Subject: Denial Notice - Under the Family and Medical Leave Act/California Family Rights Act (Family Leave)

Dear Darlene Walls,

On 7/9/2013 we were informed that you needed leave beginning on 6/17/2013 for:

☐ The birth of a child, or placement of a child with you for adoption or foster care.

☒ Your own serious health condition.

☐ Your need to care for your <spouse child parent domestic partner family member> due to his/her serious health condition.

☐ An exigency arising out of the fact that your <spouse son or daughter parent> is on active duty or call to active duty status.

☐ Your need to care for your <spouse son or daughter parent next of kin> due to his/her serious injury or illness incurred in the line of duty as a covered servicemember.

This Notice is to inform you that you are not eligible for FMLA/CFRA leave, because:

☐ You have not met the 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately <Enter Num Mos> months towards this requirement. If you are still on leave at the completion of 12 months of service please contact the HRSC to request your eligibility for FMLA/CFRA. For more information please see the attached notice of Employee Rights and Responsibilities.

☐ You have not met the 1,250 hours worked requirement within the 12 months preceding the start of your leave. As of <mm/dd/yyyy> you have worked <Enter Hours> hours towards the eligibility requirement. You can check the number of hours worked by contacting the HRSC.

KAISER PERMANENTE®
HR Service Center

☐ You exhausted your <12 26>-week entitlement to leave under the <FMLA/CFRA>

☐ Your request is for a non-qualified family member.

☒ You failed to provide sufficient certification to support your request.

- ☒ A Health Care Provider Certification form was not received.
- ☐ The information provided on the Health Care Provider Certification did not meet the definition of a serious health condition.
- ☐ The Health Care Provider Certification did not include the Frequency and Duration for an intermittent leave.
- ☐ The Health Care Provider Certification did not indicate your adult child is incapable of self-care because of a physical or mental disability.
- ☐ You failed to provide sufficient documentation to establish the required relationship between you and your family member; proof of <birth adoption/foster care domestic partner relationship marriage>.
- ☐ Military Orders
- ☐ <Certification of Exigency Certification of an injured/ill servicemember>

☐ Other:

The *Employee Rights and Responsibilities* under the FMLA are attached for your review.

While your time off is not currently protected under the FMLA and CFRA; you may become eligible for FMLA/CFRA during your leave. Please refer to the *Employee Rights and Responsibilities* for eligibility criteria or requirements. You may also be eligible for other forms of leave under Kaiser's leave policies or under an applicable collective bargaining agreement. If your leave is the result of a work-related injury, it may be subject to Workers' Compensation leave protection.

Policies, bargaining agreements and other information regarding leaves of absence can be found on My HR.

KAISER PERMANENTE®
HR Service Center

If you have any questions or concerns regarding the denial of your request for family leave, please contact Work Absence Management (WAM) at the HR Service Center at **877-4KP-HRSC (877-457-4772).** Please reference the case number located in the upper right-hand corner of this letter.

Sincerely,

WAM AGENT

Kaiser Permanente HR Service Center

KAISER PERMANENTE®

HR Service Center

EMPLOYEE RIGHTS AND RESPONSIBILITIES
UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is a current member of the Armed forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the service member medically unfit to perform his or her duties for which the service member is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or 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.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility. Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

DOWNEY SERVICE AREA

NEW EMPLOYEE ORIENTATION CHECKLIST

Newly Hired and Transferring Employees

2/25/08

PRINT NAME (LAST)	(FIRST)		DATE OF HIRE
WALLS	DARLENE		~~3/5/12~~
JOB TITLE	**FACILITY (MEDICAL CENTER)**	**DEPARTMENT**	**DATE OF TRANSFER**
NURSING AT.	DMC	MED/SURG	3/5/12

ORGANIZATIONAL POLICIES

AVAILABILITY OF PERSONNEL FILE
EQUAL EMPLOYMENT OPPORTUNITY
AFFIRMATIVE ACTION PROGRAM
UNION MEMBERSHIP/COLLECTIVE BARGAINING AGREEMENT (IF APPLICABLE)
ATTENDANCE POLICY
CONFIDENTIALITY OF INFORMATION
QUALITY OF SERVICE STANDARDS
EMPLOYEE IDENTIFICATION BADGE REQUIREMENT
PROPERTY REMOVAL RULES
ALCOHOL AND DRUG POLICY
PAYDAY – WHERE, WHEN
CORPORATE COMPLIANCE
HIPAA – PART I
2000 SMOKE FREE

SAFETY AND HEALTH

ANNUAL HEALTH SCREENING
EMPLOYEE HEALTH SERVICES
OCCUPATIONAL SAFETY HEALTH STANDARDS ACT
SECURITY/THREAT MANAGEMENT
EMERGENCY PREPAREDNESS PLAN
RADIATION SAFETY
INFECTION CONTROL/STANDARD UNIVERSAL PRECAUTIONS
BODY MECHANICS
ASBESTOS NOTIFICATION
PATIENT & EMPLOYEE SAFETY

EMPLOYEE SERVICES

WORKER'S COMPENSATION
STATE DISABILITY INSURANCE
EMPLOYEE ASSISTANCE PROGRAM
KAISERIDER
CHILD CARE RESOURCES AND REFERRAL SERVICES
SERVICE EXCELLENCE PROGRAM
KAISER FEDERAL

ADDITIONAL SUBJECTS

PERFORMANCE IMPROVEMENT
RISK MANAGEMENT
CUSTOMER SERVICE
DIVERSITY/CLAS STANDARDS
ADVANCE DIRECTIVES
BIOETHICS
PATIENT RIGHTS
NEO BINDER

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE NEW EMPLOYEE ORIENTATION HANDBOOK AND THAT IT IS MY RESPONSIBILITY TO READ AND UNDERSTAND ITS CONTENTS.
THE ABOVE INFORMATION HAS BEEN COVERED WITH ME DURING MY NEW EMPLOYEE ORIENTATION.

EMPLOYEE SIGNATURE	DATE
Darlene Walls	3/7/12
STAFF EDUCATION REPRESENTATIVE SIGNATURE	**DATE**
[signature]	3/7/12

NS-1293 (8/03) WHITE - HUMAN RESOURCES SERVICE CENTER CANARY - MANAGER PINK - EMPLOYEE

KAISER PERMANENTE.

Course Completion Form

REGION: So Cal

COURSE TITLE: General Compliance Training for New Employees 2012

CLASSROOM INSTRUCTOR: Ferdin Alonso

COMPLETION DATE: 3/6/12

Instructions: To receive credit for this course, complete the fields below. Print clearly. To complete the I.D. Number and Name fields, use the information as it appears on your paycheck.

Your Information		
EMPLOYEE/PHYSICIAN I.D. NUMBER: 530105	NUID #, IF KNOWN: X835065	
LAST NAME: WALLS	FIRST NAME: DARLENE	MIDDLE INITIAL:
WORK PHONE NUMBER, TIELINE:	WORK PHONE NUMBER, OUTSIDE:	
DEPARTMENT: MED/SURG	LOCATION/FACILITY NAME: DMC	
Manager Information		
LAST NAME: Lenaburg	FIRST NAME: Michelle	WORK NUMBER: 562) 657-8527
Course Information		
DELIVERY TYPE: ILT—Instructor-Led Training	COURSE ID: CPL:NACPL CNE 2012 ILT	

Course Completion Attestation

I understand that required compliance training is an important part of Kaiser Permanente's compliance program. My signature indicates that I, and no one on my behalf, have completed the *General Compliance Training for New Employees 2012* course.

x Darlene Walls — 3/6/12

SIGNATURE — DATE ATTENDED/COMPLETED

Principles of Responsibility Attestation

- I have received, read, and familiarized myself with a copy of the *Principles of Responsibility*.
- I understand that I am expected to conduct myself in an ethical and responsible manner in compliance with the *Principles of Responsibility* at all times. I also acknowledge my failure to comply with these principles can result in disciplinary action, up to and including termination.
- I understand that I am also required, in good faith, to report any suspected compliance or ethics concerns I become aware of, and that I am protected from retaliation for reporting.
- If I have any questions, I will seek clarification from the compliance and ethics resources listed in the "Know How to Get Help" chapter.

x Darlene Walls — 3/6/12

SIGNATURE — DATE ATTENDED/COMPLETED

Please check your classification:

☐ KP Employee (Employee, Per Diem, etc.)	☐ PMG Physician (Physician, Per Diem, etc.)

Version 1.0 11/18/2011

KAISER PERMANENTE.

(3)

2870 CONFIDENTIALITY AGREEMENT

Instructions: 1. To ensure efficient and effective service, submit form online. Immediate confirmation will be sent to you upon receipt of your online submittal.
2. If online submittal is not feasible, fax your form to HR Service Center (877) 477-2329 or interoffice mail to HR Service Center, Alameda.
3. Remember to print copy of form before submitting.
4. The Effective Date represents the date the Confidentiality Agreement is signed.

* Employee ID	* Work Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
530105	MED/SURG	3/5/12
* Employee First Name	Employee Middle Name	* Employee Last Name
DARLENE		WALLS

* Job Title	* Location
NURSING ATTENDENT	DMC

AGREEMENT

In my job, I may see or hear confidential information in any form (oral, written, or electronic) regarding:

- HEALTH PLAN MEMBERS AND PATIENTS AND/OR THEIR FAMILY MEMBERS (such as patient records, test results, conversations, financial information)
- EMPLOYEES, PHYSICIANS, VOLUNTEERS, CONTRACTORS (such as employment records, corrective actions/disciplinary actions)
- BUSINESS INFORMATION (such as member rates, marketing plans, financial projections)

I will protect the confidentiality of this information. Access to this information is allowed only if I need to know it to do my job.

I AGREE THAT:

1. I will protect the privacy of our patients, members, and employees.
2. I will not misuse confidential information of patients, members, employees or Kaiser Permanente (including confidential business and personnel information) and I will only access information I have been instructed or authorized to access to do my job. With respect to Protected Health Information, I will only access or use such information as it is necessary to provide medical care to the member and/or patient or as necessary for billing and payment or health plan operations.
3. I will not access my own or my family members' PHI. Instead, I will follow the same procedures that apply to non-employee health plan members.
4. I will not share, change, remove or destroy any confidential information unless it is part of my job to do so. If any of these tasks are part of my job, I will follow the correct department procedure or the instructions of my supervisor/chief of service (such as shredding confidential paper). If a demand is made upon me from outside Kaiser Permanente to disclose confidential information, I will obtain approval from my supervisor before disclosing such information.
5. I understand that inappropriate or unauthorized access, use or disclosure of PHI may result in legally required reporting to governmental authorities, including my name.
6. I know that confidential information I learn on the job does not belong to me and that Kaiser Permanente may take away my access to confidential information at any time.
7. If I have access to electronic equipment and/or records, I will keep my computer password secret and I will not share it with any unauthorized individual. I am responsible if I fail to protect my password or other means of accessing confidential information.
8. I will not use anyone elses password to access any Kaiser Permanente system unless I am authorized to do so. If I am authorized to do so (e.g., in order to perform computer systems maintenance), I will follow procedures to ensure the password is changed and that confidential information is not at risk.
9. I will lock my computer when I step away to prevent someone else accessing the computer under my logon. I understand that I am personally responsible for any accesses under my logon.
10. If I leave Kaiser Permanente I will not share any confidential information that I learned or had access to during my employment.
11. On termination of my employment, I will promptly return to Kaiser Permanente all originals and copies of documents containing Kaiser Permanente's information or data in my possession or control, unless the documents were provided to me as part of my employment record.

KAISER PERMANENTE.

2870 CONFIDENTIALITY AGREEMENT

* First Name	Middle Name	* Last Name
DARLENE		WALLS
* Employee ID	* Work Phone Number (###)###-####	* Effective Date (mm/dd/yyyy)
530105	MED/SURG	3/5/12

AGREEMENT - (Continued)

Examples of Breaches of Confidentiality (What you should NOT do.)

These are examples only and do not include all possible breaches of confidentiality.

- Unauthorized reading of patient account information.
- Unauthorized reading of a patient's chart.
- Unauthorized access to my own medical information.
- Accessing medical information of friends, co-workers, family members, or anyone else, unless it is required for my job.
- Discussing confidential information in a public area such as a waiting room or elevator.
- Discussing or otherwise sharing confidential information with anyone in your personal life, including family members or friends.
- Accessing records for any reason other than for legitimate business purpose.
- Accessing records of family, friends, co-workers, patients in the media, well known political figures, celebrities, or anyone else about whom you are curious.
- Sending confidential information to your personal e-mail account, unless you are authorized to do so and the information is transmitted in accordance with required procedures (e.g., encrypted).
- Saving confidential electronic information to a KP-owned or non-KP-owned flash drive, CD, or any other removable or transportable storage device unless you first secure permission as outlined in the Secure Electronic Storage provisions of the KP Information Security Policy.
- Saving confidential electronic information to a KP-owned or non-KP-owned workstation, laptop computer, personal digital assistant, or any other mobile computing device unless you first secure permission as outlined in the Secure Electronic Storage provisions of the KP Information Security Policy.
- Using personal devices (digital cameras, camera phones) to take photographs that may include confidential information as the primary subject or in the background.
- Documenting or referencing confidential information on any social networking site, such as Twitter, My Space.
- Telling a co-worker your password so that he or she can login to your work.
- Telling an unauthorized person the access codes for employee files or patient accounts.
- Being away from your workstation while you are logged into an application, without locking your system to protect confidential information.
- Unauthorized use of a co-worker's password to logon to a Kaiser Permanente information system.
- Unauthorized use of a user ID to access employee files or patient accounts.
- Allowing a co-worker to use your secured application* for which he/she does not have access after you have logged in.

* secured application = any computer program that allows access to confidential information. A secured application usually requires a user name and password to log in.

2870

CONFIDENTIALITY AGREEMENT

* First Name	Middle Name	* Last Name
DARLENE		WALLS
*** Employee ID**	*** Work Phone Number (###)###-####**	*** Effective Date (mm/dd/yyyy)**
530105	MED/SURG	3/5/12

AGREEMENT - (Continued)

12. I understand that I am responsible for my access, use, or misuse of confidential information and know that my access to confidential information may be audited.
13. I understand that my supervisor/chief of service or other managers and/or the Compliance Hot Line are available if I think someone is misusing confidential information or is misusing my password. I further understand that Kaiser Permanente will not tolerate any retaliation because I make such a report.
14. I understand that patient privacy and security is included in various training programs within Kaiser Permanente (for example: New Employee training, Annual Compliance Training), and by taking such training, I understand the obligations of confidentiality. I further understand that it is my responsibility to secure guidance from my supervisor or manager in the event any questions exist relating to my obligations regarding confidentiality.
15. I understand that failure to comply with this agreement may result in disciplinary action up to and including termination of employment or other relationship with Kaiser Permanente. I understand that I may also be subject to other remedies allowed by law.
16. I understand that I must also comply with any laws, regulations, and other Kaiser Permanente policies, including the Principles of Responsibility that address confidentiality.
17. By signing (or selecting the submit button below), I agree that I have read, understand, and that I will comply with this Confidentiality Agreement.

SIGNATURE (Required if not submitted online)

Darlene Walls	3/6/12
* Employee Signature	* Date (mm/dd/yyyy)

After completing the form:
1. Print form to keep a copy for your records.
2. Print another copy and sign it for your supervisor.
3. Press the Submit button.
4. Wait for a pop-up screen to confirm the form has been submitted. (This may take a few minutes.)
5. Submit online or fax your form to HR Service Center (877) 477-2329 or interoffice mail to HR Service Center, Alameda.

HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist

KAISER PERMANENTE

(2)

2862 DRUG-FREE WORKPLACE - EMPLOYEE ACKNOWLEDGEMENT

Instructions: 1. This form cannot be submitted on-line.
2. Either complete on-line and print or print and complete by hand - print clearly using blue or black ink.
3. Items marked with asterisk (*) are required fields.
4. When complete - fax to the number below. Be sure to retain the original and the fax receipt for your records.
5. The Effective Date represents the date the Employee Acknowledgement form is signed.

* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
530105	323) 674-5660	3/7/12
*** First Name**	**Middle Name**	*** Last Name**
DARLENE		WALLS

1. EMPLOYEE INFORMATION

* Work Phone Number - Tieline (###) ###-####	* Work Phone Number - Outside (###) ###-####	NUID # (if known)
MED/SURG	MED/SURG	X835065

Location/Facility Name	Department
DMC	~~DMC~~ MED/SURG

2. ACKNOWLEDGEMENT

I understand that, as a provider of health care, Kaiser Permanente recognizes that alcohol and drug abuse/chemical dependency is a chronic disease and major health problem that can have tragic consequences for individuals, families, and the workplace.

As a condition of employment, all employees are expected to abide by the organization's policy which prohibits the use and/or abuse of drugs and alcohol in the workplace.

By my signature below, I acknowledge, understand, accept, and agree to comply with this policy. I also understand that failure to comply with this policy will result in corrective/disciplinary action, up to and including termination of employment.

DRUG-FREE WORKPLACE ATTESTATION

- I have received a copy of the policy NATL.HR.030, Drug-Free Workplace.
- I have read, understood, and familiarized myself with this policy, and understand that Kaiser Permanente is committed to providing a drug-free workplace.
- I understand that it is my responsibility to comply with this policy, and that this policy applies to me.
- I agree to abide by the terms of the policy, as a condition of employment.
- I understand that violations of this policy will subject me to corrective/disciplinary action, up to and including termination of employment.
- If I have any questions about this policy, I will seek clarification from my manager or a KP HR Representative.
- I understand that, in acknowledgment that chemical dependency is a chronic disease and that rehabilitative treatment is available, KP supports and strongly encourages employees with such problems to seek treatment, and will provide it when conditions and circumstances warrant.
- I understand that the responsibility for seeking, obtaining, and cooperating in such treatment is mine.
- I understand that, if I am experiencing alcohol or drug dependency, I am urged by the organization to make use of KP's confidential Employee Assistance Program, and/or such disability plans, rehabilitation programs, and health coverage plans that may be appropriate.

3. EMPLOYEE SIGNATURE

Darlene Walls	3/7/12	3/7/12
* Employee Signature	* Date (mm/dd/yyyy)	Date Policy Read Attested (mm/dd/yyyy)

HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist

2862 DRUG-FREE WORKPLACE - EMPLOYEE ACKNOWLEDGEMENT

* First Name	Middle Name	* Last Name
DARLENE		WALLS
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
530105	323) 644-5660	3/5/12

4. SUBMITTED BY

* First Name	Middle Name	* Last Name
DARlene		WALLS.

* Employee ID	* Title	* Work Phone Number (###) ###-####
530105	NURSING ATT.	

5. MANAGER INFORMATION DETAIL

* First Name	Middle Name	* Last Name
Michelle		Lenaburg

Title	Work Phone Number (###) ###-####
NURSING ATT.	562) 657-8527

HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist

LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

Instructions: 1. To ensure efficient and effective service please, submit form online.
2. Items marked with an asterisk (*) are required fields.
3. Immediate confirmation will be sent to you upon receipt of your online submittal.
4. **Supervisor/Manager:** Complete Leave of Absence Form for employee. Review Attestations; include applicable notations in the Comments Section on the Request. Be sure to print a copy of Leave of Absence Form before submitting.

* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(562) 657-8527	09/19/2012
* First Name	Middle Name	* Last Name
Darlene		Walls

1. LEAVE INFORMATION

Employee E-mail Address	Alternate Employee Phone Number (###) ###-####	New or Revised Request
		☒ New ☐ Revised

*** Leave Type:**

☒ Medical	☐ Union	☐ Care for Eligible Family Member
☐ Maternity	☐ Personal	☐ Family Military Leave
☐ Workers' Comp/Industrial	☐ Military Service	☐ Bonding

Last Day Worked (mm/dd/yyyy)	* First Day of Leave (mm/dd/yyyy)	Expected Return Date (mm/dd/yyyy)
	09/19/2012	

Is this an intermittent or reduced work schedule Leave? ☒ Intermittent ☐ Reduced Work Schedule ☐ Not Applicable

Estimated frequency and duration of absences
UNKNOWN

If absence is for Care of Eligible Family Member or Bonding:

Name of Eligible Family Member	Relationship to Employee
Is Family Member age 18 or under? If Yes, enter age ☐ Yes ☐ No	Delivery/Adoption/Foster Care Placement Date (mm/dd/yyyy) ☐ Actual Date ☐ Expected Date
Is the child's other parent employed by Kaiser Permanente? ☐ Yes ☐ No	If Yes, full name of other parent

If absence is due to Family Member's Military Service please select the reason(s) that apply:

Name of Eligible Family Member	Relationship to Employee

☐ **Qualifying Exigency,** (matters related to deployment such as Child Care issues, Financial Planning, and Family Support Sessions, Seeing off leaving or returning Service Members.)

☐ **Care for qualified Service Member who incurred injury or illness in the line of duty**

HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist

* First Name	Middle Name	* Last Name
Darlene		Walls
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(562) 657-8527	09/19/2012

1. LEAVE INFORMATION - (Continued)

If absence is for Employee's own health condition (Medical, Maternity or Workers' Comp/Industrial)

Date of illness or injury (mm/dd/yyyy)	Was hospitalization required?	Date Hospitalized (mm/dd/yyyy)
09/19/2012	☐ Yes ☐ No ☒ Unknown	

Estimated/Actual hours worked on last day	If Leave is due to maternity	Delivery Date (mm/dd/yyyy)
8	☐ Actual Delivery Date ☐ Expected Delivery Date	

If absence is pregnancy related, does the employee plan to take Bonding time immediately after the pregnancy related absence is complete?

☐ Yes ☐ No

If absence is for Union Leave

Type of Union Leave:

☐ Short Term (30 days or less) ☐ Long Term (greater than 30 days) ☐ Elected Official

Name of Union

If absence is for Military Leave

Is this absence for Military Training or Active Duty?

☐ Military Training ☐ Active Duty

*** If for Personal Leave, indicate reason**

Temporary Agency or Military Service (asked for FMLA eligibility)

Has the Employee worked for Kaiser Permanente less than one year?

☐ Yes ☒ No

Has the Employee been on active Military Duty in the past 12 months?	Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)
☐ Yes ☒ No		

Did the Employee work for Kaiser Permanente with a Temporary Agency in the year before they were hired?

☐ Yes ☐ No

HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist

KAISER PERMANENTE®

1494 LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

* First Name	Middle Name	* Last Name
Darlene		Walls
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(562) 657-8527	09/19/2012

1. LEAVE INFORMATION - (Continued)

Name of Agency		
Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)	Agency Phone Number (###) ###-####

2. COMMENTS

LAUNCHING 1480 ON BEHALF OF MICHELLE L LENABURG

3. EMPLOYEE SCHEDULE

This information is essential for the HRSC to prepare a worksheet to assist with TIME coding. This is required for employees absent for their own disability. Please use a 24 hr clock: 00:00 thru 24:00.

NOTE: This section is not applicable for the KRONOS regions.

Week 1

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start Time: (hh:mm)							
Hours:							

Week 2 (Only needed if schedule changes week to week)

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start Time: (hh:mm)							
Hours:							

4. REQUEST PAID TIME-OFF

Review your Collective Bargaining Agreement and/or Summary Plan Description Booklet before completing this section. Selections made here will not supersede conditions set in Collective Bargaining Agreements, Summary Plan Descriptions, KP and HR Policies, or applicable State and Federal Laws.

Request	Option	Amount
Did employee request EarnedTime Off (ETO)/Paid Time Off (PTO)/Vacation? ☐ Yes ☒ No	☐ Use all available hours ☐ Use selected hours	Number of hours
Did employee request to use Extended Sick Leave (ESL)/Sick Leave? ☒ Yes ☐ No	☒ Use all available hours ☐ Use selected hours	Number of hours
Did employee request to use Float Holidays? ☐ Yes ☒ No	Only available Float Holidays will be applied.	Number of days

* First Name	Middle Name	* Last Name
Darlene		Walls
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(562) 657-8527	09/19/2012

4. REQUEST PAID TIME-OFF - (Continued)

Did employee request to use Flexible Personal Days?	Number of days	OR	Number of hours
☐ Yes ☒ No			

Note: Flexible Personal Days can only be used in full day or two hour increments. Only available Flexible Personal Days will be applied.

Did employee request Military Make-up Pay?

☐ Yes ☐ No

5. SUBMITTED BY

* Name (First, MI, Last)	
Rosanne Torres	
* Employee ID	* Title
00237713	
* E-mail Address	* Work Phone Number (###) ###-####
ROSANNE.M.TORRES@KP.ORG	(562) 461-5422

6. MANAGER INFORMATION DETAIL

* Name (First, MI, Last)	
MICHELLE L LENABURG	
Supervisor ID	* Title
* E-mail Address	* Work Phone Number (###) ###-####
MICHELLE.L.LENABURG@KP.ORG	(562) 657-8527

7. ALTERNATE CONTACT INFORMATION - (if manager is unavailable or will not manage the employee while on leave)

* Name (First, MI, Last)	
* E-mail Address	* Work Phone Number (###) ###-####

HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist

KAISER PERMANENTE

1494 LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

* First Name	Middle Name	* Last Name
Dar'lene		Walls
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(562) 657-8527	09/19/2012

8. MANAGER ATTESTATION

* Checking these items acknowledges that you have read and understand each item.

☒ I agree to direct the employee requesting Leave to submit any and all supporting documentation to me or the HR Service Center.

☒ I agree to submit form 1500 - Extend Leave and any supporting documentation at the time I learn that the employee intends to extend his or her leave beyond their expected return date or fails to return on their expected date, fails to respond, and is not terminated.

☒ I agree to submit form 1510 - Return from Leave when the employee returns to work.

☒ TIME must be coded for all paid and unpaid leave taken by the employee.

9. MANAGER SIGNATURE - (Required if not submitted online.)

* Manager Signature

* Date (mm/dd/yyyy)

KAISER PERMANENTE®
HR Service Center

October 19, 2012

Employee ID: 00530105
Case Number: 35487487

Darlene Walls
16323 Cortuna Ave # 8
Bellflower, CA 90706

Subject: Notice of Eligibility - Under the Family and Medical Leave Act/California Family Rights Act (Family Leave)

Dear Darlene Walls,

On 10/17/2012, we were informed that you needed leave beginning on 09/19/2012 for:

☐ The birth of a child, or placement of a child with you for adoption or foster care.

☒ Your own serious health condition.

☐ Your need to care for your <spouse child parent domestic partner family member> due to his/her serious health condition.

☐ An exigency arising out of the fact that your <spouse son or daughter parent> is on active duty or call to active duty status.

☐ Your need to care for your <spouse son or daughter parent next of kin> due to his/her serious injury or illness incurred in the line of duty as a covered servicemember.

This notice is to inform you that you have met the eligibility requirements for FMLA.

Your eligibility was determined based on the information available to us on 10/19/2012. To qualify for FMLA/CFRA you must meet the eligibility requirements at the beginning of your leave. Please refer to the attached *Employee Rights and Responsibilities* regarding eligibility criteria or requirements. Should your employment status change prior to the start of your leave, you may not qualify for FMLA/CFRA.

Approval of your request for leave under the FMLA/CFRA is pending receipt of the documentation indicated below. The documentation must be provided to the HRSC by 11/06/2012 or your leave may be denied.

KAISER PERMANENTE®
HR Service Center

☒ Sufficient certification to support your request for FMLA/CFRA leave.

☒ 1451 Employee - Certification of Physician

☐ 1452 Family Member - Certification of Physician

☐ 1453 Service Member - Certification of Physician

☐ Sufficient certification to indicate your adult child is incapable of self-care because of a physical or mental disability. Certification may be provided on the enclosed 1452 Family Member - Certification of Physician.

☐ Sufficient documentation to establish the required relationship between you and your family member; proof of <birth marriage adoption/foster care domestic partner relationship next of kin>.

☐ Military Orders

☐ 1454 - Military Exigency - Certification

☐ Other:

☐ The certification you provided is not complete and sufficient to determine whether the FMLA/CFRA applies to your leave request. You must provide the following information no later than <mm/dd/yyyy>, or your leave may be denied, unless it is not practicable under the particular circumstances despite your diligent good faith efforts.

☐ The information provided on the Certification of Physician/Provider does not meet the definition of a serious health condition.

☐ The Certification of Physician/Provider does not include the Frequency and Duration for intermittent leave.

☐ The Certification of Physician/Provider does not indicate your adult child is incapable of self-care because of a physical or mental disability.

☐ The information provided failed to establish the required relationship between you and your family member; proof of <birth marriage adoption/foster care domestic partner relationship next of kin>.

☐ Military Orders

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HR Service Center

☐ 1453 Service Member - Certification of Physician

☐ 1454 - Military Exigency - Certification

☐ Other:

Please fax the required document(s) to the HR Service Center at **1-877-HRSC-FAX (1-877-477-2329)**. Or mail the forms to:

Kaiser Permanente HR Service Center
PO Box 2074
Oakland, CA 94604-2074

Once we obtain the information from you as specified above, we will inform you whether your leave will be designated as FMLA/CFRA leave and count towards your FMLA/CFRA leave entitlement.

Please note: Failure to provide the sufficient certification may result in delay or denial of your Family Leave.

The *Employee Rights and Responsibilities* under the FMLA are attached for your review. Policies, bargaining agreements and other information regarding leaves of absence can be found on My HR.

If you have any questions or concerns regarding your request for family leave, please contact Work Absence Management (WAM) at the HR Service Center at **877-4KP-HRSC (877-457-4772).** Please reference the case number located in the upper right-hand corner of this letter.

Sincerely,

WAM Agent
Kaiser Permanente HR Service Center

Enclosures:
☒ 1451 Employee - Certification of Physician
☐ 1452 Family Member - Certification of Physician
☐ 1453 Service Member - Certification of Physician
☐ 1454 - Military Exigency - Certification
☐ 2090 - Supplement to Sick Leave Request
☐ 2520 - Personal Data Change

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HR Service Center

EMPLOYEE RIGHTS AND RESPONSIBILITIES
UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is a current member of the Armed forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the service member medically unfit to perform his or her duties for which the service member is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or 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 t he qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility. Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

KAISER PERMANENTE®
HR Service Center

November 10, 2012

Employee ID: 00530105
Case Number: 35487487

Darlene Walls
16323 Cortuna Ave # 8
Bellflower, CA 90706

Subject: Denial Notice - Under the Family and Medical Leave Act/California Family Rights Act (Family Leave)

Dear Darlene Walls,

On 10/17/2012, we were informed that you needed leave beginning on 09/19/2012 for:

☐ The birth of a child, or placement of a child with you for adoption or foster care.

☒ Your own serious health condition.

☐ Your need to care for your <spouse child parent domestic partner family member> due to his/her serious health condition.

☐ An exigency arising out of the fact that your <spouse son or daughter parent> is on active duty or call to active duty status.

☐ Your need to care for your <spouse son or daughter parent next of kin> due to his/her serious injury or illness incurred in the line of duty as a covered servicemember.

This Notice is to inform you that you are not eligible for FMLA/CFRA leave, because:

☐ You have not met the 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately <Enter Num Mos> months towards this requirement. If you are still on leave at the completion of 12 months of service please contact the HRSC to request your eligibility for FMLA/CFRA. For more information please see the attached notice of Employee Rights and Responsibilities.

☐ You have not met the 1,250 hours worked requirement within the 12 months preceding the start of your leave. As of <mm/dd/yyyy> you have worked <Enter Hours> hours towards the eligibility requirement. You can check the number of hours worked by contacting the HRSC.

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HR Service Center

☐ You exhausted your <12 26>-week entitlement to leave under the <FMLA/CFRA>

☐ Your request is for a non-qualified family member.

☒ You failed to provide sufficient certification to support your request.

- ☒ A Health Care Provider Certification form was not received.
- ☐ The information provided on the Health Care Provider Certification did not meet the definition of a serious health condition.
- ☐ The Health Care Provider Certification did not include the Frequency and Duration for an intermittent leave.
- ☐ The Health Care Provider Certification did not indicate your adult child is incapable of self-care because of a physical or mental disability.
- ☐ You failed to provide sufficient documentation to establish the required relationship between you and your family member; proof of <birth adoption/foster care domestic partner relationship marriage>.
- ☐ Military Orders
- ☐ <Certification of Exigency Certification of an injured/ill servicemember>

☐ Other:

The *Employee Rights and Responsibilities* under the FMLA are attached for your review.

While your time off is not currently protected under the FMLA and CFRA; you may become eligible for FMLA/CFRA during your leave. Please refer to the *Employee Rights and Responsibilities* for eligibility criteria or requirements. You may also be eligible for other forms of leave under Kaiser's leave policies or under an applicable collective bargaining agreement. If your leave is the result of a work-related injury, it may be subject to Workers' Compensation leave protection.

Policies, bargaining agreements and other information regarding leaves of absence can be found on My HR.

KAISER PERMANENTE®
HR Service Center

If you have any questions or concerns regarding the denial of your request for family leave, please contact Work Absence Management (WAM) at the HR Service Center at **877-4KP-HRSC (877-457-4772).** Please reference the case number located in the upper right-hand corner of this letter.

Sincerely,

WAM Agent
HR Representative
Kaiser Permanente HR Service Center

KAISER PERMANENTE®
HR Service Center

EMPLOYEE RIGHTS AND RESPONSIBILITIES
UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

Basic Leave Entitlement
FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:
- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements
Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is a current member of the Armed forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the service member medically unfit to perform his or her duties for which the service member is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections
During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements
Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition
A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or 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.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave
An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave
Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities
Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities
Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility. Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA protected, the employer must notify the employee.

Unlawful Acts by Employers
FMLA makes it unlawful for any employer to:
- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement
An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

Instructions: 1. To ensure efficient and effective service please, submit form online.
2. Items marked with an asterisk (*) are required fields.
3. Immediate confirmation will be sent to you upon receipt of your online submittal.
4. **Supervisor/Manager:** Complete Leave of Absence Form for employee. Review Attestations; include applicable notations in the Comments Section on the Request. Be sure to print a copy of Leave of Absence Form before submitting.

* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(562) 657-8527	06/17/2013
* First Name	Middle Name	* Last Name
Darlene		Walls

1. LEAVE INFORMATION

Employee E-mail Address	Alternate Employee Phone Number (###) ###-####	New or Revised Request
		☒ New ☐ Revised

*** Leave Type:**

☒ Medical ☐ Union ☐ Care for Eligible Family Member
☐ Maternity ☐ Personal ☐ Family Military Leave
☐ Workers' Comp/Industrial ☐ Military Service ☐ Bonding

Last Day Worked (mm/dd/yyyy)	* First Day of Leave (mm/dd/yyyy)	Expected Return Date (mm/dd/yyyy)
	06/17/2013	

Is this an intermittent or reduced work schedule Leave? ☒ Intermittent ☐ Reduced Work Schedule ☐ Not Applicable

Estimated frequency and duration of absences
To be determined by Physician

If absence is for Care of Eligible Family Member or Bonding:

Name of Eligible Family Member	Relationship to Employee
Is Family Member age 18 or under? If Yes, enter age ☐ Yes ☐ No	Delivery/Adoption/Foster Care Placement Date (mm/dd/yyyy) ☐ Actual Date ☐ Expected Date
Is the child's other parent employed by Kaiser Permanente? ☐ Yes ☐ No	If Yes, full name of other parent

If absence is due to Family Member's Military Service please select the reason(s) that apply:

Name of Eligible Family Member	Relationship to Employee

☐ **Qualifying Exigency**, (matters related to deployment such as Child Care issues, Financial Planning, and Family Support Sessions, Seeing off leaving or returning Service Members.)

☐ **Care for qualified Service Member who incurred injury or illness in the line of duty**

HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist

Next Page >

* First Name	Middle Name	* Last Name
Dar l ene		Wa l l s
*** Employee ID**	*** Contact Phone Number (###) ###-####**	*** Effective Date (mm/dd/yyyy)**
00530105	(562) 657-8527	06/17/2013

1. LEAVE INFORMATION - (Continued)

If absence is for Employee's own health condition (Medical, Maternity or Workers' Comp/Industrial)

Date of illness or injury (mm/dd/yyyy)	Was hospitalization required?	Date Hospitalized (mm/dd/yyyy)
06/17/2013	☐ Yes ☐ No ☒ Unknown	

Estimated/Actual hours worked on last day	If Leave is due to maternity	Delivery Date (mm/dd/yyyy)
8	☐ Actual Delivery Date ☐ Expected Delivery Date	

If absence is pregnancy related, does the employee plan to take Bonding time immediately after the pregnancy related absence is complete?

☐ Yes ☐ No

If absence is for Union Leave

Type of Union Leave:

☐ Short Term (30 days or less) ☐ Long Term (greater than 30 days) ☐ Elected Official

Name of Union

If absence is for Military Leave

Is this absence for Military Training or Active Duty?

☐ Military Training ☐ Active Duty

*** If for Personal Leave, indicate reason**

Temporary Agency or Military Service (asked for FMLA eligibility)

Has the Employee worked for Kaiser Permanente less than one year?

☐ Yes ☒ No

Has the Employee been on active Military Duty in the past 12 months?	Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)
☐ Yes ☒ No		

Did the Employee work for Kaiser Permanente with a Temporary Agency in the year before they were hired?

☐ Yes ☐ No

HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist

KAISER PERMANENTE

1494 LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

* First Name	Middle Name	* Last Name
Darlene		Walls
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(562) 657-8527	06/17/2013

1. LEAVE INFORMATION - (Continued)

Name of Agency		
Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)	Agency Phone Number (###) ###-####

2. COMMENTS

Attendance Review 07/09/13- 1480 submitted on behalf of Manager Michelle Lenaburg. am

3. EMPLOYEE SCHEDULE

This information is essential for the HRSC to prepare a worksheet to assist with TIME coding. This is required for employees absent for their own disability. Please use a 24 hr clock: 00:00 thru 24:00.

NOTE: This section is not applicable for the KRONOS regions.

Week 1

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start Time: (hh:mm)							
Hours:							

Week 2 (Only needed if schedule changes week to week)

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start Time: (hh:mm)							
Hours:							

4. REQUEST PAID TIME-OFF

Review your Collective Bargaining Agreement and/or Summary Plan Description Booklet before completing this section. Selections made here will not supersede conditions set in Collective Bargaining Agreements, Summary Plan Descriptions, KP and HR Policies, or applicable State and Federal Laws.

Did employee request EarnedTime Off (ETO)/Paid Time Off (PTO)/Vacation? ☐ Yes ☐ No	☐ Use all available hours ☐ Use selected hours	Number of hours
Did employee request to use Extended Sick Leave (ESL)/Sick Leave? ☐ Yes ☒ No	☐ Use all available hours ☐ Use selected hours	Number of hours
Did employee request to use Float Holidays? ☐ Yes ☐ No	Only available Float Holidays will be applied.	Number of days

HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist

KAISER PERMANENTE®

* First Name	Middle Name	* Last Name
Darlene		Walls
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(562) 657-8527	06/17/2013

4. REQUEST PAID TIME-OFF - (Continued)

Did employee request to use Flexible Personal Days?	Number of days	OR	Number of hours
☐ Yes ☐ No			

Note: Flexible Personal Days can only be used in full day or two hour increments. Only available Flexible Personal Days will be applied.

Did employee request Military Make-up Pay?

☐ Yes ☐ No

5. SUBMITTED BY

* Name (First, MI, Last)	
Adriana Martinez	
* Employee ID	* Title
00289603	
* E-mail Address	* Work Phone Number (###) ###-####
Adriana.D.Martinez@kp.org	(562) 461-6808

6. MANAGER INFORMATION DETAIL

* Name (First, MI, Last)	
Michelle L. Lenaburg	
Supervisor ID	* Title
* E-mail Address	* Work Phone Number (###) ###-####
Michelle.L.Lenaburg@kp.org	(562) 657-8527

7. ALTERNATE CONTACT INFORMATION - (if manager is unavailable or will not manage the employee while on leave)

* Name (First, MI, Last)	
Barbara Lespron	
* E-mail Address	* Work Phone Number (###) ###-####
Barbara.X.Lespron@kp.org	(562) 657-9624

KAISER PERMANENTE®

LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

* First Name	Middle Name	* Last Name
Darlene		Walls
*** Employee ID**	*** Contact Phone Number (###) ###-####**	*** Effective Date (mm/dd/yyyy)**
00530105	(562) 657-8527	06/17/2013

8. MANAGER ATTESTATION

* Checking these items acknowledges that you have read and understand each item.

☒ I agree to direct the employee requesting Leave to submit any and all supporting documentation to me or the HR Service Center.

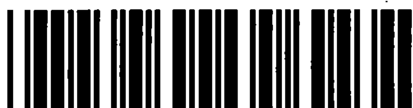
☒ I agree to submit form 1500 - Extend Leave and any supporting documentation at the time I learn that the employee intends to extend his or her leave beyond their expected return date or fails to return on their expected date, fails to respond, and is not terminated.

☒ I agree to submit form 1510 - Return from Leave when the employee returns to work.

☒ TIME must be coded for all paid and unpaid leave taken by the employee.

9. MANAGER SIGNATURE - (Required if not submitted online.)

* Manager Signature	* Date (mm/dd/yyyy)



KAISER PERMANENTE®
HR Service Center

July 16, 2013

Employee ID: 00530105
Case Number: 36209643

Darlene Walls
16323 cortuna ave # 8
Bellflower, CA 90706

Subject: Notice of Eligibility - Under the Family and Medical Leave Act/California Family Rights Act (Family Leave)

Dear Darlene Walls,

On 7/9/2013 we were informed that you needed leave beginning on 6/17/2013 for:

☐ The birth of a child, or placement of a child with you for adoption or foster care.

☒ Your own serious health condition.

☐ Your need to care for your <spouse child parent domestic partner family member> due to his/her serious health condition.

☐ An exigency arising out of the fact that your <spouse son or daughter parent> is on active duty or call to active duty status.

☐ Your need to care for your <spouse son or daughter parent next of kin> due to his/her serious injury or illness incurred in the line of duty as a covered servicemember.

This notice is to inform you that you have met the eligibility requirements for FMLA/CFRA

Your eligibility was determined based on the information available to us on 7/16/2013 To qualify for FMLA/CFRA you must meet the eligibility requirements at the beginning of your leave. Please refer to the attached *Employee Rights and Responsibilities* regarding eligibility criteria or requirements. Should your employment status change prior to the start of your leave, you may not qualify for FMLA/CFRA.

Approval of your request for leave under the FMLA/CFRA is pending receipt of the documentation indicated below. The documentation must be provided to the HRSC by 8/3/2013 or your leave may be denied.

KAISER PERMANENTE®
HR Service Center

- [x] Sufficient certification to support your request for FMLA/CFRA leave.
  - [x] 1451 Employee - Certification of Physician
  - [ ] 1452 Family Member - Certification of Physician
  - [ ] 1453 Service Member - Certification of Physician
- [ ] Sufficient certification to indicate your adult child is incapable of self-care because of a physical or mental disability. Certification may be provided on the enclosed 1452 Family Member - Certification of Physician.
- [ ] Sufficient documentation to establish the required relationship between you and your family member; proof of <birth marriage adoption/foster care domestic partner relationship next of kin>.
- [ ] Military Orders
- [ ] 1454 - Military Exigency - Certification
- [ ] Other:

- [ ] The certification you provided is not complete and sufficient to determine whether the FMLA/CFRA applies to your leave request. You must provide the following information no later than <mm/dd/yyyy>, or your leave may be denied, unless it is not practicable under the particular circumstances despite your diligent good faith efforts.
  - [ ] The information provided on the Certification of Physician/Provider does not meet the definition of a serious health condition.
  - [ ] The Certification of Physician/Provider does not include the Frequency and Duration for intermittent leave.
  - [ ] The Certification of Physician/Provider does not indicate your adult child is incapable of self-care because of a physical or mental disability.
  - [ ] The information provided failed to establish the required relationship between you and your family member; proof of <birth marriage adoption/foster care domestic partner relationship next of kin>.
  - [ ] Military Orders

KAISER PERMANENTE®
HR Service Center

☐ 1453 Service Member - Certification of Physician

☐ 1454 - Military Exigency - Certification

☐ Other:

Please fax the required document(s) to the HR Service Center at **1-877-HRSC-FAX (1-877-477-2329).** Or mail the forms to:

Kaiser Permanente HR Service Center
PO Box 2074
Oakland, CA 94604-2074

Once we obtain the information from you as specified above, we will inform you whether your leave will be designated as FMLA/CFRA leave and count towards your FMLA/CFRA leave entitlement.

Please note: Failure to provide the sufficient certification may result in delay or denial of your Family Leave.

The *Employee Rights and Responsibilities* under the FMLA are attached for your review. Policies, bargaining agreements and other information regarding leaves of absence can be found on My HR.

If you have any questions or concerns regarding your request for family leave, please contact Work Absence Management (WAM) at the HR Service Center at **877-4KP-HRSC (877-457-4772).** Please reference the case number located in the upper right-hand corner of this letter.

Sincerely,

WAM

Kaiser Permanente HR Service Center

Enclosures:

☒ 1451 Employee - Certification of Physician
☐ 1452 Family Member - Certification of Physician
☐ 1453 Service Member - Certification of Physician
☐ 1454 - Military Exigency - Certification
☐ 2090 - Supplement to Sick Leave Request
☐ 2520 - Personal Data Change

KAISER PERMANENTE®

HR Service Center

EMPLOYEE RIGHTS AND RESPONSIBILITIES
UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

Basic Leave Entitlement
FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:
- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements
Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is a current member of the Armed forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the service member medically unfit to perform his or her duties for which the service member is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections
During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements
Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition
A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or 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 t he qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave
An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave
Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities
Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities
Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility. Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA protected, the employer must notify the employee.

Unlawful Acts by Employers
FMLA makes it unlawful for any employer to:
- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement
An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

LEAVE OF ABSENCE - MEDICAL LEAVE

Instructions: 1. To ensure efficient and effective service please, submit form online.
2. Items marked with an asterisk (*) are required fields.
3. Immediate confirmation will be sent to you upon receipt of your online submittal.
4. **Supervisor/Manager:** Complete Leave of Absence Form for employee. Review Attestations; include applicable notations in the Comments Section on the Request. Be sure to print a copy of Leave of Absence Form before submitting.

* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(323) 674-5660	02/24/2014
* First Name	Middle Name	* Last Name
Darlene		Walls

1. LEAVE INFORMATION

Employee E-mail Address	Alternate Employee Phone Number (###) ###-####	New or Revised Request
		☒ New ☐ Revised

*** Leave Type:**

☒ Medical	☐ Union	☐ Care for Eligible Family Member
☐ Maternity	☐ Personal	☐ Family Military Leave
☐ Workers' Comp/Industrial	☐ Military Service	☐ Bonding

Last Day Worked (mm/dd/yyyy)	* First Day of Leave (mm/dd/yyyy)	Expected Return Date (mm/dd/yyyy)
02/21/2014	02/24/2014	03/08/2014

Is this an intermittent or reduced work schedule Leave? ☐ Intermittent ☐ Reduced Work Schedule ☐ Not Applicable

Estimated frequency and duration of absences

If absence is for Care of Eligible Family Member or Bonding:

Name of Eligible Family Member	Relationship to Employee
Is Family Member age 18 or under? If Yes, enter age ☐ Yes ☐ No	Delivery/Adoption/Foster Care Placement Date (mm/dd/yyyy) ☐ Actual Date ☐ Expected Date
Is the child's other parent employed by Kaiser Permanente? ☐ Yes ☐ No	If Yes, full name of other parent

If absence is due to Family Member's Military Service please select the reason(s) that apply:

Name of Eligible Family Member	Relationship to Employee

☐ **Qualifying Exigency**, (matters related to deployment such as Child Care issues, Financial Planning, and Family Support Sessions, Seeing off leaving or returning Service Members.)

☐ **Care for qualified Service Member who incurred injury or illness in the line of duty**

HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist

Next Page >

LEAVE OF ABSENCE - MEDICAL LEAVE

* First Name	Middle Name	* Last Name
Darlene		Walls
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(323) 674-5660	02/24/2014

1. LEAVE INFORMATION - (Continued)

If absence is for Employee's own health condition (Medical, Maternity or Workers' Comp/Industrial)

Date of illness or injury (mm/dd/yyyy)	Was hospitalization required?	Date Hospitalized (mm/dd/yyyy)
02/24/2014	☐ Yes ☒ No ☐ Unknown	

Estimated/Actual hours worked on last day	If Leave is due to maternity	Delivery Date (mm/dd/yyyy)
8	☐ Actual Delivery Date ☐ Expected Delivery Date	

If absence is pregnancy related, does the employee plan to take Bonding time immediately after the pregnancy related absence is complete?

☐ Yes ☐ No

If absence is for Union Leave

Type of Union Leave:

☐ Short Term (30 days or less) ☐ Long Term (greater than 30 days) ☐ Elected Official

Name of Union

If absence is for Military Leave

Is this absence for Military Training or Active Duty?

☐ Military Training ☐ Active Duty

*** If for Personal Leave, indicate reason**

Temporary Agency or Military Service (asked for FMLA eligibility)

Has the Employee worked for Kaiser Permanente less than one year?

☐ Yes ☒ No

Has the Employee been on active Military Duty in the past 12 months?	Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)
☐ Yes ☒ No		

Did the Employee work for Kaiser Permanente with a Temporary Agency in the year before they were hired?

☐ Yes ☐ No

KAISER PERMANENTE

LEAVE OF ABSENCE - MEDICAL LEAVE

* First Name	Middle Name	* Last Name
Darlene		Walls
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(323) 674-5660	02/24/2014

1. LEAVE INFORMATION - (Continued)

Name of Agency		
Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)	Agency Phone Number (###) ###-####

2. COMMENTS

NON-INDUSTRIAL/PROVISIONAL

3. EMPLOYEE SCHEDULE

This information is essential for the HRSC to prepare a worksheet to assist with TIME coding. This is required for employees absent for their own disability. Please use a 24 hr clock: 00:00 thru 24:00.

NOTE: This section is not applicable for the KRONOS regions.

Week 1

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start Time: (hh:mm)							
Hours:							

Week 2 (Only needed if schedule changes week to week)

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start Time: (hh:mm)							
Hours:							

4. REQUEST PAID TIME-OFF

Review your Collective Bargaining Agreement and/or Summary Plan Description Booklet before completing this section. Selections made here will not supersede conditions set in Collective Bargaining Agreements, Summary Plan Descriptions, KP and HR Policies, or applicable State and Federal Laws.

Question	Options	Number
Did employee request EarnedTime Off (ETO)/Paid Time Off (PTO)/Vacation? ☐ Yes ☒ No	☐ Use all available hours ☐ Use selected hours	Number of hours
Did employee request to use Extended Sick Leave (ESL)/Sick Leave? ☒ Yes ☐ No	☒ Use all available hours ☐ Use selected hours	Number of hours
Did employee request to use Float Holidays? ☐ Yes ☒ No	Only available Float Holidays will be applied.	Number of days

LEAVE OF ABSENCE - MEDICAL LEAVE

* First Name	Middle Name	* Last Name
Darlene		Walls
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(323) 674-5660	02/24/2014

4. REQUEST PAID TIME-OFF - (Continued)

Did employee request to use Flexible Personal Days?	Number of days	OR	Number of hours
☐ Yes ☒ No			

Note: Flexible Personal Days can only be used in full day or two hour increments. Only available Flexible Personal Days will be applied.

Did employee request Military Make-up Pay?

☐ Yes ☐ No

5. SUBMITTED BY

* Name (First, MI, Last)		
Michelle Lenaburg		
* Employee ID	* Title	
00256143		
* E-mail Address		* Work Phone Number (###) ###-####
Michelle.L.Lenaburg@kp.org		(562) 657-8527

6. MANAGER INFORMATION DETAIL

* Name (First, MI, Last)		
Michelle.L.Lenaburg@kp.org		
Supervisor ID	* Title	
* E-mail Address		* Work Phone Number (###) ###-####
Michelle.L.Lenaburg@kp.org		(562) 657-8527

7. ALTERNATE CONTACT INFORMATION - (if manager is unavailable or will not manage the employee while on leave)

* Name (First, MI, Last)	
Barbara X. Lespron	
* E-mail Address	* Work Phone Number (###) ###-####
Barbara.X.Lespron@kp.org	(562) 657-9624

HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist

LEAVE OF ABSENCE - MEDICAL LEAVE

* First Name	Middle Name	* Last Name
Darlene		Walls
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(323) 674-5660	02/24/2014

8. MANAGER ATTESTATION

* Checking these items acknowledges that you have read and understand each item.

☒ I agree to direct the employee requesting Leave to submit any and all supporting documentation to me or the HR Service Center.

☒ I agree to submit form 1500 - Extend Leave and any supporting documentation at the time I learn that the employee intends to extend his or her leave beyond their expected return date or fails to return on their expected date, fails to respond, and is not terminated.

☒ I agree to submit form 1510 - Return from Leave when the employee returns to work.

☒ TIME must be coded for all paid and unpaid leave taken by the employee.

9. MANAGER SIGNATURE - (Required if not submitted online.)

* Manager Signature	* Date (mm/dd/yyyy)

< Previous Page

1510 LEAVE OF ABSENCE - RETURN

Instructions: 1. To ensure efficient and effective service please submit form online. Please do not fax this form to the HRSC.
2. Items marked with an asterisk (*) are required fields.
3. Submit form using 8 digit Employee ID (including leading zeros).
4. Fax ONLY supporting documents (ie: physician's certification, military orders) to the HRSC at 877.477.2329. Include the 8 digit Employee ID on supporting documents.

* Employee ID	* Contact Phone Number (###) ###-####	* Return to Work Date (mm/dd/yyyy)
00530105	323674-5660	03/08/2014
* First Name	Middle Name	* Last Name
dARLENE		Walls

1. RETURN FROM LEAVE INFORMATION

Does Employee have work restrictions?	☐ Yes ☒ No	Is Employee working a reduced work schedule?	☒ Yes ☐ No	Schedule and Duration PT-days

2. COMMENTS

3. SUBMITTED BY

* First Name	Middle Name	* Last Name
Michelle	L.	Lenaburg

* Employee ID	* Title
00256143	NURSING DEPT MANAGER, RN

* E-mail Address	* Work Phone Number (###) ###-####
Michelle.L.Lenaburg@kp.org	(562)657-8527

4. MANAGER INFORMATION DETAIL

* First Name	Middle Name	* Last Name
Michelle		Lenaburg

Supervisor ID	* Title
00256143	ACD

* E-mail Address	* Work Phone Number (###) ###-####
Michelle.L.Lenaburg@kp.org	(562)657-8527

(Press the Submit button ONCE only)

After completing the form:
1. Press the Submit button once to submit request. The system will then provide confirmation.
2. Please do NOT print/fax this form to the HRSC.

HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist

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HR Service Center

April 2, 2014

Employee ID: 00530105
Case Number: 36987928

Darlene Walls
16323 cortuna ave # 8
Bellflower, CA 90706

Subject: Designation for Family Leave under the Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA)

Dear Darlene Walls,

On 02/28/2014, we were informed that you needed leave beginning on 02/24/2014 for:

☐ The birth of a child, or placement of a child with you for adoption or foster care.

☒ Your own serious health condition.

☐ Your need to care for your <spouse child parent domestic partner family member> due to his/her serious health condition.

☐ An exigency arising out of the fact that your <spouse son or daughter parent> is on active duty or call to active duty status.

☐ Your need to care for your <spouse son or daughter parent next of kin> due to his/her serious injury or illness incurred in the line of duty as a covered servicemember.

We reviewed your eligibility for leave under the FMLA/CFRA, and your supporting documentation, and determined that your FMLA/CFRA leave is approved. All leave taken for the reason checked above will be designated as FMLA/CFRA leave as long as you are eligible.

Your eligibility was determined based on the information available to us on 04/02/2014. To qualify for FMLA/CFRA you must meet the eligibility requirements at the beginning of your leave. Should your employment status change prior to the start of your leave, you may not qualify for FMLA/CFRA. The FMLA/CFRA requires that you notify us as soon as practicable if dates of scheduled leave change or are extended, or were initially unknown.

Provided there is no deviation from your anticipated leave schedule, and based on the information available to date, you are eligible for 12 workweeks which will be counted against your leave entitlement.

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☒ Our records indicate you have used 0 workweeks during the immediately preceding 12 months. As of 02/24/2014 your remaining workweeks are: 12

☒ Your continuous Family Leave begins on 02/24/2014 and ends on 03/07/2014

☐ Your intermittent Family Leave begins on <Enter Date> and ends on <Enter Date>. You are approved for the following frequency and duration of leave:
Frequency: <Enter Frequency>
Duration: <Enter Duration>

Family Leave

- Family Leave entitles you to up to twelve (12) workweeks of leave in a twelve (12) month rolling period. Military Caregiver leave is limited to 26 workweeks in a single 12 month period.
- FMLA/CFRA runs concurrently with Occupational leaves of absence and time off under Kin Care/CESLA when it is for an FMLA/CFRA qualifying reason.
- CFRA leave to care for a domestic partner with a serious health condition does not run concurrently with FMLA leave.
- An employee's pay status during Family Leave is determined in accordance with applicable laws, regional policies, and collective bargaining agreements.
- When taking Family Leave for one's own non work-related and non pregnancy-related illness/injury, an employee is required to use any available Sick/Extended Sick leave benefits.
- An employee may elect, but is not required, to use ETO, vacation or FPD hours while on FMLA/CFRA leave to care for his/her own serious health condition, or to care for a child, spouse, domestic partner, or parent.
- Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations.
- Re-certification may be required every 30 calendar days or if there has been a significant change in circumstances.

If your Family Leave is related to Pregnancy

California Pregnancy Disability Leave (PDL) and FMLA run concurrently. You may be eligible for up to, an additional 12 workweeks of leave under the California Family Rights Act (CFRA) for bonding with your newborn child. Your time off for bonding will count towards your CFRA entitlement. Any remaining FMLA entitlement will run concurrently with your bonding time under CFRA.

Intermittent Family Leave
As an eligible employee, you are entitled to take Family Leave in separate blocks of time or by a reduced work schedule for your own or a family member's serious health condition which requires continuing treatment by a health care provider and which is best accommodated through intermittent time or a reduced work schedule. Any intermittent leave taken under Family Leave shall reduce the amount of remaining Family Leave.

If you wish to take intermittent leave to care for and bond with a child within one year of the birth or placement of the child must take the leave in increments of two weeks or more at a time, with the exception that leaves of less than two weeks can be taken twice during the year.

Continuation of Benefits Under Family Leave
Kaiser Permanente will continue your health and dental benefits for a total of 12 workweeks while you are under Family Leave, whether your leave is paid or unpaid. If you are on Military Caregiver Leave, Kaiser Permanente will continue your health and dental benefits for a total of 26 workweeks in a single 12 month period. While on a paid Family Leave, your other elected benefits will continue, with the exception of the Dependent Care Spending Account.

For information regarding other Employer paid benefits while on an unpaid leave of absence, refer to your respective bargaining agreement or Summary Plan Description.

Life Insurance continues at the employer's expense for a minimum of 30 calendar days following commencement of **unpaid** Family Leave. Collective bargaining agreement provisions of represented employee groups maybe more generous than the Family Leave policy. **You may choose to continue Life Insurance coverage after this time at your own expense. If you wish to do so, and have not already completed the Life Insurance section of the Leave of Absence Request form, you may contact the HRService Center to make the necessary arrangements.**

Dependent enrollment for a newborn or adopted child
If you are on a leave of absence due to the birth or adoption of a child, you will be required to do one of the following within 31days of the birth or adoption to ensure your dependent enrollment: You may enroll on-line at:http://insidekp.kp.org/myhr or call the Human Resource Service Center (HRSC) at 1-877-457-4772 to request the Health Plan enrollment forms mailed to your address. A copy of your child's certified birth certificate/adoption documents will be required to complete the enrollment. **DO NOT DELAY YOUR ENROLLMENT! If you need additional time to submit supporting documentation, contact the Human Resources Service Center.** If you do not notify the HRSC within 31 days of the event, *you may have to wait until the next Open Enrollment period to enroll your child.*

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Health Care Spending Account
If you are a participant in the Health Care Spending Account, your contributions will stop on the date you begin an unpaid leave of absence. You will have the options to continue your contributions through COBRA during your leave.

Contributions will restart upon your return to active employment. If you return to work during the same plan year, you continue to be responsible for your **original** annual election amount unless you submit a Family Status Change form to the HRSC within 31 days of the commencement of your leave or within 31 days of your return to work from a leave.

If you return to work in a different plan year you will need to contact the HRSC if you wish to enroll for the current plan year.

Dependent Care Spending Account
If you are a participant in the Dependent Care Spending Account, your contributions will cease when you are on **paid or unpaid** leave for more than two consecutive calendar weeks. Dependent Care Spending Accounts are not eligible for continuance under COBRA.

Contributions will restart upon your return to active employment. If you return to work during the same plan year, you continue to be responsible for your **original** annual election amount unless you submit a Family Status Change form to the HRSC within 31 days of the commencement of your leave or within 31 days of your return to work from a leave. If you returned to work in a different plan year you will need to contact the HRSC if you wish to enroll for the current plan year.

For additional information regarding these flexible spending accounts, contact the HR Service Center benefits department at **877-4KP-HRSC (877-457-4772).**

If a portion of your leave is *unpaid* lasts for more than 30 days:

- You may no longer continue to accrue (as applicable) ETO/Vacation, ESL/Sick Leave.
- You will no longer receive pay for jury duty, bereavement leave, or holidays.
- Your accrual date may be adjusted forward by the length of your ***unpaid*** leave of absence, as applicable. For information regarding accrual date adjustments while on a leave of absence, refer to your respective bargaininng agreement or Summary Plan Description.

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If you need an extension of your leave
If you are unable to return to work on the specified return to work date, you are responsible for initiating a request for extension of leave. A request for extension of leave due to disability must be accompanied by a current physician certification from the health care provider. Any additional time off for this qualifying reason will be counted as FMLA up to the maximum time available, provided that sufficient certification is received. Remind your Manager to complete Form 1500 on My HR.

Returning to Work
You are encouraged to notify your supervisor of the intent to return to work at least 2 weeks prior to the expiration of the leave. In addition, if the family leave is due to your own serious health condition, you must provide a physician or practitioner certification form indicating that you are fit to return to work. Remind your Manager to complete Form 1510 on My HR.

The ***Employee Rights and Responsibilities*** under FMLA are attached for your review. Policies, bargaining agreements and other information regarding leaves of absence can be found on MyHR.

If you have any questions or concerns, please contact Work Absence Management (WAM) at the HR Service Center at **877-4KP-HRSC (877-457-4772)**. Please reference the case number located in the upper right corner of this letter.

We sincerely hope that the approved time off is valuable to you and your family.

Sincerely,

WAM Agent
HR Specialist II
Kaiser Permanente HR Service Center

Enclosures:
- ☐ LOA Quick Reference Guide
- ☐ Supplement to Sick Leave Request - Form 2090
- ☐ Personal Data Change - Form 2520
- ☐ Other:

KAISER PERMANENTE®

HR Service Center

EMPLOYEE RIGHTS AND RESPONSIBILITIES
UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

Basic Leave Entitlement
FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:
- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements
Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is a current membe r o f the Armed forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections
During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements
Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition
A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or 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.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave
An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave
Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities
Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities
Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility. Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA protected, the employer must notify the employee.

Unlawful Acts by Employers
FMLA makes it unlawful for any employer to:
- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement
An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

KAISER PERMANENTE®
National HR Service Center

September 2, 2016

Employee ID: 00530105
Case Number: 39708183

Darlene Walls
16323 cortuna ave # 8
Bellflower, CA 90706

Subject: Notice of Eligibility - Under the Family and Medical Leave Act/California Family Rights Act (Family Leave)

Dear Darlene Walls,

On 08/17/16, we were informed that you needed leave beginning on 08/17/16 for:

☐ The birth of a child, or placement of a child with you for adoption or foster care.

☒ Your own serious health condition.

☐ Your need to care for your <spouse child parent domestic partner family member> due to his/her serious health condition.

☐ An exigency arising out of the fact that your <spouse son or daughter parent> is on active duty or call to active duty status.

☐ Your need to care for your <spouse son or daughter parent next of kin> due to his/her serious injury or illness incurred in the line of duty as a covered servicemember.

This notice is to inform you that you have met the eligibility requirements for FMLA/CFRA

Your eligibility was determined based on the information available to us on 09/02/16. To qualify for FMLA/CFRA you must meet the eligibility requirements at the beginning of your leave. Please refer to the attached *Employee Rights and Responsibilities* regarding eligibility criteria or requirements. Should your employment status change prior to the start of your leave, you may not qualify for FMLA/CFRA.

Approval of your request for leave under the FMLA/CFRA is pending receipt of the documentation indicated below. The documentation must be provided to the NHRSC by 09/20/16 or your leave may be denied.

☒ Sufficient certification to support your request for FMLA/CFRA leave.

- ☒ 1451 Employee - Certification of Physician
- ☐ 1452 Family Member - Certification of Physician
- ☐ 1453 Service Member - Certification of Physician

☐ Sufficient certification to indicate your adult child is incapable of self-care because of a physical or mental disability. Certification may be provided on the enclosed 1452 Family Member - Certification of Physician.

☐ Sufficient documentation to establish the required relationship between you and your family member; proof of <birth marriage adoption/foster care domestic partner relationship next of kin>.

☐ Military Orders

☐ 1454 - Military Exigency - Certification

☐ Other:

☐ The certification you provided is not complete and sufficient to determine whether the FMLA/CFRA applies to your leave request. You must provide the following information no later than <mm/dd/yyyy>, or your leave may be denied, unless it is not practicable under the particular circumstances despite your diligent good faith efforts.

- ☐ The information provided on the Certification of Physician/Provider does not meet the definition of a serious health condition. A list of the definitions is attached for your reference.
- ☐ The Certification of Physician/Provider does not include the Frequency and Duration for intermittent leave.
- ☐ The Certification of Physician/Provider does not indicate your adult child is incapable of self-care because of a physical or mental disability.
- ☐ The information provided failed to establish the required relationship between you and your family member; proof of <birth marriage adoption/foster care domestic partner relationship next of kin>.
- ☐ Military Orders

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☐ 1453 - Service Member - Certification of Physician

☐ 1454 - Military Exigency - Certification

☐ Other:

Please fax the required document(s) to the National HR Service Center at **1-877-HRSC-FAX (1-877-477-2329).** Or mail the forms to:

Kaiser Permanente National HR Service Center
PO Box 2074
Oakland, CA 94604-2074

Once we obtain the information from you as specified above, we will inform you whether your leave will be designated as FMLA/CFRA leave and count towards your FMLA/CFRA leave entitlement.

Please note: Failure to provide the sufficient certification may result in delay or denial of your Family Leave.

The *Employee Rights and Responsibilities* and the definitions of a *Serious Health Condition* under the FMLA are attached for your review. Policies, bargaining agreements and other information regarding leaves of absence can be found on My HR.

If you have any questions or concerns regarding your request for family leave, please contact Work Absence Management (WAM) at the National HR Service Center at **877-4KP-HRSC (877-457-4772).** Please reference the case number located in the upper right-hand corner of this letter.

Sincerely,

Work Absence Management (WAM)
National HR Service Center

Enclosures:

☒ 1451 Employee - Certification of Physician
☐ 1452 Family Member - Certification of Physician
☐ 1453 Service Member - Certification of Physician
☐ 1454 - Military Exigency - Certification
☐ 2090 - Supplement to Sick Leave Request
☐ 2520 - Personal Data Change

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EMPLOYEE RIGHTS AND RESPONSIBILITIES
UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

Basic Leave Entitlement
FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:
- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements
Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is a current member of the Armed forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the service member medically unfit to perform his or her duties for which the service member is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections
During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements
Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition
A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or 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 t he qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave
An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave
Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities
Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities
Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility. Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA protected, the employer must notify the employee.

Unlawful Acts by Employers
FMLA makes it unlawful for any employer to:
- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement
An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

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Family and Medical Leave Act (FMLA)

"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.

Condition	Details
Inpatient Care	An overnight stay in a hospital, hospice, or residential medical-care facility, including any period of incapacity (i.e. inability to work, attend school, or perform other regular daily activities) or subsequent treatment in connection with such inpatient care.

Continuing treatment by a health care provider including one or more of the following:

a) Incapacity and Treatment	A period of incapacity lasting more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that **also** includes: · Treatment two or more times by or under the supervision of a health care provider (i.e. in-person visits, the first within 7 days and both within 30 days of the first day of incapacity); **or** One treatment by a health care provider (i.e., an in-person visit within 7 days of the first day of incapacity) with a continuing regimen of treatment (e.g., prescription medication, physical therapy).
b) Pregnancy	Any period of incapacity related to pregnancy or for prenatal care.
c) Chronic Conditions	Any period of incapacity or treatment for a chronic serious health condition. Requires periodic visits (at least twice a year) for treatment by, or under direct supervision of a health care provider. Continues over an extended period of time and may cause episodic rather than a continuing period of incapacity.
d) Permanent/Long-Term Conditions	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.
e) Conditions requiring multiple treatments	Any absences of incapacity to receive multiple treatments (including any period of recovery) 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 days if not treated.

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1494 LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

Instructions:
1. To ensure efficient and effective service please, submit form online.
2. Items marked with an asterisk (*) are required fields.
3. Immediate confirmation will be sent to you upon receipt of your online submittal.
4. **Supervisor/Manager:** Complete Leave of Absence Form for employee. Review Attestations; include applicable notations in the Comments Section on the Request. Be sure to print a copy of Leave of Absence Form before submitting.

* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(562) 657-8527	09/13/2015
* First Name	Middle Name	* Last Name
Darlene		Walls

1. LEAVE INFORMATION

Employee E-mail Address	Alternate Employee Phone Number (###) ###-####	New or Revised Request
		☒ New ☐ Revised

*** Leave Type:**

☒ Medical	☐ Union	☐ Care for Eligible Family Member
☐ Maternity	☐ Personal	☐ Family Military Leave
☐ Workers' Comp/Industrial	☐ Military Service	☐ Bonding

Last Day Worked (mm/dd/yyyy)	* First Day of Leave (mm/dd/yyyy)	Expected Return Date (mm/dd/yyyy)
	09/13/2015	

Is this an intermittent or reduced work schedule Leave? ☒ Intermittent ☐ Reduced Work Schedule ☐ Not Applicable

Is this a Donor Leave? ☐ Yes ☒ No ☐ Unknown

Estimated frequency and duration of absences
To be determined by physician

If absence is for Care of Eligible Family Member or Bonding:

Name of Eligible Family Member	Relationship to Employee
Is Family Member age 18 or under? If Yes, enter age ☐ Yes ☐ No	Delivery/Adoption/Foster Care Placement Date (mm/dd/yyyy) ☐ Actual Date ☐ Expected Date
Is the child's other parent employed by Kaiser Permanente? ☐ Yes ☐ No	If Yes, full name of other parent

If absence is due to Family Member's Military Service please select the reason(s) that apply:

Name of Eligible Family Member	Relationship to Employee

☐ **Qualifying Exigency**, (matters related to deployment such as Child Care issues, Financial Planning, and Family Support Sessions, Seeing off leaving or returning Service Members.)

☐ **Care for qualified Service Member who incurred injury or illness in the line of duty**

* First Name	Middle Name	* Last Name
Darlene		Walls
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(562) 657-8527	09/13/2015

1. LEAVE INFORMATION - (Continued)

If absence is for Employee's own health condition (Medical, Maternity or Workers' Comp/Industrial)

Date of illness or injury (mm/dd/yyyy)	Was hospitalization required?	Date Hospitalized (mm/dd/yyyy)
09/13/2015	☐ Yes ☒ No ☐ Unknown	

Estimated/Actual hours worked on last day	If Leave is due to maternity	Delivery Date (mm/dd/yyyy)
8	☐ Actual Delivery Date ☐ Expected Delivery Date	

If absence is pregnancy related, does the employee plan to take Bonding time immediately after the pregnancy related absence is complete?

☐ Yes ☐ No

If absence is for Union Leave

Type of Union Leave:

☐ Short Term (30 days or less) ☐ Long Term (greater than 30 days) ☐ Elected Official

Name of Union

If absence is for Military Leave

Is this absence for Military Training or Active Duty?

☐ Military Training ☐ Active Duty

*** If for Personal Leave, indicate reason**

Temporary Agency or Military Service (asked for FMLA eligibility)

Has the Employee worked for Kaiser Permanente less than one year?

☐ Yes ☒ No

Has the Employee been on active Military Duty in the past 12 months?	Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)
☐ Yes ☒ No		

Did the Employee work for Kaiser Permanente with a Temporary Agency in the year before they were hired?

☐ Yes ☐ No

LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

* First Name	Middle Name	* Last Name
Darlene		Walls
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(562) 657-8527	09/13/2015

1. LEAVE INFORMATION - (Continued)

Name of Agency		
Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)	Agency Phone Number (###) ###-####

2. COMMENTS

Attendance Review 11/12/15: 1480 submitted on behalf of Manager Michelle L. Lenaburg. am

3. EMPLOYEE SCHEDULE

This information is essential for the NHRSC to prepare a worksheet to assist with TIME coding. This is required for employees absent for their own disability. Please use a 24 hr clock: 00:00 thru 24:00.

NOTE: This section is not applicable for the KRONOS regions.

Week 1

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start Time: (hh:mm)							
Hours:							

Week 2 (Only needed if schedule changes week to week)

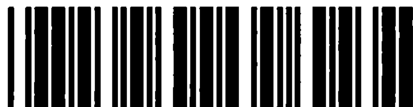
	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start Time: (hh:mm)							
Hours:							

4. REQUEST PAID TIME-OFF

Review your Collective Bargaining Agreement and/or Summary Plan Description Booklet before completing this section. Selections made here will not supersede conditions set in Collective Bargaining Agreements, Summary Plan Descriptions, KP and HR Policies, or applicable State and Federal Laws.

Did employee request EarnedTime Off (ETO)/Paid Time Off (PTO)/Vacation? ☐ Yes ☐ No	☐ Use all available hours ☐ Use selected hours	Number of hours
Did employee request to use Extended Sick Leave (ESL)/Sick Leave? ☐ Yes ☐ No	☐ Use all available hours ☐ Use selected hours	Number of hours
Did employee request to use Float Holidays? ☐ Yes ☐ No	Only available Float Holidays will be applied.	Number of days

National HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist



1494 LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

* First Name	Middle Name	* Last Name
Darlene		Walls
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(562) 657-8527	09/13/2015

4. REQUEST PAID TIME-OFF - (Continued)

Did employee request to use Flexible Personal Days? ☐ Yes ☐ No	Number of days	OR	Number of hours
Note: Flexible Personal Days can only be used in full day or two hour increments. Only available Flexible Personal Days will be applied.			
Did employee request Military Make-up Pay? ☐ Yes ☐ No			

5. SUBMITTED BY

* Name (First, MI, Last)		
Adriana Martinez		
* Employee ID	* Title	
00289603		
* E-mail Address		* Work Phone Number (###) ###-####
Adriana.D.Martinez@kp.org		(562) 461-6808

6. MANAGER INFORMATION DETAIL

* Name (First, MI, Last)		
Michelle Lenaburg		
Supervisor ID	* Title	
* E-mail Address		* Work Phone Number (###) ###-####
Michelle.L.Lenaburg@kp.org		(562) 657-8527

7. ALTERNATE CONTACT INFORMATION - Someone, in addition to the Manager, who should receive leave communication (i.e. time coding, fmla status, etc)

* Name (First, MI, Last)	
Barbara X Lespron	
* E-mail Address	* Work Phone Number (###) ###-####
Barbara.X.Lespron@kp.org	(562) 657-9624

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* First Name	Middle Name	* Last Name
Darlene		Walls
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(562) 657-8527	09/13/2015

8. MANAGER ATTESTATION

* Checking these items acknowledges that you have read and understand each item.

☒ I agree to direct the employee requesting Leave to submit any and all supporting documentation to me or the National HR Service Center.

☒ I agree to submit form 1500 - Extend Leave and any supporting documentation at the time I learn that the employee intends to extend his or her leave beyond their expected return date or fails to return on their expected date, fails to respond, and is not terminated.

☒ I agree to submit form 1510 - Return from Leave when the employee returns to work.

☒ TIME must be coded for all paid and unpaid leave taken by the employee.

9. MANAGER SIGNATURE - (Required if not submitted online.)

* Manager Signature	* Date (mm/dd/yyyy)

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National HR Service Center

November 21, 2015

Employee ID: 00530105
Case Number: 38807656

Darlene Walls
16323 cortuna ave # 8
Bellflower, CA 90706

Subject: Notice of Eligibility - Under the Family and Medical Leave Act/California Family Rights Act (Family Leave)

Dear Darlene Walls,

On 11/12/2015 we were informed that you needed leave beginning on 09/13/2015 for:

☐ The birth of a child, or placement of a child with you for adoption or foster care.

☒ Your own serious health condition.

☐ Your need to care for your <spouse child parent domestic partner family member> due to his/her serious health condition.

☐ An exigency arising out of the fact that your <spouse son or daughter parent> is on active duty or call to active duty status.

☐ Your need to care for your <spouse son or daughter parent next of kin> due to his/her serious injury or illness incurred in the line of duty as a covered servicemember.

This notice is to inform you that you have met the eligibility requirements for FMLA/CFRA

Your eligibility was determined based on the information available to us on 11/23/2015. To qualify for FMLA/CFRA you must meet the eligibility requirements at the beginning of your leave. Please refer to the attached *Employee Rights and Responsibilities* regarding eligibility criteria or requirements. Should your employment status change prior to the start of your leave, you may not qualify for FMLA/CFRA.

Approval of your request for leave under the FMLA/CFRA is pending receipt of the documentation indicated below. The documentation must be provided to the NHRSC by 12/11/2015 or your leave may be denied.

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National HR Service Center

- ☒ Sufficient certification to support your request for FMLA/CFRA leave.
  - ☒ 1451 Employee - Certification of Physician
  - ☐ 1452 Family Member - Certification of Physician
  - ☐ 1453 Service Member - Certification of Physician
- ☐ Sufficient certification to indicate your adult child is incapable of self-care because of a physical or mental disability. Certification may be provided on the enclosed 1452 Family Member - Certification of Physician.
- ☐ Sufficient documentation to establish the required relationship between you and your family member; proof of <birth marriage adoption/foster care domestic partner relationship next of kin>.
- ☐ Military Orders
- ☐ 1454 - Military Exigency - Certification
- ☐ Other:

☐ The certification you provided is not complete and sufficient to determine whether the FMLA/CFRA applies to your leave request. You must provide the following information no later than <mm/dd/yyyy>, or your leave may be denied, unless it is not practicable under the particular circumstances despite your diligent good faith efforts.

- ☐ The information provided on the Certification of Physician/Provider does not meet the definition of a serious health condition. A list of the definitions is attached for your reference.
- ☐ The Certification of Physician/Provider does not include the Frequency and Duration for intermittent leave.
- ☐ The Certification of Physician/Provider does not indicate your adult child is incapable of self-care because of a physical or mental disability.
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- ☐ Military Orders

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National HR Service Center

☐ 1453 - Service Member - Certification of Physician

☐ 1454 - Military Exigency - Certification

☐ Other:

Please fax the required document(s) to the National HR Service Center at **1-877-HRSC-FAX (1-877-477-2329).** Or mail the forms to:

Kaiser Permanente National HR Service Center
PO Box 2074
Oakland, CA 94604-2074

Once we obtain the information from you as specified above, we will inform you whether your leave will be designated as FMLA/CFRA leave and count towards your FMLA/CFRA leave entitlement.

Please note: Failure to provide the sufficient certification may result in delay or denial of your Family Leave.

The *Employee Rights and Responsibilities* and the definitions of a *Serious Health Condition* under the FMLA are attached for your review. Policies, bargaining agreements and other information regarding leaves of absence can be found on My HR.

If you have any questions or concerns regarding your request for family leave, please contact Work Absence Management (WAM) at the National HR Service Center at **877-4KP-HRSC (877-457-4772).** Please reference the case number located in the upper right-hand corner of this letter.

Sincerely,

Work Absence Management (WAM)
National HR Service Center

Enclosures:

☒ 1451 Employee - Certification of Physician
☐ 1452 Family Member - Certification of Physician
☐ 1453 Service Member - Certification of Physician
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☐ 2090 - Supplement to Sick Leave Request
☐ 2520 - Personal Data Change

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National HR Service Center

EMPLOYEE RIGHTS AND RESPONSIBILITIES
UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

Basic Leave Entitlement
FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:
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- To care for the employee's spouse, son or daughter or parent, who has a serious health condition; or
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Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements
Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition
A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or 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 t he qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave
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Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

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Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

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An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

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National HR Service Center

Family and Medical Leave Act (FMLA)

"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.

Condition	Details
Inpatient Care	An overnight stay in a hospital, hospice, or residential medical-care facility, including any period of incapacity (i.e. inability to work, attend school, or perform other regular daily activities) or subsequent treatment in connection with such inpatient care.

Continuing treatment by a health care provider including one or more of the following:

a) Incapacity and Treatment	A period of incapacity lasting more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that **also** includes: · Treatment two or more times by or under the supervision of a health care provider (i.e. in-person visits, the first within 7 days and both within 30 days of the first day of incapacity); **or** One treatment by a health care provider (i.e., an in-person visit within 7 days of the first day of incapacity) with a continuing regimen of treatment (e.g., prescription medication, physical therapy).
b) Pregnancy	Any period of incapacity related to pregnancy or for prenatal care.
c) Chronic Conditions	Any period of incapacity or treatment for a chronic serious health condition. Requires periodic visits (at least twice a year) for treatment by, or under direct supervision of a health care provider. Continues over an extended period of time and may cause episodic rather than a continuing period of incapacity.
d) Permanent/Long-Term Conditions	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.
e) Conditions requiring multiple treatments	Any absences of incapacity to receive multiple treatments (including any period of recovery) 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 days if not treated.

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December 16, 2015

Employee ID: 00530105
Case Number: 38807656

Darlene Walls
16323 cortuna ave # 8
Bellflower, CA 90706

Subject: Denial Notice - Under the Family and Medical Leave Act/California Family Rights Act (Family Leave)

Dear Darlene Walls,

On 11/12/2015, we were informed that you needed leave beginning on 09/13/15 for:

☐ The birth of a child, or placement of a child with you for adoption or foster care.

☒ Your own serious health condition.

☐ Your need to care for your <spouse child parent domestic partner family member> due to his/her serious health condition.

☐ An exigency arising out of the fact that your <spouse son or daughter parent> is on active duty or call to active duty status.

☐ Your need to care for your <spouse son or daughter parent next of kin> due to his/her serious injury or illness incurred in the line of duty as a covered servicemember.

This Notice is to inform you that you are not eligible for FMLA/CFRA leave, because:

☐ You have not met the 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately <Enter Num Mos> months towards this requirement. If you are still on leave at the completion of 12 months of service please contact the NHRSC to request your eligibility for FMLA/CFRA. For more information please see the attached notice of Employee Rights and Responsibilities.

☐ You have not met the 1,250 hours worked requirement within the 12 months preceding the start of your leave. As of <mm/dd/yyyy> you have worked <Enter Hours> hours towards the eligibility requirement. You can check the number of hours worked by contacting the NHRSC.

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☐ You exhausted your <12 26>-week entitlement to leave under the <FMLA/CFRA>

☐ Your request is for a non-qualified family member.

☒ You failed to provide sufficient certification to support your request.

- ☒ A Health Care Provider Certification form was not received.
- ☐ The information provided on the Health Care Provider Certification did not meet the definition of a serious health condition.
- ☐ The Health Care Provider Certification did not include the Frequency and Duration for an intermittent leave.
- ☐ The Health Care Provider Certification did not indicate your adult child is incapable of self-care because of a physical or mental disability.
- ☐ You failed to provide sufficient documentation to establish the required relationship between you and your family member; proof of <birth adoption/foster care domestic partner relationship marriage>.
- ☐ Military Orders
- ☐ <Certification of Exigency Certification of an injured/ill servicemember>

☐ Other:

The *Employee Rights and Responsibilities* under the FMLA are attached for your review.

While your time off is not currently protected under the FMLA and CFRA; you may become eligible for FMLA/CFRA during your leave. Please refer to the *Employee Rights and Responsibilities* for eligibility criteria or requirements. You may also be eligible for other forms of leave under Kaiser's leave policies or under an applicable collective bargaining agreement. If your leave is the result of a work-related injury, it may be subject to Workers' Compensation leave protection.

Policies, bargaining agreements and other information regarding leaves of absence can be found on My HR.

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If you have any questions or concerns regarding the denial of your request for family leave, please contact Work Absence Management (WAM) at the National HR Service Center at **877-4KP-HRSC (877-457-4772).** Please reference the case number located in the upper right-hand corner of this letter.

Sincerely,

Work Absence Management

Kaiser Permanente National HR Service Center

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National HR Service Center

EMPLOYEE RIGHTS AND RESPONSIBILITIES
UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

Basic Leave Entitlement
FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:
- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements
Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is a current member of the Armed forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the service member medically unfit to perform his or her duties for which the service member is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections
During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements
Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition
A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or 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.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave
An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave
Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities
Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities
Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility. Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA protected, the employer must notify the employee.

Unlawful Acts by Employers
FMLA makes it unlawful for any employer to:
- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement
An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

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LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

Instructions:
1. To ensure efficient and effective service please, submit form online.
2. Items marked with an asterisk (*) are required fields.
3. Immediate confirmation will be sent to you upon receipt of your online submittal.
4. **Supervisor/Manager:** Complete Leave of Absence Form for employee. Review Attestations; include applicable notations in the Comments Section on the Request. Be sure to print a copy of Leave of Absence Form before submitting.

* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(562) 657-8527	01/30/2016
* First Name	Middle Name	* Last Name
Darlene		Walls

1. LEAVE INFORMATION

Employee E-mail Address	Alternate Employee Phone Number (###) ###-####	New or Revised Request
		☒ New ☐ Revised

*** Leave Type:**

☒ Medical	☐ Union	☐ Care for Eligible Family Member
☐ Maternity	☐ Personal	☐ Family Military Leave
☐ Workers' Comp/Industrial	☐ Military Service	☐ Bonding

Last Day Worked (mm/dd/yyyy)	* First Day of Leave (mm/dd/yyyy)	Expected Return Date (mm/dd/yyyy)
	01/30/2016	

Is this an intermittent or reduced work schedule Leave? ☒ Intermittent ☐ Reduced Work Schedule ☐ Not Applicable

Is this a Donor Leave? ☐ Yes ☒ No ☐ Unknown

Estimated frequency and duration of absences
To be determined by physician

If absence is for Care of Eligible Family Member or Bonding:

Name of Eligible Family Member	Relationship to Employee
Is Family Member age 18 or under? If Yes, enter age ☐ Yes ☐ No	Delivery/Adoption/Foster Care Placement Date (mm/dd/yyyy) ☐ Actual Date ☐ Expected Date
Is the child's other parent employed by Kaiser Permanente? ☐ Yes ☐ No	If Yes, full name of other parent

If absence is due to Family Member's Military Service please select the reason(s) that apply:

Name of Eligible Family Member	Relationship to Employee

☐ **Qualifying Exigency,** (matters related to deployment such as Child Care issues, Financial Planning, and Family Support Sessions, Seeing off leaving or returning Service Members.)

☐ **Care for qualified Service Member who incurred injury or illness in the line of duty**

National HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist

Next Page >

* First Name	Middle Name	* Last Name
Darlene		Walls
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(562) 657-8527	01/30/2016

1. LEAVE INFORMATION - (Continued)

If absence is for Employee's own health condition (Medical, Maternity or Workers' Comp/Industrial)

Date of illness or injury (mm/dd/yyyy)	Was hospitalization required?	Date Hospitalized (mm/dd/yyyy)
01/30/2016	☐ Yes ☒ No ☐ Unknown	

Estimated/Actual hours worked on last day	If Leave is due to maternity	Delivery Date (mm/dd/yyyy)
8	☐ Actual Delivery Date ☐ Expected Delivery Date	

If absence is pregnancy related, does the employee plan to take Bonding time immediately after the pregnancy related absence is complete?

☐ Yes ☐ No

If absence is for Union Leave

Type of Union Leave:

☐ Short Term (30 days or less) ☐ Long Term (greater than 30 days) ☐ Elected Official

Name of Union

If absence is for Military Leave

Is this absence for Military Training or Active Duty?

☐ Military Training ☐ Active Duty

*** If for Personal Leave, indicate reason**

Temporary Agency or Military Service (asked for FMLA eligibility)

Has the Employee worked for Kaiser Permanente less than one year?

☐ Yes ☒ No

Has the Employee been on active Military Duty in the past 12 months?	Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)
☐ Yes ☒ No		

Did the Employee work for Kaiser Permanente with a Temporary Agency in the year before they were hired?

☐ Yes ☐ No

LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

* First Name	Middle Name	* Last Name
Darlene		Walls
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(562) 657-8527	01/30/2016

1. LEAVE INFORMATION - (Continued)

Name of Agency		
Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)	Agency Phone Number (###) ###-####

2. COMMENTS

Attendance Review 03/08/16: 1480 submitted on behalf of Manager Michelle Lenaburg. am

3. EMPLOYEE SCHEDULE

This information is essential for the NHRSC to prepare a worksheet to assist with TIME coding. This is required for employees absent for their own disability. Please use a 24 hr clock: 00:00 thru 24:00.

NOTE: This section is not applicable for the KRONOS regions.

Week 1

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start Time: (hh:mm)							
Hours:							

Week 2 (Only needed if schedule changes week to week)

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start Time: (hh:mm)							
Hours:							

4. REQUEST PAID TIME-OFF

Review your Collective Bargaining Agreement and/or Summary Plan Description Booklet before completing this section. Selections made here will not supersede conditions set in Collective Bargaining Agreements, Summary Plan Descriptions, KP and HR Policies, or applicable State and Federal Laws.

Question	Option	Amount
Did employee request EarnedTime Off (ETO)/Paid Time Off (PTO)/Vacation? ☐ Yes ☐ No	☐ Use all available hours ☐ Use selected hours	Number of hours
Did employee request to use Extended Sick Leave (ESL)/Sick Leave? ☐ Yes ☐ No	☐ Use all available hours ☐ Use selected hours	Number of hours
Did employee request to use Float Holidays? ☐ Yes ☐ No	Only available Float Holidays will be applied.	Number of days

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1494 **LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT**

* First Name	Middle Name	* Last Name
Darlene		Walls
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(562) 657-8527	01/30/2016

4. REQUEST PAID TIME-OFF - (Continued)

Did employee request to use Flexible Personal Days? ☐ Yes ☐ No	Number of days	OR	Number of hours

Note: Flexible Personal Days can only be used in full day or two hour increments. Only available Flexible Personal Days will be applied.

Did employee request Military Make-up Pay?
☐ Yes ☐ No

5. SUBMITTED BY

* Name (First, MI, Last)	
Adriana Martinez	
* Employee ID	* Title
00289603	
* E-mail Address	* Work Phone Number (###) ###-####
Adriana.D.Martinez@kp.org	(562) 461-6808

6. MANAGER INFORMATION DETAIL

* Name (First, MI, Last)	
Michelle Lenaburg	
Supervisor ID	* Title
* E-mail Address	* Work Phone Number (###) ###-####
Michelle.L.Lenaburg@kp.org	(562) 657-8527

7. ALTERNATE CONTACT INFORMATION - Someone, in addition to the Manager, who should receive leave communication (i.e. time coding, fmla status, etc)

* Name (First, MI, Last)	
Barbara X Lespron	
* E-mail Address	* Work Phone Number (###) ###-####
Barbara.X.Lespron@kp.org	(562) 657-9624

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* First Name	Middle Name	* Last Name
Darlene		Walls
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(562) 657-8527	01/30/2016

8. MANAGER ATTESTATION

* Checking these items acknowledges that you have read and understand each item.

☒ I agree to direct the employee requesting Leave to submit any and all supporting documentation to me or the National HR Service Center.

☒ I agree to submit form 1500 - Extend Leave and any supporting documentation at the time I learn that the employee intends to extend his or her leave beyond their expected return date or fails to return on their expected date, fails to respond, and is not terminated.

☒ I agree to submit form 1510 - Return from Leave when the employee returns to work.

☒ TIME must be coded for all paid and unpaid leave taken by the employee.

9. MANAGER SIGNATURE - (Required if not submitted online.)

* Manager Signature	* Date (mm/dd/yyyy)

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National HR Service Center

March 16, 2016

Employee ID: 00530105
Case Number: 39193694

Darlene Walls
16323 cortuna ave # 8
Bellflower, CA 90706

Subject: Notice of Eligibility - Under the Family and Medical Leave Act/California Family Rights Act (Family Leave)

Dear Darlene Walls,

On 03/08/16, we were informed that you needed leave beginning on 01/30/16 for:

☐ The birth of a child, or placement of a child with you for adoption or foster care.

☒ Your own serious health condition.

☐ Your need to care for your <spouse child parent domestic partner family member> due to his/her serious health condition.

☐ An exigency arising out of the fact that your <spouse son or daughter parent> is on active duty or call to active duty status.

☐ Your need to care for your <spouse son or daughter parent next of kin> due to his/her serious injury or illness incurred in the line of duty as a covered servicemember.

This notice is to inform you that you have met the eligibility requirements for FMLA/CFRA

Your eligibility was determined based on the information available to us on 03/16/16. To qualify for FMLA/CFRA you must meet the eligibility requirements at the beginning of your leave. Please refer to the attached *Employee Rights and Responsibilities* regarding eligibility criteria or requirements. Should your employment status change prior to the start of your leave, you may not qualify for FMLA/CFRA.

Approval of your request for leave under the FMLA/CFRA is pending receipt of the documentation indicated below. The documentation must be provided to the NHRSC by 04/03/16 or your leave may be denied.

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National HR Service Center

- ☒ Sufficient certification to support your request for FMLA/CFRA leave.
  - ☒ 1451 Employee - Certification of Physician
  - ☐ 1452 Family Member - Certification of Physician
  - ☐ 1453 Service Member - Certification of Physician
- ☐ Sufficient certification to indicate your adult child is incapable of self-care because of a physical or mental disability. Certification may be provided on the enclosed 1452 Family Member - Certification of Physician.
- ☐ Sufficient documentation to establish the required relationship between you and your family member; proof of <birth marriage adoption/foster care domestic partner relationship next of kin>.
- ☐ Military Orders
- ☐ 1454 - Military Exigency - Certification
- ☐ Other:

☐ The certification you provided is not complete and sufficient to determine whether the FMLA/CFRA applies to your leave request. You must provide the following information no later than <mm/dd/yyyy>, or your leave may be denied, unless it is not practicable under the particular circumstances despite your diligent good faith efforts.

- ☐ The information provided on the Certification of Physician/Provider does not meet the definition of a serious health condition. A list of the definitions is attached for your reference.
- ☐ The Certification of Physician/Provider does not include the Frequency and Duration for intermittent leave.
- ☐ The Certification of Physician/Provider does not indicate your adult child is incapable of self-care because of a physical or mental disability.
- ☐ The information provided failed to establish the required relationship between you and your family member; proof of <birth marriage adoption/foster care domestic partner relationship next of kin>.
- ☐ Military Orders

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☐ 1453 - Service Member - Certification of Physician

☐ 1454 - Military Exigency - Certification

☐ Other:

Please fax the required document(s) to the National HR Service Center at **1-877-HRSC-FAX (1-877-477-2329).** Or mail the forms to:

Kaiser Permanente National HR Service Center
PO Box 2074
Oakland, CA 94604-2074

Once we obtain the information from you as specified above, we will inform you whether your leave will be designated as FMLA/CFRA leave and count towards your FMLA/CFRA leave entitlement.

Please note: Failure to provide the sufficient certification may result in delay or denial of your Family Leave.

The *Employee Rights and Responsibilities* and the definitions of a *Serious Health Condition* under the FMLA are attached for your review. Policies, bargaining agreements and other information regarding leaves of absence can be found on My HR.

If you have any questions or concerns regarding your request for family leave, please contact Work Absence Management (WAM) at the National HR Service Center at **877-4KP-HRSC (877-457-4772).** Please reference the case number located in the upper right-hand corner of this letter.

Sincerely,

Work Absence Management (WAM)
National HR Service Center

Enclosures:

☒ 1451 Employee - Certification of Physician
☐ 1452 Family Member - Certification of Physician
☐ 1453 Service Member - Certification of Physician
☐ 1454 - Military Exigency - Certification
☐ 2090 - Supplement to Sick Leave Request
☐ 2520 - Personal Data Change

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National HR Service Center

EMPLOYEE RIGHTS AND RESPONSIBILITIES
UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

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Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or 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 t he qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility. Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

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National HR Service Center

Family and Medical Leave Act (FMLA)

"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.

Condition	Details
Inpatient Care	An overnight stay in a hospital, hospice, or residential medical-care facility, including any period of incapacity (i.e. inability to work, attend school, or perform other regular daily activities) or subsequent treatment in connection with such inpatient care.

Continuing treatment by a health care provider including one or more of the following:

a) Incapacity and Treatment	A period of incapacity lasting more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that **also** includes: · Treatment two or more times by or under the supervision of a health care provider (i.e. in-person visits, the first within 7 days and both within 30 days of the first day of incapacity); **or** One treatment by a health care provider (i.e., an in-person visit within 7 days of the first day of incapacity) with a continuing regimen of treatment (e.g., prescription medication, physical therapy).
b) Pregnancy	Any period of incapacity related to pregnancy or for prenatal care.
c) Chronic Conditions	Any period of incapacity or treatment for a chronic serious health condition. Requires periodic visits (at least twice a year) for treatment by, or under direct supervision of a health care provider. Continues over an extended period of time and may cause episodic rather than a continuing period of incapacity.
d) Permanent/Long-Term Conditions	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.
e) Conditions requiring multiple treatments	Any absences of incapacity to receive multiple treatments (including any period of recovery) 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 days if not treated.

KAISER PERMANENTE®
National HR Service Center

April 5, 2016

Employee ID: 00530105
Case Number: 39193694

Darlene Walls
16323 cortuna ave # 8
Bellflower, CA 90706

Subject: Denial Notice - Under the Family and Medical Leave Act/California Family Rights Act (Family Leave)

Dear Darlene Walls,

On 03/08/16, we were informed that you needed leave beginning on 01/30/16 for:

☐ The birth of a child, or placement of a child with you for adoption or foster care.

☒ Your own serious health condition.

☐ Your need to care for your <spouse child parent domestic partner family member> due to his/her serious health condition.

☐ An exigency arising out of the fact that your <spouse son or daughter parent> is on active duty or call to active duty status.

☐ Your need to care for your <spouse son or daughter parent next of kin> due to his/her serious injury or illness incurred in the line of duty as a covered servicemember.

This Notice is to inform you that you are not eligible for FMLA/CFRA leave, because:

☐ You have not met the 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately <Enter Num Mos> months towards this requirement. If you are still on leave at the completion of 12 months of service please contact the NHRSC to request your eligibility for FMLA/CFRA. For more information please see the attached notice of Employee Rights and Responsibilities.

☐ You have not met the 1,250 hours worked requirement within the 12 months preceding the start of your leave. As of <mm/dd/yyyy> you have worked <Enter Hours> hours towards the eligibility requirement. You can check the number of hours worked by contacting the NHRSC.

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☐ You exhausted your <12 26>-week entitlement to leave under the <FMLA/CFRA>

☐ Your request is for a non-qualified family member.

☒ You failed to provide sufficient certification to support your request.

- ☒ A Health Care Provider Certification form was not received.
- ☐ The information provided on the Health Care Provider Certification did not meet the definition of a serious health condition.
- ☐ The Health Care Provider Certification did not include the Frequency and Duration for an intermittent leave.
- ☐ The Health Care Provider Certification did not indicate your adult child is incapable of self-care because of a physical or mental disability.
- ☐ You failed to provide sufficient documentation to establish the required relationship between you and your family member; proof of <birth adoption/foster care domestic partner relationship marriage>.
- ☐ Military Orders
- ☐ <Certification of Exigency Certification of an injured/ill servicemember>

☐ Other:

The *Employee Rights and Responsibilities* under the FMLA are attached for your review.

While your time off is not currently protected under the FMLA and CFRA; you may become eligible for FMLA/CFRA during your leave. Please refer to the *Employee Rights and Responsibilities* for eligibility criteria or requirements. You may also be eligible for other forms of leave under Kaiser's leave policies or under an applicable collective bargaining agreement. If your leave is the result of a work-related injury, it may be subject to Workers' Compensation leave protection.

Policies, bargaining agreements and other information regarding leaves of absence can be found on My HR.

KAISER PERMANENTE®
National HR Service Center

If you have any questions or concerns regarding the denial of your request for family leave, please contact Work Absence Management (WAM) at the National HR Service Center at **877-4KP-HRSC (877-457-4772).** Please reference the case number located in the upper right-hand corner of this letter.

Sincerely,

Work Absence Management

Kaiser Permanente National HR Service Center

KAISER PERMANENTE®

National HR Service Center

EMPLOYEE RIGHTS AND RESPONSIBILITIES
UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

Basic Leave Entitlement
FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:
- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements
Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is a current member of the Armed forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the service member medically unfit to perform his or her duties for which the service member is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections
During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements
Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition
A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or 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.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave
An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave
Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities
Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities
Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility. Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA protected, the employer must notify the employee.

Unlawful Acts by Employers
FMLA makes it unlawful for any employer to:
- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement
An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

KAISER PERMANENTE®
National HR Service Center

April 18, 2016

Employee ID: 00530105
Case Number: 39193694

Darlene Walls
16323 cortuna ave # 8
Bellflower, CA 90706

Subject: Designation for Family Leave under the Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA)

Dear Darlene,

On 03/08/2016, we were informed that you needed leave beginning on 01/30/2016 for:

☐ The birth of a child, or placement of a child with you for adoption or foster care.

☒ Your own serious health condition.

☐ Your need to care for your <spouse child parent domestic partner family member> due to his/her serious health condition.

☐ An exigency arising out of the fact that your <spouse son or daughter parent> is on active duty or call to active duty status.

☐ Your need to care for your <spouse son or daughter parent next of kin> due to his/her serious injury or illness incurred in the line of duty as a covered service member.

We reviewed your eligibility for leave under the FMLA/CFRA, and your supporting documentation, and determined that your FMLA/CFRA leave is approved. All leave taken for the reason checked above will be designated as FMLA/CFRA leave as long as you are eligible.

Your eligibility was determined based on the information available to us on 04/18/2016. To qualify for FMLA/CFRA you must meet the eligibility requirements at the beginning of your leave. Should your employment status change prior to the start of your leave, you may not qualify for FMLA/CFRA. The FMLA/CFRA requires that you notify us as soon as practicable if dates of scheduled leave change or are extended, or were initially unknown.

Provided there is no deviation from your anticipated leave schedule, and based on the information available to date, you are eligible for 433.44 hours which will be counted against your leave entitlement.

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National HR Service Center

☐ Our records indicate you have used 0 hours during the immediately preceding 12 months. As of <Enter Date> your remaining <hours workweeks> are:

☐ Your continuous Family Leave begins on <Enter Date> and ends on <Enter Date>.

☒ Your intermittent Family Leave begins on 04/12/2016 and ends on 07/30/2016. You are approved for the following frequency and duration of leave:

Frequency: 2 times per month
Duration: 1 day per episode

Family Leave

- Family Leave entitles you to up to twelve (12) workweeks of leave in a twelve (12) month rolling period. Military Caregiver leave is limited to 26 workweeks in a single 12 month period.
- FMLA/CFRA runs concurrently with Occupational leaves of absence and time off under Kin Care/CESLA when it is for an FMLA/CFRA qualifying reason.
- CFRA leave to care for a domestic partner with a serious health condition does not run concurrently with FMLA leave.
- An employee's pay status during Family Leave is determined in accordance with applicable laws, regional policies, and collective bargaining agreements.
- When taking Family Leave for one's own non work-related and non pregnancy-related illness/injury, an employee is required to use any available Sick/Extended Sick leave benefits.
- An employee may elect, but is not required, to use ETO, vacation or FPD hours while on FMLA/CFRA leave to care for his/her own serious health condition, or to care for a child, spouse, domestic partner, or parent.
- Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations.
- Re-certification may be required every 30 calendar days or if there has been a significant change in circumstances.

If your Family Leave is related to Pregnancy

California Pregnancy Disability Leave (PDL) and FMLA run concurrently. You may be eligible for up to, an additional 12 workweeks of leave under the California Family Rights Act (CFRA) for bonding with your newborn child. Your time off for bonding will count towards your CFRA entitlement. Any remaining FMLA entitlement will run concurrently with your bonding time under CFRA.

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Intermittent Family Leave
As an eligible employee, you are entitled to take Family Leave in separate blocks of time or by a reduced work schedule for your own or a family member's serious health condition which requires continuing treatment by a health care provider and which is best accommodated through intermittent time or a reduced work schedule. Any intermittent leave taken under Family Leave shall reduce the amount of remaining Family Leave.

If you wish to take intermittent leave to care for and bond with a child within one year of the birth or placement of the child must take the leave in increments of two weeks or more at a time, with the exception that leaves of less than two weeks can be taken twice during the year.

Continuation of Benefits Under Family Leave
Kaiser Permanente will continue your health and dental benefits for a total of 12 workweeks while you are under Family Leave, whether your leave is paid or unpaid. If you are on Military Caregiver Leave, Kaiser Permanente will continue your health and dental benefits for a total of 26 workweeks in a single 12 month period. While on a paid Family Leave, your other elected benefits will continue, with the exception of the Dependent Care Spending Account.

For information regarding other Employer paid benefits while on an unpaid leave of absence, refer to your respective bargaining agreement or Summary Plan Description.

Life Insurance continues at the employer's expense for a minimum of 30 calendar days following commencement of **unpaid** Family Leave. Collective bargaining agreement provisions of represented employee groups maybe more generous than the Family Leave policy. **You may choose to continue Life Insurance coverage after this time at your own expense. If you wish to do so, you may contact the National HR Service Center (NHRSC) to make the necessary arrangements.**

Dependent enrollment for a newborn or adopted child
You will need to complete benefit enrollment within 31 days of the birth or adoption to ensure coverage for your new dependent.

Enroll on-line at: http://kp.org/myhr:

DAY 1	*Report your Qualifying Event/Family Status Change:* Go to the appropriate life event in the Home and Family section of the left-hand navigation, (i.e. getting married or having a baby) and enter the information requested.
DAY 2	Make benefit changes on-line: Log on and follow the online process to enroll your dependent.

DAY 3	Confirm Benefit change: To confirm that your enrollment was successfully completed, log on and print a confirmation statement for your records.
DAY 4	Submit supporting documents: Be sure to submit any required supporting documentation to the NHRSC.

A copy of your child's certified birth certificate will be required to complete the enrollment. Verification of your dependent's Social Security Number (SSN) may also be required.

DO NOT DELAY YOUR ENROLLMENT! If you need additional time to submit supporting documentation, contact the NHRSC.

If you do not notify the NHRSC within 31 days of the event, *you may have to wait until the next Open Enrollment period to enroll your child.*

Spending Accounts
If you enrolled in a Spending Account (Health Care, Dependent Care or Commuter) please go to the *Benefits, Pay & Employment* section on My HR at http://insidekp.kp.org/myhr/ for eligibility, contributions and any changes due to your leave of absence or return from leave.

If you need an extension of your leave
If you are unable to return to work on the specified return to work date, you are responsible for initiating a request for extension of leave. A request for extension of leave due to disability must be accompanied by a current physician certification from the health care provider. Any additional time off for this qualifying reason will be counted as FMLA up to the maximum time available, provided that sufficient certification is received. Remind your Manager to complete Form 1500 on My HR.

Returning to Work
You are encouraged to notify your supervisor of the intent to return to work at least 2 weeks prior to the expiration of the leave. In addition, if the family leave is due to your own serious health condition, you must provide a physician or practitioner certification form indicating that you are fit to return to work. Remind your Manager to complete Form 1510 on My HR.

The ***Employee Rights and Responsibilities*** under FMLA are attached for your review. Policies, bargaining agreements and other information regarding leaves of absence can be found on My HR at http://insidekp.kp.org/myhr/ or you may contact NHRSC at 877-4KP-HRSC (877-457-4772) and select Leaves of Absence.

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National HR Service Center

Please reference the case number located in the upper right corner of this letter.

Sincerely,

Work Absence Management

Enclosures:

- ☐ LOA Quick Reference Guide
- ☐ Supplement to Sick Leave Request - Form 2090
- ☐ Personal Data Change - Form 2520
- ☐ Other:

KAISER PERMANENTE®

National HR Service Center

EMPLOYEE RIGHTS AND RESPONSIBILITIES
UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

Basic Leave Entitlement
FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:
- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements
Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is a current membe r o f the Armed forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections
During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements
Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition
A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or 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.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave
An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave
Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities
Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities
Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility. Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA protected, the employer must notify the employee.

Unlawful Acts by Employers
FMLA makes it unlawful for any employer to:
- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement
An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

Instructions:
1. To ensure efficient and effective service please, submit form online.
2. Items marked with an asterisk (*) are required fields.
3. Immediate confirmation will be sent to you upon receipt of your online submittal.
4. **Supervisor/Manager:** Complete Leave of Absence Form for employee. Review Attestations; include applicable notations in the Comments Section on the Request. Be sure to print a copy of Leave of Absence Form before submitting.

* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(213) 401-8827	08/17/2016
* First Name	Middle Name	* Last Name
Darlene		Walls

1. LEAVE INFORMATION

Employee E-mail Address	Alternate Employee Phone Number (###) ###-####	New or Revised Request
		☒ New ☐ Revised

*** Leave Type:**

☒ Medical	☐ Union	☐ Care for Eligible Family Member
☐ Maternity	☐ Personal	☐ Family Military Leave
☐ Workers' Comp/Industrial	☐ Military Service	☐ Bonding

Last Day Worked (mm/dd/yyyy)	* First Day of Leave (mm/dd/yyyy)	Expected Return Date (mm/dd/yyyy)
	08/17/2016	

Is this an intermittent or reduced work schedule Leave? ☒ Intermittent ☐ Reduced Work Schedule ☐ Not Applicable

Is this a Donor Leave? ☐ Yes ☒ No ☐ Unknown

Estimated frequency and duration of absences
as prescribed by physician

If absence is for Care of Eligible Family Member or Bonding:

Name of Eligible Family Member	Relationship to Employee
Is Family Member age 18 or under? If Yes, enter age ☐ Yes ☐ No	Delivery/Adoption/Foster Care Placement Date (mm/dd/yyyy) ☐ Actual Date ☐ Expected Date
Is the child's other parent employed by Kaiser Permanente? ☐ Yes ☐ No	If Yes, full name of other parent

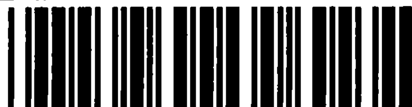
If absence is due to Family Member's Military Service please select the reason(s) that apply:

Name of Eligible Family Member	Relationship to Employee

☐ **Qualifying Exigency**, (matters related to deployment such as Child Care issues, Financial Planning, and Family Support Sessions, Seeing off leaving or returning Service Members.)

☐ **Care for qualified Service Member who incurred injury or illness in the line of duty**

National HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist



Next Page >

* First Name	Middle Name	* Last Name
Dar lene		Wa l l s
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(213) 401-8827	08/17/2016

1. LEAVE INFORMATION - (Continued)

If absence is for Employee's own health condition (Medical, Maternity or Workers' Comp/Industrial)

Date of illness or injury (mm/dd/yyyy)	Was hospitalization required?	Date Hospitalized (mm/dd/yyyy)
07/12/2016	☐ Yes ☒ No ☐ Unknown	

Estimated/Actual hours worked on last day	If Leave is due to maternity	Delivery Date (mm/dd/yyyy)
8	☐ Actual Delivery Date ☐ Expected Delivery Date	

If absence is pregnancy related, does the employee plan to take Bonding time immediately after the pregnancy related absence is complete?

☐ Yes ☐ No

If absence is for Union Leave

Type of Union Leave:

☐ Short Term (30 days or less) ☐ Long Term (greater than 30 days) ☐ Elected Official

Name of Union

If absence is for Military Leave

Is this absence for Military Training or Active Duty?

☐ Military Training ☐ Active Duty

*** If for Personal Leave, indicate reason**

Temporary Agency or Military Service (asked for FMLA eligibility)

Has the Employee worked for Kaiser Permanente less than one year?

☐ Yes ☒ No

Has the Employee been on active Military Duty in the past 12 months?	Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)
☐ Yes ☒ No		

Did the Employee work for Kaiser Permanente with a Temporary Agency in the year before they were hired?

☐ Yes ☐ No

LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

* First Name	Middle Name	* Last Name
Darlene		Walls
*** Employee ID**	*** Contact Phone Number (###) ###-####**	*** Effective Date (mm/dd/yyyy)**
00530105	(213) 401-8827	08/17/2016

1. LEAVE INFORMATION - (Continued)

Name of Agency		
Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)	Agency Phone Number (###) ###-####

2. COMMENTS

3. EMPLOYEE SCHEDULE

This information is essential for the NHRSC to prepare a worksheet to assist with TIME coding. This is required for employees absent for their own disability. Please use a 24 hr clock: 00:00 thru 24:00.

NOTE: This section is not applicable for the KRONOS regions.

Week 1

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start Time: (hh:mm)							
Hours:							

Week 2 (Only needed if schedule changes week to week)

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start Time: (hh:mm)							
Hours:							

4. REQUEST PAID TIME-OFF

Review your Collective Bargaining Agreement and/or Summary Plan Description Booklet before completing this section. Selections made here will not supersede conditions set in Collective Bargaining Agreements, Summary Plan Descriptions, KP and HR Policies, or applicable State and Federal Laws.

Question	Option	Amount
Did employee request EarnedTime Off (ETO)/Paid Time Off (PTO)/Vacation? ☐ Yes ☒ No	☐ Use all available hours ☐ Use selected hours	Number of hours
Did employee request to use Extended Sick Leave (ESL)/Sick Leave? ☒ Yes ☐ No	☒ Use all available hours ☐ Use selected hours	Number of hours
Did employee request to use Float Holidays? ☐ Yes ☒ No	Only available Float Holidays will be applied.	Number of days

National HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist

< Previous Page Next Page >

LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

* First Name	Middle Name	* Last Name
Darlene		Walls
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(213) 401-8827	08/17/2016

4. REQUEST PAID TIME-OFF - (Continued)

Did employee request to use Flexible Personal Days?	Number of days	OR	Number of hours
☐ Yes ☒ No			

Note: Flexible Personal Days can only be used in full day or two hour increments. Only available Flexible Personal Days will be applied.

Did employee request Military Make-up Pay?

☐ Yes ☐ No

5. SUBMITTED BY

* Name (First, MI, Last)	
Su-Xian Hu	
* Employee ID	* Title
00533906	
* E-mail Address	* Work Phone Number (###) ###-####
suxian.x.hu@kp.org	(562) 657-8593

6. MANAGER INFORMATION DETAIL

* Name (First, MI, Last)	
Danny Jimenez	
Supervisor ID	* Title
* E-mail Address	* Work Phone Number (###) ###-####
danny.p.jimenez@kp.org	(562) 657-8527

7. ALTERNATE CONTACT INFORMATION - Someone, in addition to the Manager, who should receive leave communication (i.e. time coding, fmla status, etc)

* Name (First, MI, Last)	
Barbara Lespron	
* E-mail Address	* Work Phone Number (###) ###-####
barbara.x.lespron@kp.org	(562) 657-9624

LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

* First Name	Middle Name	* Last Name
Darlene		Walls
*** Employee ID**	*** Contact Phone Number (###) ###-####**	*** Effective Date (mm/dd/yyyy)**
00530105	(213) 401-8827	08/17/2016

8. MANAGER ATTESTATION

* Checking these items acknowledges that you have read and understand each item.

☒ I agree to direct the employee requesting Leave to submit any and all supporting documentation to me or the National HR Service Center.

☒ I agree to submit form 1500 - Extend Leave and any supporting documentation at the time I learn that the employee intends to extend his or her leave beyond their expected return date or fails to return on their expected date, fails to respond, and is not terminated.

☒ I agree to submit form 1510 - Return from Leave when the employee returns to work.

☒ TIME must be coded for all paid and unpaid leave taken by the employee.

9. MANAGER SIGNATURE - (Required if not submitted online.)

* Manager Signature	* Date (mm/dd/yyyy)

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National HR Service Center

September 16, 2016

Employee ID: 00530105
Case Number: 39708183

Darlene Walls
16323 cortuna ave # 8
Bellflower, CA 90706

Subject: Designation for Family Leave under the Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA)

Dear Darlene,

On 08/17/16 we were informed that you needed leave beginning on 08/17/16 for:

☐ The birth of a child, or placement of a child with you for adoption or foster care.

☒ Your own serious health condition.

☐ Your need to care for your <spouse child parent domestic partner family member> due to his/her serious health condition.

☐ An exigency arising out of the fact that your <spouse son or daughter parent> is on active duty or call to active duty status.

☐ Your need to care for your <spouse son or daughter parent next of kin> due to his/her serious injury or illness incurred in the line of duty as a covered service member.

We reviewed your eligibility for leave under the FMLA/CFRA, and your supporting documentation, and determined that your FMLA/CFRA, leave is approved. All leave taken for the reason checked above will be designated as FMLA/CFRA, leave as long as you are eligible.

Your eligibility was determined based on the information available to us on 09/16/16. To qualify for FMLA/CFRA you must meet the eligibility requirements at the beginning of your leave. Should your employment status change prior to the start of your leave, you may not qualify for FMLA/CFRA, The FMLA/CFRA requires that you notify us as soon as practicable if dates of scheduled leave change or are extended, or were initially unknown.

Provided there is no deviation from your anticipated leave schedule, and based on the information available to date, you are eligible for 480 hours which will be counted against your leave entitlement.

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☒ Our records indicate you have used 40 hours FMLA/CFRA, during the immediately preceding 12 months. As of 08/17/16 your remaining hours are: 392.96

☐ Your continuous Family Leave begins on <Enter Date> and ends on <Enter Date>.

☒ Your intermittent Family Leave begins on 08/17/16 and ends on 02/16/17. You are approved for the following frequency and duration of leave:

Frequency: 2 times per month
Duration: 1 day per episode

Family Leave

- Family Leave entitles you to up to twelve (12) workweeks of leave in a twelve (12) month rolling period. Military Caregiver leave is limited to 26 workweeks in a single 12 month period.
- FMLA/CFRA runs concurrently with Occupational leaves of absence and time off under Kin Care/CESLA when it is for an FMLA/CFRA qualifying reason.
- CFRA leave to care for a domestic partner with a serious health condition does not run concurrently with FMLA leave.
- An employee's pay status during Family Leave is determined in accordance with applicable laws, regional policies, and collective bargaining agreements.
- When taking Family Leave for one's own non work-related and non pregnancy-related illness/injury, an employee is required to use any available Sick/Extended Sick leave benefits.
- An employee may elect, but is not required, to use ETO, vacation or FPD hours while on FMLA/CFRA leave to care for his/her own serious health condition, or to care for a child, spouse, domestic partner, or parent.
- Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations.
- Re-certification may be required every 30 calendar days or if there has been a significant change in circumstances.

If your Family Leave is related to Pregnancy

California Pregnancy Disability Leave (PDL) and FMLA run concurrently. You may be eligible for up to, an additional 12 workweeks of leave under the California Family Rights Act (CFRA) for bonding with your newborn child. Your time off for bonding will count towards your CFRA entitlement. Any remaining FMLA entitlement will run concurrently with your bonding time under CFRA.

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Intermittent Family Leave
As an eligible employee, you are entitled to take Family Leave in separate blocks of time or by a reduced work schedule for your own or a family member's serious health condition which requires continuing treatment by a health care provider and which is best accommodated through intermittent time or a reduced work schedule. Any intermittent leave taken under Family Leave shall reduce the amount of remaining Family Leave.

If you wish to take intermittent leave to care for and bond with a child within one year of the birth or placement of the child must take the leave in increments of two weeks or more at a time, with the exception that leaves of less than two weeks can be taken twice during the year.

Continuation of Benefits Under Family Leave
Kaiser Permanente will continue your health and dental benefits for a total of 12 workweeks while you are under Family Leave, whether your leave is paid or unpaid. If you are on Military Caregiver Leave, Kaiser Permanente will continue your health and dental benefits for a total of 26 workweeks in a single 12 month period. While on a paid Family Leave, your other elected benefits will continue, with the exception of the Dependent Care Spending Account.

For information regarding other Employer paid benefits while on an unpaid leave of absence, refer to your respective bargaining agreement or Summary Plan Description.

Life Insurance continues at the employer's expense for a minimum of 30 calendar days following commencement of **unpaid** Family Leave. Collective bargaining agreement provisions of represented employee groups maybe more generous than the Family Leave policy. **You may choose to continue Life Insurance coverage after this time at your own expense. If you wish to do so, you may contact the National HR Service Center (NHRSC) to make the necessary arrangements.**

Dependent enrollment for a newborn or adopted child
You will need to complete benefit enrollment within 31 days of the birth or adoption to ensure coverage for your new dependent.

Enroll on-line at: http://kp.org/myhr:

DAY 1	*Report your Qualifying Event/Family Status Change:* Go to the appropriate life event in the Home and Family section of the left-hand navigation, (i.e. getting married or having a baby) and enter the information requested.
DAY 2	Make benefit changes on-line: Log on and follow the online process to enroll your dependent.

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National HR Service Center

DAY 3	Confirm Benefit change: To confirm that your enrollment was successfully completed, log on and print a confirmation statement for your records.
DAY 4	Submit supporting documents: Be sure to submit any required supporting documentation to the NHRSC.

A copy of your child's certified birth certificate will be required to complete the enrollment. Verification of your dependent's Social Security Number (SSN) may also be required.

DO NOT DELAY YOUR ENROLLMENT! If you need additional time to submit supporting documentation, contact the NHRSC.

If you do not notify the NHRSC within 31 days of the event, *you may have to wait until the next Open Enrollment period to enroll your child.*

Spending Accounts
If you enrolled in a Spending Account (Health Care, Dependent Care or Commuter) please go to the *Benefits, Pay & Employment* section on My HR at http://insidekp.kp.org/myhr/ for eligibility, contributions and any changes due to your leave of absence or return from leave.

If you need an extension of your leave
If you are unable to return to work on the specified return to work date, you are responsible for initiating a request for extension of leave. A request for extension of leave due to disability must be accompanied by a current physician certification from the health care provider. Any additional time off for this qualifying reason will be counted as FMLA up to the maximum time available, provided that sufficient certification is received. Remind your Manager to complete Form 1500 on My HR.

Returning to Work
You are encouraged to notify your supervisor of the intent to return to work at least 2 weeks prior to the expiration of the leave. In addition, if the family leave is due to your own serious health condition, you must provide a physician or practitioner certification form indicating that you are fit to return to work. Remind your Manager to complete Form 1510 on My HR.

The ***Employee Rights and Responsibilities*** under FMLA are attached for your review. Policies, bargaining agreements and other information regarding leaves of absence can be found on My HR at http://insidekp.kp.org/myhr/ or you may contact NHRSC at 877-4KP-HRSC (877-457-4772) and select Leaves of Absence.

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Please reference the case number located in the upper right corner of this letter.

Sincerely,

Work Absence Management

Enclosures:

☒ LOA Quick Reference Guide
☐ Supplement to Sick Leave Request - Form 2090
☐ Personal Data Change - Form 2520
☐ Other:

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EMPLOYEE RIGHTS AND RESPONSIBILITIES
UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

Basic Leave Entitlement
FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:
- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements
Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is a current membe r o f the Armed forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections
During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements
Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition
A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or 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.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave
An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave
Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities
Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities
Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility. Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA protected, the employer must notify the employee.

Unlawful Acts by Employers
FMLA makes it unlawful for any employer to:
- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement
An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

Instructions: 1. To ensure efficient and effective service please, submit form online.
2. Items marked with an asterisk (*) are required fields.
3. Immediate confirmation will be sent to you upon receipt of your online submittal.
4. **Supervisor/Manager:** Complete Leave of Absence Form for employee. Review Attestations; include applicable notations in the Comments Section on the Request. Be sure to print a copy of Leave of Absence Form before submitting.

* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(562) 657-8527	03/18/2017
* First Name	Middle Name	* Last Name
Darlene		Walls

1. LEAVE INFORMATION

Employee E-mail Address	Alternate Employee Phone Number (###) ###-####	New or Revised Request
		☒ New ☐ Revised

*** Leave Type:**

☒ Medical ☐ Union ☐ Care for Eligible Family Member
☐ Maternity ☐ Personal ☐ Family Military Leave
☐ Workers' Comp/Industrial ☐ Military Service ☐ Bonding

Last Day Worked (mm/dd/yyyy)	* First Day of Leave (mm/dd/yyyy)	Expected Return Date (mm/dd/yyyy)
	03/18/2017	

Is this an intermittent or reduced work schedule Leave? ☒ Intermittent ☐ Reduced Work Schedule ☐ Not Applicable

Is this a Donor Leave? ☐ Yes ☒ No ☐ Unknown

Estimated frequency and duration of absences
to be determined by physician

If absence is for Care of Eligible Family Member or Bonding:

Name of Eligible Family Member	Relationship to Employee
Is Family Member age 18 or under? If Yes, enter age ☐ Yes ☐ No	Delivery/Adoption/Foster Care Placement Date (mm/dd/yyyy) ☐ Actual Date ☐ Expected Date
Is the child's other parent employed by Kaiser Permanente? ☐ Yes ☐ No	If Yes, full name of other parent

If absence is due to Family Member's Military Service please select the reason(s) that apply:

Name of Eligible Family Member	Relationship to Employee

☐ **Qualifying Exigency,** (matters related to deployment such as Child Care issues, Financial Planning, and Family Support Sessions, Seeing off leaving or returning Service Members.)

☐ **Care for qualified Service Member who incurred injury or illness in the line of duty**

National HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist

* First Name	Middle Name	* Last Name
Dar l ene		Wa l l s
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(562) 657-8527	03/18/2017

1. LEAVE INFORMATION - (Continued)

If absence is for Employee's own health condition (Medical, Maternity or Workers' Comp/Industrial)

Date of illness or injury (mm/dd/yyyy)	Was hospitalization required?	Date Hospitalized (mm/dd/yyyy)
03/18/2017	☐ Yes ☒ No ☐ Unknown	

Estimated/Actual hours worked on last day	If Leave is due to maternity	Delivery Date (mm/dd/yyyy)
12	☐ Actual Delivery Date ☐ Expected Delivery Date	

If absence is pregnancy related, does the employee plan to take Bonding time immediately after the pregnancy related absence is complete?

☐ Yes ☐ No

If absence is for Union Leave

Type of Union Leave:

☐ Short Term (30 days or less) ☐ Long Term (greater than 30 days) ☐ Elected Official

Name of Union

If absence is for Military Leave

Is this absence for Military Training or Active Duty?

☐ Military Training ☐ Active Duty

*** If for Personal Leave, indicate reason**

Temporary Agency or Military Service (asked for FMLA eligibility)

Has the Employee worked for Kaiser Permanente less than one year?

☐ Yes ☒ No

Has the Employee been on active Military Duty in the past 12 months?	Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)
☐ Yes ☒ No		

Did the Employee work for Kaiser Permanente with a Temporary Agency in the year before they were hired?

☐ Yes ☐ No

LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

* First Name	Middle Name	* Last Name
Darlene		Walls
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(562) 657-8527	03/18/2017

1. LEAVE INFORMATION - (Continued)

Name of Agency		
Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)	Agency Phone Number (###) ###-####

2. COMMENTS

Attendance Review 06/16/17-1480 submitted on behalf of manager. EH

3. EMPLOYEE SCHEDULE

This information is essential for the NHRSC to prepare a worksheet to assist with TIME coding. This is required for employees absent for their own disability. Please use a 24 hr clock: 00:00 thru 24:00.

NOTE: This section is not applicable for the KRONOS regions.

Week 1

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start Time: (hh:mm)							
Hours:							

Week 2 (Only needed if schedule changes week to week)

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start Time: (hh:mm)							
Hours:							

4. REQUEST PAID TIME-OFF

Review your Collective Bargaining Agreement and/or Summary Plan Description Booklet before completing this section. Selections made here will not supersede conditions set in Collective Bargaining Agreements, Summary Plan Descriptions, KP and HR Policies, or applicable State and Federal Laws.

Did employee request EarnedTime Off (ETO)/Paid Time Off (PTO)/Vacation? ☐ Yes ☐ No	☐ Use all available hours ☐ Use selected hours	Number of hours
Did employee request to use Extended Sick Leave (ESL)/Sick Leave? ☐ Yes ☐ No	☐ Use all available hours ☐ Use selected hours	Number of hours
Did employee request to use Float Holidays? ☐ Yes ☐ No	Only available Float Holidays will be applied.	Number of days

National HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist

LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

* First Name	Middle Name	* Last Name
Darlene		Walls
*** Employee ID**	*** Contact Phone Number (###) ###-####**	*** Effective Date (mm/dd/yyyy)**
00530105	(562) 657-8527	03/18/2017

4. REQUEST PAID TIME-OFF - (Continued)

Did employee request to use Flexible Personal Days? ☐Yes ☐No	Number of days	OR	Number of hours
Note: Flexible Personal Days can only be used in full day or two hour increments. Only available Flexible Personal Days will be applied.			
Did employee request Military Make-up Pay? ☐Yes ☐No			

5. SUBMITTED BY

* Name (First, MI, Last)	
Erik A Humbert	
*** Employee ID**	*** Title**
00677786	
*** E-mail Address**	*** Work Phone Number (###) ###-####**
erik.a.humbert@kp.org	(562) 622-4029

6. MANAGER INFORMATION DETAIL

* Name (First, MI, Last)	
danny jimenez	
Supervisor ID	*** Title**
*** E-mail Address**	*** Work Phone Number (###) ###-####**
danny.p.jimenez@kp.org	(562) 657-8527

7. ALTERNATE CONTACT INFORMATION - Someone, in addition to the Manager, who should receive leave communication (i.e. time coding, fmla status, etc)

* Name (First, MI, Last)	
*** E-mail Address**	*** Work Phone Number (###) ###-####**

National HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist

LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

* First Name	Middle Name	* Last Name
Darlene		Walls
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(562) 657-8527	03/18/2017

8. MANAGER ATTESTATION

* Checking these items acknowledges that you have read and understand each item.

☒ I agree to direct the employee requesting Leave to submit any and all supporting documentation to me or the National HR Service Center.

☒ I agree to submit form 1500 - Extend Leave and any supporting documentation at the time I learn that the employee intends to extend his or her leave beyond their expected return date or fails to return on their expected date, fails to respond, and is not terminated.

☒ I agree to submit form 1510 - Return from Leave when the employee returns to work.

☒ TIME must be coded for all paid and unpaid leave taken by the employee.

9. MANAGER SIGNATURE - (Required if not submitted online.)

* Manager Signature

* Date (mm/dd/yyyy)

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National HR Service Center

June 16, 2017

Employee ID: 00530105
Case Number: 40751154

Darlene Walls
16323 cortuna ave # 8
Bellflower, CA 90706

Subject: Notice of Eligibility - Under the Family and Medical Leave Act/California Family Rights Act (Family Leave)

Dear Darlene Walls,

On 06/16/2017, we were informed that you needed leave beginning on 03/18/2017 for:

☐ The birth of a child, or placement of a child with you for adoption or foster care.

☒ Your own serious health condition.

☐ Your need to care for your <spouse child parent domestic partner family member> due to his/her serious health condition.

☐ An exigency arising out of the fact that your <spouse son or daughter parent> is on active duty or call to active duty status.

☐ Your need to care for your <spouse son or daughter parent next of kin> due to his/her serious injury or illness incurred in the line of duty as a covered servicemember.

This notice is to inform you that you have met the eligibility requirements for FMLA/ CFRA

Your eligibility was determined based on the information available to us on 6/16/2017. To qualify for FMLA/ CFRA you must meet the eligibility requirements at the beginning of your leave. Please refer to the attached *Employee Rights and Responsibilities* regarding eligibility criteria or requirements. Should your employment status change prior to the start of your leave, you may not qualify for FMLA/CFRA.

Approval of your request for leave under the FMLA/CFRA is pending receipt of the documentation indicated below. The documentation must be provided to the NHRSC by 7/4/2017 or your leave may be denied.

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☒ Sufficient certification to support your request for FMLA/CFRA leave.

- ☒ 1451 Employee - Certification of Physician
- ☐ 1452 Family Member - Certification of Physician
- ☐ 1453 Service Member - Certification of Physician

☐ Sufficient certification to indicate your adult child is incapable of self-care because of a physical or mental disability. Certification may be provided on the enclosed 1452 Family Member - Certification of Physician.

☐ Sufficient documentation to establish the required relationship between you and your family member; proof of <birth marriage adoption/foster care domestic partner relationship next of kin>.

☐ Military Orders

☐ 1454 - Military Exigency - Certification

☐ Other:

☐ The certification you provided is not complete and sufficient to determine whether the FMLA/CFRA applies to your leave request. You must provide the following information no later than <mm/dd/yyyy>, or your leave may be denied, unless it is not practicable under the particular circumstances despite your diligent good faith efforts.

- ☐ The information provided on the Certification of Physician/Provider does not meet the definition of a serious health condition. A list of the definitions is attached for your reference.
- ☐ The Certification of Physician/Provider does not include the Frequency and Duration for intermittent leave.
- ☐ The Certification of Physician/Provider does not indicate your adult child is incapable of self-care because of a physical or mental disability.
- ☐ The information provided failed to establish the required relationship between you and your family member; proof of <birth marriage adoption/foster care domestic partner relationship next of kin>.
- ☐ Military Orders

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- ☐ 1453 - Service Member - Certification of Physician
- ☐ 1454 - Military Exigency - Certification
- ☐ Other:

Please fax the required document(s) to the National HR Service Center at **1-877-HRSC-FAX (1-877-477-2329).** Or mail the forms to:

Kaiser Permanente National HR Service Center
PO Box 2074
Oakland, CA 94604-2074

Once we obtain the information from you as specified above, we will inform you whether your leave will be designated as FMLA/CFRA leave and count towards your FMLA/CFRA leave entitlement.

Please note: Failure to provide the sufficient certification may result in delay or denial of your Family Leave.

The *Employee Rights and Responsibilities* and the definitions of a *Serious Health Condition* under the FMLA are attached for your review. Policies, bargaining agreements and other information regarding leaves of absence can be found on My HR.

If you have any questions or concerns regarding your request for family leave, please contact Work Absence Management (WAM) at the National HR Service Center at **877-4KP-HRSC (877-457-4772).** Please reference the case number located in the upper right-hand corner of this letter.

Sincerely,

Work Absence Management (WAM)
National HR Service Center

Enclosures:

- ☒ 1451 Employee - Certification of Physician
- ☐ 1452 Family Member - Certification of Physician
- ☐ 1453 Service Member - Certification of Physician
- ☐ 1454 - Military Exigency - Certification
- ☐ 2090 - Supplement to Sick Leave Request
- ☐ 2520 - Personal Data Change

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EMPLOYEE RIGHTS AND RESPONSIBILITIES
UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

Basic Leave Entitlement
FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:
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- To care for the employee's spouse, son or daughter or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

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FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is a current member of the Armed forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the service member medically unfit to perform his or her duties for which the service member is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections
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Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

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Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

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An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

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Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities
Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities
Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility. Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA protected, the employer must notify the employee.

Unlawful Acts by Employers
FMLA makes it unlawful for any employer to:
- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement
An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

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National HR Service Center

Family and Medical Leave Act (FMLA)

"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.

Condition	Details
Inpatient Care	An overnight stay in a hospital, hospice, or residential medical-care facility, including any period of incapacity (i.e. inability to work, attend school, or perform other regular daily activities) or subsequent treatment in connection with such inpatient care.

Continuing treatment by a health care provider including one or more of the following:

a) Incapacity and Treatment	A period of incapacity lasting more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that **also** includes: • Treatment two or more times by or under the supervision of a health care provider (i.e. in-person visits, the first within 7 days and both within 30 days of the first day of incapacity); **or** One treatment by a health care provider (i.e., an in-person visit within 7 days of the first day of incapacity) with a continuing regimen of treatment (e.g., prescription medication, physical therapy).
b) Pregnancy	Any period of incapacity related to pregnancy or for prenatal care.
c) Chronic Conditions	Any period of incapacity or treatment for a chronic serious health condition. Requires periodic visits (at least twice a year) for treatment by, or under direct supervision of a health care provider. Continues over an extended period of time and may cause episodic rather than a continuing period of incapacity.
d) Permanent/Long-Term Conditions	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.
e) Conditions requiring multiple treatments	Any absences of incapacity to receive multiple treatments (including any period of recovery) 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 days if not treated.

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July 5, 2017

Employee ID: 00530105
Case Number: 40751154

Darlene Walls
16323 cortuna ave # 8
Bellflower, CA 90706

Subject: Denial Notice - Under the Family and Medical Leave Act/California Family Rights Act (Family Leave)

Dear Darlene Walls,

On 06/16/17, we were informed that you needed leave beginning on 03/18/17 for:

☐ The birth of a child, or placement of a child with you for adoption or foster care.

☒ Your own serious health condition.

☐ Your need to care for your <spouse child parent domestic partner family member> due to his/her serious health condition.

☐ An exigency arising out of the fact that your <spouse son or daughter parent> is on active duty or call to active duty status.

☐ Your need to care for your <spouse son or daughter parent next of kin> due to his/her serious injury or illness incurred in the line of duty as a covered servicemember.

This Notice is to inform you that you are <u>not eligible</u> for FMLA/CFRA leave, because:

☐ You have not met the 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately <Enter Num Mos> months towards this requirement. If you are still on leave at the completion of 12 months of service please contact the NHRSC to request your eligibility for FMLA/CFRA. For more information please see the attached notice of Employee Rights and Responsibilities.

☐ You have not met the 1,250 hours worked requirement within the 12 months preceding the start of your leave. As of <mm/dd/yyyy> you have worked <Enter Hours> hours towards the eligibility requirement. You can check the number of hours worked by contacting the NHRSC.

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☐ You exhausted your <12 26>-week entitlement to leave under the <FMLA/CFRA>

☐ Your request is for a non-qualified family member.

☒ You failed to provide sufficient certification to support your request.

- ☒ A Health Care Provider Certification form was not received.
- ☐ The information provided on the Health Care Provider Certification did not meet the definition of a serious health condition.
- ☐ The Health Care Provider Certification did not include the Frequency and Duration for an intermittent leave.
- ☐ The Health Care Provider Certification did not indicate your adult child is incapable of self-care because of a physical or mental disability.
- ☐ You failed to provide sufficient documentation to establish the required relationship between you and your family member; proof of <birth adoption/foster care domestic partner relationship marriage>.
- ☐ Military Orders
- ☐ <Certification of Exigency Certification of an injured/ill servicemember>

☐ Other:

The *Employee Rights and Responsibilities* under the FMLA are attached for your review.

While your time off is not currently protected under the FMLA and CFRA; you may become eligible for FMLA/CFRA during your leave. Please refer to the *Employee Rights and Responsibilities* for eligibility criteria or requirements. You may also be eligible for other forms of leave under Kaiser's leave policies or under an applicable collective bargaining agreement. If your leave is the result of a work-related injury, it may be subject to Workers' Compensation leave protection.

Policies, bargaining agreements and other information regarding leaves of absence can be found on My HR.

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National HR Service Center

If you have any questions or concerns regarding the denial of your request for family leave, please contact Work Absence Management (WAM) at the National HR Service Center at **877-4KP-HRSC (877-457-4772).** Please reference the case number located in the upper right-hand corner of this letter.

Sincerely,

Work Absence Management

Kaiser Permanente National HR Service Center

KAISER PERMANENTE®
National HR Service Center

EMPLOYEE RIGHTS AND RESPONSIBILITIES
UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

Basic Leave Entitlement
FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:
- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements
Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is a current member of the Armed forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the service member medically unfit to perform his or her duties for which the service member is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections
During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements
Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition
A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or 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.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave
An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave
Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities
Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities
Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility. Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA protected, the employer must notify the employee.

Unlawful Acts by Employers
FMLA makes it unlawful for any employer to:
- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement
An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

LEAVE OF ABSENCE - CARE FOR FAMILY MEMBER

Instructions: 1. To ensure efficient and effective service please, submit form online.
2. Items marked with an asterisk (*) are required fields.
3. Immediate confirmation will be sent to you upon receipt of your online submittal.
4. **Supervisor/Manager:** Complete Leave of Absence Form for employee. Review Attestations; include applicable notations in the Comments Section on the Request. Be sure to print a copy of Leave of Absence Form before submitting.

* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(213) 401-8827	09/16/2017
* First Name	Middle Name	* Last Name
Darlene		Walls

1. LEAVE INFORMATION

Employee E-mail Address	Alternate Employee Phone Number (###) ###-####	New or Revised Request
		☐ New ☐ Revised

*** Leave Type:**

☐ Medical	☐ Union	☒ Care for Eligible Family Member
☐ Maternity	☐ Personal	☐ Family Military Leave
☐ Workers' Comp/Industrial	☐ Military Service	☐ Bonding

Last Day Worked (mm/dd/yyyy)	* First Day of Leave (mm/dd/yyyy)	Expected Return Date (mm/dd/yyyy)
09/14/2017	09/16/2017	09/21/2017

Is this an intermittent or reduced work schedule Leave? ☐ Intermittent ☐ Reduced Work Schedule ☒ Not Applicable

Is this a Donor Leave? ☐ Yes ☐ No ☐ Unknown

Estimated frequency and duration of absences

If absence is for Care of Eligible Family Member or Bonding:

Name of Eligible Family Member	Relationship to Employee
Delores Williams	Mother
Is Family Member age 18 or under? If Yes, enter age ☐ Yes ☒ No	Delivery/Adoption/Foster Care Placement Date (mm/dd/yyyy) ☐ Actual Date ☐ Expected Date
Is the child's other parent employed by Kaiser Permanente? ☐ Yes ☐ No	If Yes, full name of other parent

If absence is due to Family Member's Military Service please select the reason(s) that apply:

Name of Eligible Family Member	Relationship to Employee

☐ **Qualifying Exigency,** (matters related to deployment such as Child Care issues, Financial Planning, and Family Support Sessions, Seeing off leaving or returning Service Members.)

☐ **Care for qualified Service Member who incurred injury or illness in the line of duty**

National HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist

Next Page >

LEAVE OF ABSENCE - CARE FOR FAMILY MEMBER

* First Name	Middle Name	* Last Name
Darlene		Walls
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(213) 401-8827	09/16/2017

1. LEAVE INFORMATION - (Continued)

If absence is for Employee's own health condition (Medical, Maternity or Workers' Comp/Industrial)

Date of illness or injury (mm/dd/yyyy)	Was hospitalization required? ☐ Yes ☐ No ☐ Unknown	Date Hospitalized (mm/dd/yyyy)

Estimated/Actual hours worked on last day	If Leave is due to maternity ☐ Actual Delivery Date ☐ Expected Delivery Date	Delivery Date (mm/dd/yyyy)

If absence is pregnancy related, does the employee plan to take Bonding time immediately after the pregnancy related absence is complete?

☐ Yes ☐ No

If absence is for Union Leave

Type of Union Leave:

☐ Short Term (30 days or less) ☐ Long Term (greater than 30 days) ☐ Elected Official

Name of Union

If absence is for Military Leave

Is this absence for Military Training or Active Duty?

☐ Military Training ☐ Active Duty

*** If for Personal Leave, indicate reason**

Temporary Agency or Military Service (asked for FMLA eligibility)

Has the Employee worked for Kaiser Permanente less than one year?

☐ Yes ☒ No

Has the Employee been on active Military Duty in the past 12 months? ☐ Yes ☒ No	Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)

Did the Employee work for Kaiser Permanente with a Temporary Agency in the year before they were hired?

☐ Yes ☐ No

LEAVE OF ABSENCE - CARE FOR FAMILY MEMBER

* First Name	Middle Name	* Last Name
Darlene		Walls
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(213) 401-8827	09/16/2017

1. LEAVE INFORMATION - (Continued)

Name of Agency		
Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)	Agency Phone Number (###) ###-####

2. COMMENTS

3. EMPLOYEE SCHEDULE

This information is essential for the NHRSC to prepare a worksheet to assist with TIME coding. This is required for employees absent for their own disability. Please use a 24 hr clock: 00:00 thru 24:00.

NOTE: This section is not applicable for the KRONOS regions.

Week 1

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start Time: (hh:mm)							
Hours:							

Week 2 (Only needed if schedule changes week to week)

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start Time: (hh:mm)							
Hours:							

4. REQUEST PAID TIME-OFF

Review your Collective Bargaining Agreement and/or Summary Plan Description Booklet before completing this section. Selections made here will not supersede conditions set in Collective Bargaining Agreements, Summary Plan Descriptions, KP and HR Policies, or applicable State and Federal Laws.

Question	Options	Number
Did employee request EarnedTime Off (ETO)/Paid Time Off (PTO)/Vacation? ☒ Yes ☐ No	☒ Use all available hours ☐ Use selected hours	Number of hours
Did employee request to use Extended Sick Leave (ESL)/Sick Leave? ☒ Yes ☐ No	☒ Use all available hours ☐ Use selected hours	Number of hours
Did employee request to use Float Holidays? ☐ Yes ☐ No	Only available Float Holidays will be applied.	Number of days

National HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist

LEAVE OF ABSENCE - CARE FOR FAMILY MEMBER

* First Name	Middle Name	* Last Name
Darlene		Walls
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(213) 401-8827	09/16/2017

4. REQUEST PAID TIME-OFF - (Continued)

Did employee request to use Flexible Personal Days? ☐ Yes ☐ No	Number of days	OR	Number of hours
Note: Flexible Personal Days can only be used in full day or two hour increments. Only available Flexible Personal Days will be applied.			
Did employee request Military Make-up Pay? ☐ Yes ☐ No			

5. SUBMITTED BY

* Name (First, MI, Last)	
Danny P Jimenez	
* Employee ID	* Title
00685629	
* E-mail Address	* Work Phone Number (###) ###-####
danny.p.jimenez@kp.org	(562) 657-8527

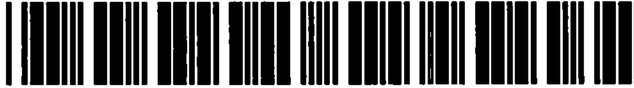
6. MANAGER INFORMATION DETAIL

* Name (First, MI, Last)	
Danny Jimenez	
Supervisor ID	* Title
* E-mail Address	* Work Phone Number (###) ###-####
danny.p.jimenez@kp.org	(562) 657-8527

7. ALTERNATE CONTACT INFORMATION - Someone, in addition to the Manager, who should receive leave communication (i.e. time coding, fmla status, etc)

* Name (First, MI, Last)	
* E-mail Address	* Work Phone Number (###) ###-####

National HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist



LEAVE OF ABSENCE - CARE FOR FAMILY MEMBER

* First Name	Middle Name	* Last Name
Darlene		Walls
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(213) 401-8827	09/16/2017

8. MANAGER ATTESTATION

* Checking these items acknowledges that you have read and understand each item.

☒ I agree to direct the employee requesting Leave to submit any and all supporting documentation to me or the National HR Service Center.

☒ I agree to submit form 1500 - Extend Leave and any supporting documentation at the time I learn that the employee intends to extend his or her leave beyond their expected return date or fails to return on their expected date, fails to respond, and is not terminated.

☒ I agree to submit form 1510 - Return from Leave when the employee returns to work.

☒ TIME must be coded for all paid and unpaid leave taken by the employee.

9. MANAGER SIGNATURE - (Required if not submitted online.)

* Manager Signature	* Date (mm/dd/yyyy)

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National HR Service Center

September 11, 2017

Employee ID: 00530105
Case Number: 41038744

Darlene Walls
16323 cortuna ave # 8
Bellflower, CA 90706

Subject: Notice of Eligibility - Under the Family and Medical Leave Act/California Family Rights Act (Family Leave)

Dear Darlene Walls,

On 09/11/2017, we were informed that you needed leave beginning on 09/16/2017 for:

☐ The birth of a child, or placement of a child with you for adoption or foster care.

☐ Your own serious health condition.

☒ Your need to care for your mother due to his/her serious health condition.

☐ An exigency arising out of the fact that your <spouse son or daughter parent> is on active duty or call to active duty status.

☐ Your need to care for your <spouse son or daughter parent next of kin> due to his/her serious injury or illness incurred in the line of duty as a covered servicemember.

This notice is to inform you that you have met the eligibility requirements for FMLA/ CFRA

Your eligibility was determined based on the information available to us on 9/11/2017. To qualify for FMLA/ CFRA you must meet the eligibility requirements at the beginning of your leave. Please refer to the attached *Employee Rights and Responsibilities* regarding eligibility criteria or requirements. Should your employment status change prior to the start of your leave, you may not qualify for FMLA/CFRA.

Approval of your request for leave under the FMLA/CFRA is pending receipt of the documentation indicated below. The documentation must be provided to the NHRSC by 10/4/2017 or your leave may be denied.

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National HR Service Center

- [x] Sufficient certification to support your request for FMLA/CFRA leave.
  - [ ] 1451 Employee - Certification of Physician
  - [x] 1452 Family Member - Certification of Physician
  - [ ] 1453 Service Member - Certification of Physician
- [ ] Sufficient certification to indicate your adult child is incapable of self-care because of a physical or mental disability. Certification may be provided on the enclosed 1452 Family Member - Certification of Physician.
- [ ] Sufficient documentation to establish the required relationship between you and your family member; proof of <birth marriage adoption/foster care domestic partner relationship next of kin>.
- [ ] Military Orders
- [ ] 1454 - Military Exigency - Certification
- [ ] Other:

- [ ] The certification you provided is not complete and sufficient to determine whether the FMLA/CFRA applies to your leave request. You must provide the following information no later than <mm/dd/yyyy>, or your leave may be denied, unless it is not practicable under the particular circumstances despite your diligent good faith efforts.
  - [ ] The information provided on the Certification of Physician/Provider does not meet the definition of a serious health condition. A list of the definitions is attached for your reference.
  - [ ] The Certification of Physician/Provider does not include the Frequency and Duration for intermittent leave.
  - [ ] The Certification of Physician/Provider does not indicate your adult child is incapable of self-care because of a physical or mental disability.
  - [ ] The information provided failed to establish the required relationship between you and your family member; proof of <birth marriage adoption/foster care domestic partner relationship next of kin>.
  - [ ] Military Orders

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☐ 1453 - Service Member - Certification of Physician

☐ 1454 - Military Exigency - Certification

☐ Other:

Please fax the required document(s) to the National HR Service Center at **1-877-HRSC-FAX (1-877-477-2329).** Or mail the forms to:

Kaiser Permanente National HR Service Center
PO Box 2074
Oakland, CA 94604-2074

Once we obtain the information from you as specified above, we will inform you whether your leave will be designated as FMLA/CFRA leave and count towards your FMLA/CFRA leave entitlement.

Please note: Failure to provide the sufficient certification may result in delay or denial of your Family Leave.

The *Employee Rights and Responsibilities* and the definitions of a *Serious Health Condition* under the FMLA are attached for your review. Policies, bargaining agreements and other information regarding leaves of absence can be found on My HR.

If you have any questions or concerns regarding your request for family leave, please contact Work Absence Management (WAM) at the National HR Service Center at **877-4KP-HRSC (877-457-4772).** Please reference the case number located in the upper right-hand corner of this letter.

Sincerely,

Work Absence Management (WAM)
National HR Service Center

Enclosures:

☐ 1451 Employee - Certification of Physician
☒ 1452 Family Member - Certification of Physician
☐ 1453 Service Member - Certification of Physician
☐ 1454 - Military Exigency - Certification
☐ 2090 - Supplement to Sick Leave Request
☐ 2520 - Personal Data Change

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National HR Service Center

EMPLOYEE RIGHTS AND RESPONSIBILITIES
UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is a current member of the Armed forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the service member medically unfit to perform his or her duties for which the service member is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or 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 t he qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility. Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

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National HR Service Center

Family and Medical Leave Act (FMLA)

"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.

Condition	Details
Inpatient Care	An overnight stay in a hospital, hospice, or residential medical-care facility, including any period of incapacity (i.e. inability to work, attend school, or perform other regular daily activities) or subsequent treatment in connection with such inpatient care.

Continuing treatment by a health care provider including one or more of the following:

a) Incapacity and Treatment	A period of incapacity lasting more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that **also** includes: · Treatment two or more times by or under the supervision of a health care provider (i.e. in-person visits, the first within 7 days and both within 30 days of the first day of incapacity); **or** One treatment by a health care provider (i.e., an in-person visit within 7 days of the first day of incapacity) with a continuing regimen of treatment (e.g., prescription medication, physical therapy).
b) Pregnancy	Any period of incapacity related to pregnancy or for prenatal care.
c) Chronic Conditions	Any period of incapacity or treatment for a chronic serious health condition. Requires periodic visits (at least twice a year) for treatment by, or under direct supervision of a health care provider. Continues over an extended period of time and may cause episodic rather than a continuing period of incapacity.
d) Permanent/Long-Term Conditions	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.
e) Conditions requiring multiple treatments	Any absences of incapacity to receive multiple treatments (including any period of recovery) 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 days if not treated.

LEAVE OF ABSENCE - CARE FOR FAMILY MEMBER

Instructions: 1. To ensure efficient and effective service please, submit form online.
2. Items marked with an asterisk (*) are required fields.
3. Immediate confirmation will be sent to you upon receipt of your online submittal.
4. **Supervisor/Manager:** Complete Leave of Absence Form for employee. Review Attestations; include applicable notations in the Comments Section on the Request. Be sure to print a copy of Leave of Absence Form before submitting.

* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(213) 401-8827	09/13/2017
*** First Name**	**Middle Name**	*** Last Name**
Darlene		Walls

1. LEAVE INFORMATION

Employee E-mail Address	Alternate Employee Phone Number (###) ###-####	New or Revised Request
		☐ New ☒ Revised

*** Leave Type:**

☐ Medical ☐ Union ☒ Care for Eligible Family Member
☐ Maternity ☐ Personal ☐ Family Military Leave
☐ Workers' Comp/Industrial ☐ Military Service ☐ Bonding

Last Day Worked (mm/dd/yyyy)	* First Day of Leave (mm/dd/yyyy)	Expected Return Date (mm/dd/yyyy)
09/12/2017	09/13/2017	09/25/2017

Is this an intermittent or reduced work schedule Leave? ☐ Intermittent ☐ Reduced Work Schedule ☒ Not Applicable

Is this a Donor Leave? ☐ Yes ☐ No ☐ Unknown

Estimated frequency and duration of absences

If absence is for Care of Eligible Family Member or Bonding:

Name of Eligible Family Member	Relationship to Employee
Delores Williams	Mother
Is Family Member age 18 or under? If Yes, enter age ☐ Yes ☒ No	Delivery/Adoption/Foster Care Placement Date (mm/dd/yyyy) ☐ Actual Date ☐ Expected Date
Is the child's other parent employed by Kaiser Permanente? ☐ Yes ☐ No	If Yes, full name of other parent

If absence is due to Family Member's Military Service please select the reason(s) that apply:

Name of Eligible Family Member	Relationship to Employee

☐ **Qualifying Exigency,** (matters related to deployment such as Child Care issues, Financial Planning, and Family Support Sessions, Seeing off leaving or returning Service Members.)

☐ **Care for qualified Service Member who incurred injury or illness in the line of duty**

National HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist

Next Page >

* First Name	Middle Name	* Last Name
Darlene		Walls
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(213) 401-8827	09/13/2017

1. LEAVE INFORMATION - (Continued)

If absence is for Employee's own health condition (Medical, Maternity or Workers' Comp/Industrial)

Date of illness or injury (mm/dd/yyyy)

Was hospitalization required? ☐ Yes ☐ No ☐ Unknown

Date Hospitalized (mm/dd/yyyy)

Estimated/Actual hours worked on last day

If Leave is due to maternity ☐ Actual Delivery Date ☐ Expected Delivery Date

Delivery Date (mm/dd/yyyy)

If absence is pregnancy related, does the employee plan to take Bonding time immediately after the pregnancy related absence is complete?

☐ Yes ☐ No

If absence is for Union Leave

Type of Union Leave:

☐ Short Term (30 days or less) ☐ Long Term (greater than 30 days) ☐ Elected Official

Name of Union

If absence is for Military Leave

Is this absence for Military Training or Active Duty?

☐ Military Training ☐ Active Duty

*** If for Personal Leave, indicate reason**

Temporary Agency or Military Service (asked for FMLA eligibility)

Has the Employee worked for Kaiser Permanente less than one year?

☐ Yes ☒ No

Has the Employee been on active Military Duty in the past 12 months? ☐ Yes ☒ No

Start Date (mm/dd/yyyy)

End Date (mm/dd/yyyy)

Did the Employee work for Kaiser Permanente with a Temporary Agency in the year before they were hired?

☐ Yes ☐ No

LEAVE OF ABSENCE - CARE FOR FAMILY MEMBER

* First Name	Middle Name	* Last Name
Darlene		Walls
*** Employee ID**	*** Contact Phone Number (###) ###-####**	*** Effective Date (mm/dd/yyyy)**
00530105	(213) 401-8827	09/13/2017

1. LEAVE INFORMATION - (Continued)

Name of Agency		
Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)	Agency Phone Number (###) ###-####

2. COMMENTS

Revision of previously launched 1480 on 9/11/2017

3. EMPLOYEE SCHEDULE

This information is essential for the NHRSC to prepare a worksheet to assist with TIME coding. This is required for employees absent for their own disability. Please use a 24 hr clock: 00:00 thru 24:00.

NOTE: This section is not applicable for the KRONOS regions.

Week 1

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start Time: (hh:mm)							
Hours:							

Week 2 (Only needed if schedule changes week to week)

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start Time: (hh:mm)							
Hours:							

4. REQUEST PAID TIME-OFF

Review your Collective Bargaining Agreement and/or Summary Plan Description Booklet before completing this section. Selections made here will not supersede conditions set in Collective Bargaining Agreements, Summary Plan Descriptions, KP and HR Policies, or applicable State and Federal Laws.

Question	Option	Amount
Did employee request EarnedTime Off (ETO)/Paid Time Off (PTO)/Vacation? ☒ Yes ☐ No	☒ Use all available hours ☐ Use selected hours	Number of hours
Did employee request to use Extended Sick Leave (ESL)/Sick Leave? ☒ Yes ☐ No	☒ Use all available hours ☐ Use selected hours	Number of hours
Did employee request to use Float Holidays? ☐ Yes ☐ No	Only available Float Holidays will be applied.	Number of days

National HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist

LEAVE OF ABSENCE - CARE FOR FAMILY MEMBER

* First Name	Middle Name	* Last Name
Dar lene		Wa l l s
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(213) 401-8827	09/13/2017

4. REQUEST PAID TIME-OFF - (Continued)

Did employee request to use Flexible Personal Days? ☐ Yes ☐ No	Number of days	OR	Number of hours
Note: Flexible Personal Days can only be used in full day or two hour increments. Only available Flexible Personal Days will be applied.			
Did employee request Military Make-up Pay? ☐ Yes ☐ No			

5. SUBMITTED BY

* Name (First, MI, Last)	
Danny P Jimenez	
* Employee ID	* Title
00685629	
* E-mail Address	* Work Phone Number (###) ###-####
danny.p.jimenez@kp.org	(562) 657-8527

6. MANAGER INFORMATION DETAIL

* Name (First, MI, Last)	
Danny Jimenez	
Supervisor ID	* Title
* E-mail Address	* Work Phone Number (###) ###-####
danny.p.jimenez@kp.org	(562) 657-8527

7. ALTERNATE CONTACT INFORMATION - Someone, in addition to the Manager, who should receive leave communication (i.e. time coding, fmla status, etc)

* Name (First, MI, Last)	
* E-mail Address	* Work Phone Number (###) ###-####

* First Name	Middle Name	* Last Name
Dar lene		Wal ls
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(213) 401-8827	09/13/2017

8. MANAGER ATTESTATION

* Checking these items acknowledges that you have read and understand each item.

☒ I agree to direct the employee requesting Leave to submit any and all supporting documentation to me or the National HR Service Center.

☒ I agree to submit form 1500 - Extend Leave and any supporting documentation at the time I learn that the employee intends to extend his or her leave beyond their expected return date or fails to return on their expected date, fails to respond, and is not terminated.

☒ I agree to submit form 1510 - Return from Leave when the employee returns to work.

☒ TIME must be coded for all paid and unpaid leave taken by the employee.

9. MANAGER SIGNATURE - (Required if not submitted online.)

* Manager Signature	* Date (mm/dd/yyyy)

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National HR Service Center

October 9, 2017

Employee ID: 00530105
Case Number: 41038744

Darlene Walls
16323 cortuna ave # 8
Bellflower, CA 90706

Subject: Designation for Family Leave under the Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA)

Dear Darlene,

On 09/11/2017, we were informed that you needed leave beginning on 09/13/2017 for:

☐ The birth of a child, or placement of a child with you for adoption or foster care.

☐ Your own serious health condition.

☒ Your need to care for your parent due to her serious health condition.

☐ An exigency arising out of the fact that your <spouse son or daughter parent> is on active duty or call to active duty status.

☐ Your need to care for your <spouse son or daughter parent next of kin> due to his/her serious injury or illness incurred in the line of duty as a covered service member.

We reviewed your eligibility for leave under the FMLA/CFRA, and your supporting documentation, and determined that your FMLA/CFRA leave is approved. All leave taken for the reason checked above will be designated as FMLA/CFRA leave as long as you are eligible.

Your eligibility was determined based on the information available to us on 10/09/2017. To qualify for FMLA/CFRA you must meet the eligibility requirements at the beginning of your leave. Should your employment status change prior to the start of your leave, you may not qualify for FMLA/CFRA. The FMLA/CFRA requires that you notify us as soon as practicable if dates of scheduled leave change or are extended, or were initially unknown.

Provided there is no deviation from your anticipated leave schedule, and based on the information available to date, you are eligible for 12 workweeks which will be counted against your leave entitlement.

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☒ Our records indicate you have used 1 workweeks, 2 days during the immediately preceding 12 months. As of 09/13/2017 your remaining workweeks are: 10 and 5 days

☒ Your continuous Family Leave begins on 09/13/2017 and ends on 09/20/2017.

☐ Your intermittent Family Leave begins on <Enter Date> and ends on <Enter Date>. You are approved for the following frequency and duration of leave:
Frequency: <Enter Frequency>
Duration:

Family Leave
- Family Leave entitles you to up to twelve (12) workweeks of leave in a twelve (12) month rolling period. Military Caregiver leave is limited to 26 workweeks in a single 12 month period.
- FMLA/CFRA runs concurrently with Occupational leaves of absence and time off under Kin Care/CESLA when it is for an FMLA/CFRA qualifying reason.
- CFRA leave to care for a domestic partner with a serious health condition does not run concurrently with FMLA leave.
- An employee's pay status during Family Leave is determined in accordance with applicable laws, regional policies, and collective bargaining agreements.
- When taking Family Leave for one's own non work-related and non pregnancy-related illness/injury, an employee is required to use any available Sick/Extended Sick leave benefits.
- An employee may elect, but is not required, to use ETO, vacation or FPD hours while on FMLA/CFRA leave to care for his/her own serious health condition, or to care for a child, spouse, domestic partner, or parent.
- Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations.
- Re-certification may be required every 30 calendar days or if there has been a significant change in circumstances.

If your Family Leave is related to Pregnancy
California Pregnancy Disability Leave (PDL) and FMLA run concurrently. You may be eligible for up to, an additional 12 workweeks of leave under the California Family Rights Act (CFRA) for bonding with your newborn child. Your time off for bonding will count towards your CFRA entitlement. Any remaining FMLA entitlement will run concurrently with your bonding time under CFRA.

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Intermittent Family Leave
As an eligible employee, you are entitled to take Family Leave in separate blocks of time or by a reduced work schedule for your own or a family member's serious health condition which requires continuing treatment by a health care provider and which is best accommodated through intermittent time or a reduced work schedule. Any intermittent leave taken under Family Leave shall reduce the amount of remaining Family Leave.

If you wish to take intermittent leave to care for and bond with a child within one year of the birth or placement of the child must take the leave in increments of two weeks or more at a time, with the exception that leaves of less than two weeks can be taken twice during the year.

Continuation of Benefits Under Family Leave
Kaiser Permanente will continue your health and dental benefits for a total of 12 workweeks while you are under Family Leave, whether your leave is paid or unpaid. If you are on Military Caregiver Leave, Kaiser Permanente will continue your health and dental benefits for a total of 26 workweeks in a single 12 month period. While on a paid Family Leave, your other elected benefits will continue, with the exception of the Dependent Care Spending Account.

For information regarding other Employer paid benefits while on an unpaid leave of absence, refer to your respective bargaining agreement or Summary Plan Description.

Life Insurance continues at the employer's expense for a minimum of 30 calendar days following commencement of **unpaid** Family Leave. Collective bargaining agreement provisions of represented employee groups maybe more generous than the Family Leave policy. **You may choose to continue Life Insurance coverage after this time at your own expense. If you wish to do so, you may contact the National HR Service Center (NHRSC) to make the necessary arrangements.**

Dependent enrollment for a newborn or adopted child
You will need to complete benefit enrollment within 31 days of the birth or adoption to ensure coverage for your new dependent.

Enroll on-line at: http://kp.org/myhr:

DAY 1	*Report your Qualifying Event/Family Status Change:* Go to the appropriate life event in the Home and Family section of the left-hand navigation, (i.e. getting married or having a baby) and enter the information requested.
DAY 2	Make benefit changes on-line: Log on and follow the online process to enroll your dependent.

DAY 3	Confirm Benefit change: To confirm that your enrollment was successfully completed, log on and print a confirmation statement for your records.
DAY 4	Submit supporting documents: Be sure to submit any required supporting documentation to the NHRSC.

A copy of your child's certified birth certificate will be required to complete the enrollment. Verification of your dependent's Social Security Number (SSN) may also be required.

DO NOT DELAY YOUR ENROLLMENT! If you need additional time to submit supporting documentation, contact the NHRSC.

If you do not notify the NHRSC within 31 days of the event, *you may have to wait until the next Open Enrollment period to enroll your child.*

Spending Accounts
If you enrolled in a Spending Account (Health Care, Dependent Care or Commuter) please go to the *Benefits, Pay & Employment* section on My HR at http://insidekp.kp.org/myhr/ for eligibility, contributions and any changes due to your leave of absence or return from leave.

If you need an extension of your leave
If you are unable to return to work on the specified return to work date, you are responsible for initiating a request for extension of leave. A request for extension of leave due to disability must be accompanied by a current physician certification from the health care provider. Any additional time off for this qualifying reason will be counted as FMLA up to the maximum time available, provided that sufficient certification is received. Remind your Manager to complete Form 1500 on My HR.

Returning to Work
You are encouraged to notify your supervisor of the intent to return to work at least 2 weeks prior to the expiration of the leave. In addition, if the family leave is due to your own serious health condition, you must provide a physician or practitioner certification form indicating that you are fit to return to work. Remind your Manager to complete Form 1510 on My HR.

The ***Employee Rights and Responsibilities*** under FMLA are attached for your review. Policies, bargaining agreements and other information regarding leaves of absence can be found on My HR at http://insidekp.kp.org/myhr/ or you may contact NHRSC at 877-4KP-HRSC (877-457-4772) and select Leaves of Absence.

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Please reference the case number located in the upper right corner of this letter.

Sincerely,

Work Absence Management

Enclosures:

☐ LOA Quick Reference Guide
☐ Supplement to Sick Leave Request - Form 2090
☐ Personal Data Change - Form 2520
☐ Other:

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EMPLOYEE RIGHTS AND RESPONSIBILITIES
UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

Basic Leave Entitlement
FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:
- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements
Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is a current membe r o f the Armed forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections
During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements
Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition
A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or 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.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave
An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave
Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities
Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities
Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility. Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA protected, the employer must notify the employee.

Unlawful Acts by Employers
FMLA makes it unlawful for any employer to:
- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement
An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

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October 9, 2017

Employee ID: 00530105
Case Number: 41121450

Darlene Walls
16323 cortuna ave # 8
Bellflower, CA 90706

Subject: Designation for Family Leave under the Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA)

Dear Darlene,

On 10/02/2017, we were informed that you needed leave beginning on 09/02/2017 for:

☐ The birth of a child, or placement of a child with you for adoption or foster care.

☒ Your own serious health condition.

☐ Your need to care for your <spouse child parent domestic partner family member> due to his/her serious health condition.

☐ An exigency arising out of the fact that your <spouse son or daughter parent> is on active duty or call to active duty status.

☐ Your need to care for your <spouse son or daughter parent next of kin> due to his/her serious injury or illness incurred in the line of duty as a covered service member.

We reviewed your eligibility for leave under the FMLA/CFRA, and your supporting documentation, and determined that your FMLA/CFRA leave is approved. All leave taken for the reason checked above will be designated as FMLA/CFRA leave as long as you are eligible.

Your eligibility was determined based on the information available to us on 10/09/2017. To qualify for FMLA/CFRA you must meet the eligibility requirements at the beginning of your leave. Should your employment status change prior to the start of your leave, you may not qualify for FMLA/CFRA. The FMLA/CFRA requires that you notify us as soon as practicable if dates of scheduled leave change or are extended, or were initially unknown.

Provided there is no deviation from your anticipated leave schedule, and based on the information available to date, you are eligible for 402.97 hours workweeks> which will be counted against your leave entitlement.

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☒ Our records indicate you have used 42.08 hours during the immediately preceding 12 months. As of 09/02/2017 your remaining hours are: 360.89

☐ Your continuous Family Leave begins on <Enter Date> and ends on <Enter Date>.

☒ Your intermittent Family Leave begins on 09/02/2017 and ends on 12/23/2017. You are approved for the following frequency and duration of leave:

Frequency: <Enter Frequency>
Duration:

Family Leave

- Family Leave entitles you to up to twelve (12) workweeks of leave in a twelve (12) month rolling period. Military Caregiver leave is limited to 26 workweeks in a single 12 month period.
- FMLA/CFRA runs concurrently with Occupational leaves of absence and time off under Kin Care/CESLA when it is for an FMLA/CFRA qualifying reason.
- CFRA leave to care for a domestic partner with a serious health condition does not run concurrently with FMLA leave.
- An employee's pay status during Family Leave is determined in accordance with applicable laws, regional policies, and collective bargaining agreements.
- When taking Family Leave for one's own non work-related and non pregnancy-related illness/injury, an employee is required to use any available Sick/Extended Sick leave benefits.
- An employee may elect, but is not required, to use ETO, vacation or FPD hours while on FMLA/CFRA leave to care for his/her own serious health condition, or to care for a child, spouse, domestic partner, or parent.
- Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations.
- Re-certification may be required every 30 calendar days or if there has been a significant change in circumstances.

If your Family Leave is related to Pregnancy

California Pregnancy Disability Leave (PDL) and FMLA run concurrently. You may be eligible for up to, an additional 12 workweeks of leave under the California Family Rights Act (CFRA) for bonding with your newborn child. Your time off for bonding will count towards your CFRA entitlement. Any remaining FMLA entitlement will run concurrently with your bonding time under CFRA.

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Intermittent Family Leave
As an eligible employee, you are entitled to take Family Leave in separate blocks of time or by a reduced work schedule for your own or a family member's serious health condition which requires continuing treatment by a health care provider and which is best accommodated through intermittent time or a reduced work schedule. Any intermittent leave taken under Family Leave shall reduce the amount of remaining Family Leave.

If you wish to take intermittent leave to care for and bond with a child within one year of the birth or placement of the child must take the leave in increments of two weeks or more at a time, with the exception that leaves of less than two weeks can be taken twice during the year.

Continuation of Benefits Under Family Leave
Kaiser Permanente will continue your health and dental benefits for a total of 12 workweeks while you are under Family Leave, whether your leave is paid or unpaid. If you are on Military Caregiver Leave, Kaiser Permanente will continue your health and dental benefits for a total of 26 workweeks in a single 12 month period. While on a paid Family Leave, your other elected benefits will continue, with the exception of the Dependent Care Spending Account.

For information regarding other Employer paid benefits while on an unpaid leave of absence, refer to your respective bargaining agreement or Summary Plan Description.

Life Insurance continues at the employer's expense for a minimum of 30 calendar days following commencement of **unpaid** Family Leave. Collective bargaining agreement provisions of represented employee groups maybe more generous than the Family Leave policy. **You may choose to continue Life Insurance coverage after this time at your own expense. If you wish to do so, you may contact the National HR Service Center (NHRSC) to make the necessary arrangements.**

Dependent enrollment for a newborn or adopted child
You will need to complete benefit enrollment within 31 days of the birth or adoption to ensure coverage for your new dependent.

Enroll on-line at: http://kp.org/myhr:

DAY 1	*Report your Qualifying Event/Family Status Change:* Go to the appropriate life event in the Home and Family section of the left-hand navigation, (i.e. getting married or having a baby) and enter the information requested.
DAY 2	Make benefit changes on-line: Log on and follow the online process to enroll your dependent.

DAY 3	Confirm Benefit change: To confirm that your enrollment was successfully completed, log on and print a confirmation statement for your records.
DAY 4	Submit supporting documents: Be sure to submit any required supporting documentation to the NHRSC.

A copy of your child's certified birth certificate will be required to complete the enrollment. Verification of your dependent's Social Security Number (SSN) may also be required.

DO NOT DELAY YOUR ENROLLMENT! If you need additional time to submit supporting documentation, contact the NHRSC.

If you do not notify the NHRSC within 31 days of the event, *you may have to wait until the next Open Enrollment period to enroll your child.*

Spending Accounts
If you enrolled in a Spending Account (Health Care, Dependent Care or Commuter) please go to the *Benefits, Pay & Employment* section on My HR at http://insidekp.kp.org/myhr/ for eligibility, contributions and any changes due to your leave of absence or return from leave.

If you need an extension of your leave
If you are unable to return to work on the specified return to work date, you are responsible for initiating a request for extension of leave. A request for extension of leave due to disability must be accompanied by a current physician certification from the health care provider. Any additional time off for this qualifying reason will be counted as FMLA up to the maximum time available, provided that sufficient certification is received. Remind your Manager to complete Form 1500 on My HR.

Returning to Work
You are encouraged to notify your supervisor of the intent to return to work at least 2 weeks prior to the expiration of the leave. In addition, if the family leave is due to your own serious health condition, you must provide a physician or practitioner certification form indicating that you are fit to return to work. Remind your Manager to complete Form 1510 on My HR.

The ***Employee Rights and Responsibilities*** under FMLA are attached for your review. Policies, bargaining agreements and other information regarding leaves of absence can be found on My HR at http://insidekp.kp.org/myhr/ or you may contact NHRSC at 877-4KP-HRSC (877-457-4772) and select Leaves of Absence.

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National HR Service Center

Please reference the case number located in the upper right corner of this letter.

Sincerely,

Work Absence Management

Enclosures:

☒ LOA Quick Reference Guide
☐ Supplement to Sick Leave Request - Form 2090
☐ Personal Data Change - Form 2520
☐ Other:

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National HR Service Center

EMPLOYEE RIGHTS AND RESPONSIBILITIES
UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

Basic Leave Entitlement
FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:
- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements
Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is a current membe r o f the Armed forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections
During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements
Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition
A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or 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.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave
An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave
Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities
Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities
Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility. Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA protected, the employer must notify the employee.

Unlawful Acts by Employers
FMLA makes it unlawful for any employer to:
- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement
An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

Instructions:
1. To ensure efficient and effective service please, submit form online.
2. Items marked with an asterisk (*) are required fields.
3. Immediate confirmation will be sent to you upon receipt of your online submittal.
4. **Supervisor/Manager:** Complete Leave of Absence Form for employee. Review Attestations; include applicable notations in the Comments Section on the Request. Be sure to print a copy of Leave of Absence Form before submitting.

* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(562) 657-8527	10/15/2017
*** First Name**	**Middle Name**	*** Last Name**
Darlene		Walls

1. LEAVE INFORMATION

Employee E-mail Address	Alternate Employee Phone Number (###) ###-####	New or Revised Request
		☒ New ☐ Revised

*** Leave Type:**

☒ Medical	☐ Union	☐ Care for Eligible Family Member
☐ Maternity	☐ Personal	☐ Family Military Leave
☐ Workers' Comp/Industrial	☐ Military Service	☐ Bonding

Last Day Worked (mm/dd/yyyy)	* First Day of Leave (mm/dd/yyyy)	Expected Return Date (mm/dd/yyyy)
	10/15/2017	

Is this an intermittent or reduced work schedule Leave? ☒ Intermittent ☐ Reduced Work Schedule ☐ Not Applicable

Is this a Donor Leave? ☐ Yes ☒ No ☐ Unknown

Estimated frequency and duration of absences
tbd by physician

If absence is for Care of Eligible Family Member or Bonding:

Name of Eligible Family Member	Relationship to Employee
Is Family Member age 18 or under? If Yes, enter age ☐ Yes ☐ No	Delivery/Adoption/Foster Care Placement Date (mm/dd/yyyy) ☐ Actual Date ☐ Expected Date
Is the child's other parent employed by Kaiser Permanente? ☐ Yes ☐ No	If Yes, full name of other parent

If absence is due to Family Member's Military Service please select the reason(s) that apply:

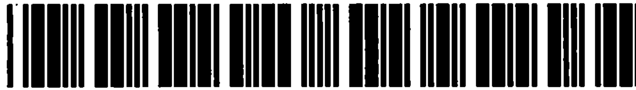
Name of Eligible Family Member	Relationship to Employee

☐ **Qualifying Exigency,** (matters related to deployment such as Child Care issues, Financial Planning, and Family Support Sessions, Seeing off leaving or returning Service Members.)

☐ **Care for qualified Service Member who incurred injury or illness in the line of duty**

National HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist

Next Page >



* First Name	Middle Name	* Last Name
Darlene		Walls
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(562) 657-8527	10/15/2017

1. LEAVE INFORMATION - (Continued)

If absence is for Employee's own health condition (Medical, Maternity or Workers' Comp/Industrial)

Date of illness or injury (mm/dd/yyyy)	Was hospitalization required?	Date Hospitalized (mm/dd/yyyy)
10/15/2017	☐ Yes ☒ No ☐ Unknown	

Estimated/Actual hours worked on last day	If Leave is due to maternity	Delivery Date (mm/dd/yyyy)
8	☐ Actual Delivery Date ☐ Expected Delivery Date	

If absence is pregnancy related, does the employee plan to take Bonding time immediately after the pregnancy related absence is complete?

☐ Yes ☐ No

If absence is for Union Leave

Type of Union Leave:

☐ Short Term (30 days or less) ☐ Long Term (greater than 30 days) ☐ Elected Official

Name of Union

If absence is for Military Leave

Is this absence for Military Training or Active Duty?

☐ Military Training ☐ Active Duty

*** If for Personal Leave, indicate reason**

Temporary Agency or Military Service (asked for FMLA eligibility)

Has the Employee worked for Kaiser Permanente less than one year?

☐ Yes ☒ No

Has the Employee been on active Military Duty in the past 12 months?	Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)
☐ Yes ☒ No		

Did the Employee work for Kaiser Permanente with a Temporary Agency in the year before they were hired?

☐ Yes ☐ No

National HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist

LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

* First Name	Middle Name	* Last Name
Darlene		Walls
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(562) 657-8527	10/15/2017

1. LEAVE INFORMATION - (Continued)

Name of Agency		
Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)	Agency Phone Number (###) ###-####

2. COMMENTS

3. EMPLOYEE SCHEDULE

This information is essential for the NHRSC to prepare a worksheet to assist with TIME coding. This is required for employees absent for their own disability. Please use a 24 hr clock: 00:00 thru 24:00.

NOTE: This section is not applicable for the KRONOS regions.

Week 1

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start Time: (hh:mm)							
Hours:							

Week 2 (Only needed if schedule changes week to week)

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start Time: (hh:mm)							
Hours:							

4. REQUEST PAID TIME-OFF

Review your Collective Bargaining Agreement and/or Summary Plan Description Booklet before completing this section. Selections made here will not supersede conditions set in Collective Bargaining Agreements, Summary Plan Descriptions, KP and HR Policies, or applicable State and Federal Laws.

Question	Option	Amount
Did employee request EarnedTime Off (ETO)/Paid Time Off (PTO)/Vacation? ☐ Yes ☐ No	☐ Use all available hours ☐ Use selected hours	Number of hours
Did employee request to use Extended Sick Leave (ESL)/Sick Leave? ☐ Yes ☐ No	☐ Use all available hours ☐ Use selected hours	Number of hours
Did employee request to use Float Holidays? ☐ Yes ☐ No	Only available Float Holidays will be applied.	Number of days

National HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist

LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

* First Name	Middle Name	* Last Name
Darlene		Walls
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(562) 657-8527	10/15/2017

4. REQUEST PAID TIME-OFF - (Continued)

Did employee request to use Flexible Personal Days? ☐Yes ☐No	Number of days	OR	Number of hours
Note: Flexible Personal Days can only be used in full day or two hour increments. Only available Flexible Personal Days will be applied.			
Did employee request Military Make-up Pay? ☐Yes ☐No			

5. SUBMITTED BY

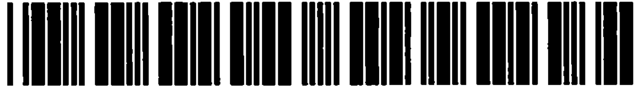
* Name (First, MI, Last)	
Erik A Humbert	
* Employee ID	* Title
00677786	
* E-mail Address	* Work Phone Number (###) ###-####
erik.a.humbert@kp.org	(562) 657-8527

6. MANAGER INFORMATION DETAIL

* Name (First, MI, Last)	
danny j imenez	
Supervisor ID	* Title
* E-mail Address	* Work Phone Number (###) ###-####
danny.p.jimenez@kp.org	(562) 657-8527

7. ALTERNATE CONTACT INFORMATION - Someone, in addition to the Manager, who should receive leave communication (i.e. time coding, fmla status, etc)

* Name (First, MI, Last)	
* E-mail Address	* Work Phone Number (###) ###-####



LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

* First Name	Middle Name	* Last Name
Darlene		Walls
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(562) 657-8527	10/15/2017

8. MANAGER ATTESTATION

* Checking these items acknowledges that you have read and understand each item.

☒ I agree to direct the employee requesting Leave to submit any and all supporting documentation to me or the National HR Service Center.

☒ I agree to submit form 1500 - Extend Leave and any supporting documentation at the time I learn that the employee intends to extend his or her leave beyond their expected return date or fails to return on their expected date, fails to respond, and is not terminated.

☒ I agree to submit form 1510 - Return from Leave when the employee returns to work.

☒ TIME must be coded for all paid and unpaid leave taken by the employee.

9. MANAGER SIGNATURE - (Required if not submitted online.)

* Manager Signature

* Date (mm/dd/yyyy)

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National HR Service Center

January 9, 2018

Employee ID: 00530105
Case Number: 41467995

Darlene Walls
16323 cortuna ave # 8
Bellflower, CA 90706

Subject: Notice of Eligibility - Under the Family and Medical Leave Act/California Family Rights Act (Family Leave)

Dear Darlene Walls, *CONDITION #2*

On 01/03/18, we were informed that you needed leave beginning on 10/15/17 for:

☐ The birth of a child, or placement of a child with you for adoption or foster care.

☒ Your own serious health condition.

☐ Your need to care for your <spouse child parent domestic partner family member> due to his/her serious health condition.

☐ An exigency arising out of the fact that your <spouse son or daughter parent> is on active duty or call to active duty status.

☐ Your need to care for your <spouse son or daughter parent next of kin> due to his/her serious injury or illness incurred in the line of duty as a covered servicemember.

This notice is to inform you that you have met the eligibility requirements for FMLA/CFRA

Your eligibility was determined based on the information available to us on 01/09/18. To qualify for FMLA/CFRA you must meet the eligibility requirements at the beginning of your leave. Please refer to the attached *Employee Rights and Responsibilities* regarding eligibility criteria or requirements. Should your employment status change prior to the start of your leave, you may not qualify for FMLA/CFRA.

Approval of your request for leave under the FMLA/CFRA is pending receipt of the documentation indicated below. The documentation must be provided to the NHRSC by 01/27/18 or your leave may be denied.

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☒ Sufficient certification to support your request for FMLA/CFRA leave.

- ☒ 1451 Employee - Certification of Physician
- ☐ 1452 Family Member - Certification of Physician
- ☐ 1453 Service Member - Certification of Physician

☐ Sufficient certification to indicate your adult child is incapable of self-care because of a physical or mental disability. Certification may be provided on the enclosed 1452 Family Member - Certification of Physician.

☐ Sufficient documentation to establish the required relationship between you and your family member; proof of <birth marriage adoption/foster care domestic partner relationship next of kin>.

☐ Military Orders

☐ 1454 - Military Exigency - Certification

☐ Other:

☐ The certification you provided is not complete and sufficient to determine whether the FMLA/CFRA applies to your leave request. You must provide the following information no later than <mm/dd/yyyy>, or your leave may be denied, unless it is not practicable under the particular circumstances despite your diligent good faith efforts.

☐ The information provided on the Certification of Physician/Provider does not meet the definition of a serious health condition. A list of the definitions is attached for your reference.

☐ The Certification of Physician/Provider does not include the Frequency and Duration for intermittent leave.

☐ The Certification of Physician/Provider does not indicate your adult child is incapable of self-care because of a physical or mental disability.

☐ The information provided failed to establish the required relationship between you and your family member; proof of <birth marriage adoption/foster care domestic partner relationship next of kin>.

☐ Military Orders

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National HR Service Center

☐ 1453 - Service Member - Certification of Physician

☐ 1454 - Military Exigency - Certification

☐ Other:

Please fax the required document(s) to the National HR Service Center at **1-877-HRSC-FAX (1-877-477-2329)**. Or mail the forms to:

Kaiser Permanente National HR Service Center
PO Box 2074
Oakland, CA 94604-2074

Once we obtain the information from you as specified above, we will inform you whether your leave will be designated as FMLA/CFRA leave and count towards your FMLA/CFRA leave entitlement.

Please note: Failure to provide the sufficient certification may result in delay or denial of your Family Leave.

The *Employee Rights and Responsibilities* and the definitions of a *Serious Health Condition* under the FMLA are attached for your review. Policies, bargaining agreements and other information regarding leaves of absence can be found on My HR.

If you have any questions or concerns regarding your request for family leave, please contact Work Absence Management (WAM) at the National HR Service Center at **877-4KP-HRSC (877-457-4772).** Please reference the case number located in the upper right-hand corner of this letter.

Sincerely,

Work Absence Management (WAM)
National HR Service Center

Enclosures:

☒ 1451 Employee - Certification of Physician
☐ 1452 Family Member - Certification of Physician
☐ 1453 Service Member - Certification of Physician
☐ 1454 - Military Exigency - Certification
☐ 2090 - Supplement to Sick Leave Request
☐ 2520 - Personal Data Change

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National HR Service Center

EMPLOYEE RIGHTS AND RESPONSIBILITIES
UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

Basic Leave Entitlement
FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:
- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements
Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

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Benefits and Protections
During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements
Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition
A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or 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 t he qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave
An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave
Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities
Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities
Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility. Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA protected, the employer must notify the employee.

Unlawful Acts by Employers
FMLA makes it unlawful for any employer to:
- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement
An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

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National HR Service Center

Family and Medical Leave Act (FMLA)

"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.

Condition	Details
Inpatient Care	An overnight stay in a hospital, hospice, or residential medical-care facility, including any period of incapacity (i.e. inability to work, attend school, or perform other regular daily activities) or subsequent treatment in connection with such inpatient care.

Continuing treatment by a health care provider including one or more of the following:

a) Incapacity and Treatment	A period of incapacity lasting more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that **also** includes: · Treatment two or more times by or under the supervision of a health care provider (i.e. in-person visits, the first within 7 days and both within 30 days of the first day of incapacity); **or** One treatment by a health care provider (i.e., an in-person visit within 7 days of the first day of incapacity) with a continuing regimen of treatment (e.g., prescription medication, physical therapy).
b) Pregnancy	Any period of incapacity related to pregnancy or for prenatal care.
c) Chronic Conditions	Any period of incapacity or treatment for a chronic serious health condition. Requires periodic visits (at least twice a year) for treatment by, or under direct supervision of a health care provider. Continues over an extended period of time and may cause episodic rather than a continuing period of incapacity.
d) Permanent/Long-Term Conditions	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.
e) Conditions requiring multiple treatments	Any absences of incapacity to receive multiple treatments (including any period of recovery) 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 days if not treated.

KAISER PERMANENTE®
National HR Service Center

January 29, 2018

Employee ID: 00530105
Case Number: 41467995

Darlene Walls
16323 cortuna ave # 8
Bellflower, CA 90706

Subject: Denial Notice - Under the Family and Medical Leave Act/California Family Rights Act (Family Leave)

Dear Darlene Walls,

On 01/03/2018, we were informed that you needed leave beginning on 10/15/2017 for:

☐ The birth of a child, or placement of a child with you for adoption or foster care.

☒ Your own serious health condition.

☐ Your need to care for your <spouse child parent domestic partner family member> due to his/her serious health condition.

☐ An exigency arising out of the fact that your <spouse son or daughter parent> is on active duty or call to active duty status.

☐ Your need to care for your <spouse son or daughter parent next of kin> due to his/her serious injury or illness incurred in the line of duty as a covered servicemember.

This Notice is to inform you that you are <u>not eligible</u> for FMLA/CFRA leave, because:

☐ You have not met the 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately <Enter Num Mos> months towards this requirement. If you are still on leave at the completion of 12 months of service please contact the NHRSC to request your eligibility for FMLA/CFRA. For more information please see the attached notice of Employee Rights and Responsibilities.

☐ You have not met the 1,250 hours worked requirement within the 12 months preceding the start of your leave. As of <mm/dd/yyyy> you have worked <Enter Hours> hours towards the eligibility requirement. You can check the number of hours worked by contacting the NHRSC.

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National HR Service Center

☐ You exhausted your <12 26>-week entitlement to leave under the <FMLA/CFRA>

☐ Your request is for a non-qualified family member.

☒ You failed to provide sufficient certification to support your request.

- ☒ A Health Care Provider Certification form was not received.
- ☐ The information provided on the Health Care Provider Certification did not meet the definition of a serious health condition.
- ☐ The Health Care Provider Certification did not include the Frequency and Duration for an intermittent leave.
- ☐ The Health Care Provider Certification did not indicate your adult child is incapable of self-care because of a physical or mental disability.
- ☐ You failed to provide sufficient documentation to establish the required relationship between you and your family member; proof of <birth adoption/foster care domestic partner relationship marriage>.
- ☐ Military Orders
- ☐ <Certification of Exigency Certification of an injured/ill servicemember>

☐ Other:

The *Employee Rights and Responsibilities* under the FMLA are attached for your review.

While your time off is not currently protected under the FMLA and CFRA; you may become eligible for FMLA/CFRA during your leave. Please refer to the *Employee Rights and Responsibilities* for eligibility criteria or requirements. You may also be eligible for other forms of leave under Kaiser's leave policies or under an applicable collective bargaining agreement. If your leave is the result of a work-related injury, it may be subject to Workers' Compensation leave protection.

Policies, bargaining agreements and other information regarding leaves of absence can be found on My HR.

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National HR Service Center

If you have any questions or concerns regarding the denial of your request for family leave, please contact Work Absence Management (WAM) at the National HR Service Center at **877-4KP-HRSC (877-457-4772).** Please reference the case number located in the upper right-hand corner of this letter.

Sincerely,

Work Absence Management (WAM)
Kaiser Permanente National HR Service Center

KAISER PERMANENTE®

National HR Service Center

EMPLOYEE RIGHTS AND RESPONSIBILITIES
UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

Basic Leave Entitlement
FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:
- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements
Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is a current member of the Armed forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the service member medically unfit to perform his or her duties for which the service member is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections
During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements
Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition
A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or 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.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave
An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave
Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities
Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities
Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility. Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA protected, the employer must notify the employee.

Unlawful Acts by Employers
FMLA makes it unlawful for any employer to:
- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement
An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

Instructions: 1. To ensure efficient and effective service please, submit form online.
2. Items marked with an asterisk (*) are required fields.
3. Immediate confirmation will be sent to you upon receipt of your online submittal.
4. **Supervisor/Manager:** Complete Leave of Absence Form for employee. Review Attestations; include applicable notations in the Comments Section on the Request. Be sure to print a copy of Leave of Absence Form before submitting.

* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(213) 401-8827	01/03/2018
* First Name	Middle Name	* Last Name
Darlene		Walls

1. LEAVE INFORMATION

Employee E-mail Address	Alternate Employee Phone Number (###) ###-####	New or Revised Request
		☐ New ☐ Revised

*** Leave Type:**

☒ Medical	☐ Union	☐ Care for Eligible Family Member
☐ Maternity	☐ Personal	☐ Family Military Leave
☐ Workers' Comp/Industrial	☐ Military Service	☐ Bonding

Last Day Worked (mm/dd/yyyy)	* First Day of Leave (mm/dd/yyyy)	Expected Return Date (mm/dd/yyyy)
	01/03/2018	

Is this an intermittent or reduced work schedule Leave? ☒ Intermittent ☐ Reduced Work Schedule ☐ Not Applicable

Is this a Donor Leave? ☐ Yes ☒ No ☐ Unknown

Estimated frequency and duration of absences
Frequency 2 times per month
Duration 1 day per episode

If absence is for Care of Eligible Family Member or Bonding:

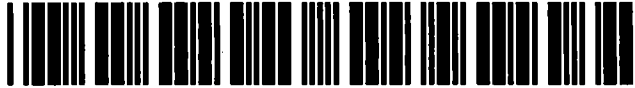
Name of Eligible Family Member	Relationship to Employee
Is Family Member age 18 or under? If Yes, enter age ☐ Yes ☐ No	Delivery/Adoption/Foster Care Placement Date (mm/dd/yyyy) ☐ Actual Date ☐ Expected Date
Is the child's other parent employed by Kaiser Permanente? ☐ Yes ☐ No	If Yes, full name of other parent

If absence is due to Family Member's Military Service please select the reason(s) that apply:

Name of Eligible Family Member	Relationship to Employee

☐ **Qualifying Exigency**, (matters related to deployment such as Child Care issues, Financial Planning, and Family Support Sessions, Seeing off leaving or returning Service Members.)

☐ **Care for qualified Service Member who incurred injury or illness in the line of duty**



* First Name	Middle Name	* Last Name
Darlene		Walls
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(213) 401-8827	01/03/2018

1. LEAVE INFORMATION - (Continued)

If absence is for Employee's own health condition (Medical, Maternity or Workers' Comp/Industrial)

Date of illness or injury (mm/dd/yyyy)	Was hospitalization required?	Date Hospitalized (mm/dd/yyyy)
01/03/2018	☐ Yes ☒ No ☐ Unknown	

Estimated/Actual hours worked on last day	If Leave is due to maternity	Delivery Date (mm/dd/yyyy)
8	☐ Actual Delivery Date ☐ Expected Delivery Date	

If absence is pregnancy related, does the employee plan to take Bonding time immediately after the pregnancy related absence is complete?

☐ Yes ☐ No

If absence is for Union Leave

Type of Union Leave:

☐ Short Term (30 days or less) ☐ Long Term (greater than 30 days) ☐ Elected Official

Name of Union

If absence is for Military Leave

Is this absence for Military Training or Active Duty?

☐ Military Training ☐ Active Duty

*** If for Personal Leave, indicate reason**

Temporary Agency or Military Service (asked for FMLA eligibility)

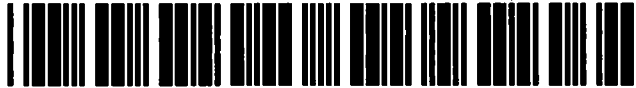
Has the Employee worked for Kaiser Permanente less than one year?

☐ Yes ☒ No

Has the Employee been on active Military Duty in the past 12 months?	Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)
☐ Yes ☒ No		

Did the Employee work for Kaiser Permanente with a Temporary Agency in the year before they were hired?

☐ Yes ☐ No



LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

* First Name	Middle Name	* Last Name
Dar l ene		Wa l l s
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(213) 401-8827	01/03/2018

1. LEAVE INFORMATION - (Continued)

Name of Agency		
Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)	Agency Phone Number (###) ###-####

2. COMMENTS

3. EMPLOYEE SCHEDULE

This information is essential for the NHRSC to prepare a worksheet to assist with TIME coding. This is required for employees absent for their own disability. Please use a 24 hr clock: 00:00 thru 24:00.

NOTE: This section is not applicable for the KRONOS regions.

Week 1

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start Time: (hh:mm)							
Hours:							

Week 2 (Only needed if schedule changes week to week)

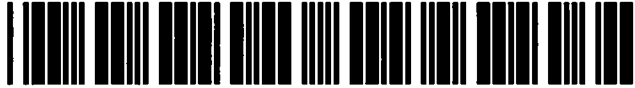
	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start Time: (hh:mm)							
Hours:							

4. REQUEST PAID TIME-OFF

Review your Collective Bargaining Agreement and/or Summary Plan Description Booklet before completing this section. Selections made here will not supersede conditions set in Collective Bargaining Agreements, Summary Plan Descriptions, KP and HR Policies, or applicable State and Federal Laws.

Did employee request EarnedTime Off (ETO)/Paid Time Off (PTO)/Vacation? ☐ Yes ☐ No	☐ Use all available hours ☐ Use selected hours	Number of hours
Did employee request to use Extended Sick Leave (ESL)/Sick Leave? ☐ Yes ☐ No	☐ Use all available hours ☐ Use selected hours	Number of hours
Did employee request to use Float Holidays? ☐ Yes ☐ No	Only available Float Holidays will be applied.	Number of days

National HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist



LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

* First Name	Middle Name	* Last Name
Darlene		Walls
*** Employee ID**	*** Contact Phone Number (###) ###-####**	*** Effective Date (mm/dd/yyyy)**
00530105	(213) 401-8827	01/03/2018

4. REQUEST PAID TIME-OFF - (Continued)

Did employee request to use Flexible Personal Days? ☐Yes ☐No	Number of days	OR	Number of hours
Note: Flexible Personal Days can only be used in full day or two hour increments. Only available Flexible Personal Days will be applied.			
Did employee request Military Make-up Pay? ☐Yes ☐No			

5. SUBMITTED BY

* Name (First, MI, Last)	
Danny P Jimenez	
*** Employee ID**	*** Title**
00685629	
*** E-mail Address**	*** Work Phone Number (###) ###-####**
danny.p.jimenez@kp.org	(562) 657-8527

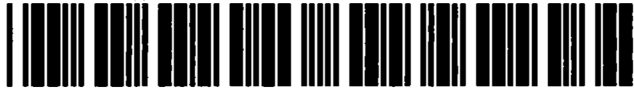
6. MANAGER INFORMATION DETAIL

* Name (First, MI, Last)	
Danny Jimenez	
Supervisor ID	*** Title**
*** E-mail Address**	*** Work Phone Number (###) ###-####**
danny.p.jimenez@kp.org	(562) 657-8527

7. ALTERNATE CONTACT INFORMATION - Someone, in addition to the Manager, who should receive leave communication (i.e. time coding, fmla status, etc)

* Name (First, MI, Last)	
*** E-mail Address**	*** Work Phone Number (###) ###-####**

National HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist



* First Name	Middle Name	* Last Name
Darlene		Walls
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(213) 401-8827	01/03/2018

8. MANAGER ATTESTATION

* Checking these items acknowledges that you have read and understand each item.

☒ I agree to direct the employee requesting Leave to submit any and all supporting documentation to me or the National HR Service Center.

☒ I agree to submit form 1500 - Extend Leave and any supporting documentation at the time I learn that the employee intends to extend his or her leave beyond their expected return date or fails to return on their expected date, fails to respond, and is not terminated.

☒ I agree to submit form 1510 - Return from Leave when the employee returns to work.

☒ TIME must be coded for all paid and unpaid leave taken by the employee.

9. MANAGER SIGNATURE - (Required if not submitted online.)

* Manager Signature	* Date (mm/dd/yyyy)

KAISER PERMANENTE®
National HR Service Center

February 26, 2018

Employee ID: 00530105
Case Number: 41121450

Darlene Walls
16323 cortuna ave # 8
Bellflower, CA 90706

Subject: Family Leave Extension under the Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA)

Dear Darlene Walls,

On 02/13/18, we were informed that you requested an extension of your leave that began on 09/02/17 for:

☐ The birth of a child, or placement of a child with you for adoption or foster care.

☒ Your own serious health condition.

☐ Your need to care for your <spouse child parent domestic partner family member> due to his/her serious health condition.

☐ An exigency arising out of the fact that your <spouse son or daughter parent> is on active duty or call to active duty status.

☐ Your need to care for your <spouse son or daughter parent next of kin> due to his/her serious injury or illness incurred in the line of duty as a covered servicemember.

☒ This Notice is to inform you that your request for an extension has been approved for the period: 01/03/18 to 07/03/18. Additionally, your FMLA/CFRA will be exhausted effective 09/01/18.

You are approved for the following frequency and duration of leave:
Frequency: 2 episodes per month
Duration: 1 day per episode

☐ This Notice is to inform you that, while you remain eligible for leave under the FMLA/CFRA, approval of your request is pending receipt of sufficient certification to support your request for FMLA/CFRA leave, as indicated below. The documentation must be provided to the NHRSC by <Enter Date>, or your request for an extension may be denied.

- ☐ 1451 Employee - Certification of Physician
- ☐ 1452 Family Member - Certification of Physician
- ☐ Other:

☐ This Notice is to inform you that your request for an extension is **denied** because:

- ☐ You exhausted your <12 26>-workweek entitlement to leave under <FMLA/CFRA CFRA> effective <Enter Date>.
- ☐ A Health Care Provider Certification form was not received.
- ☐ The certification document you submitted was not sufficient to support your request.
- ☐ Other:

The *Employee Rights and Responsibilities* under the FMLA are attached for your review.

If your request for an extension of family leave is denied, your time off is not protected under FMLA/CFRA. Please refer to the *Employee Rights and Responsibilities* for eligibility criteria and requirements. You may be eligible for other types of leave under Kaiser's HR Policies or under an applicable Collective Bargaining Agreement. If your leave is the result of a work-related injury, it may be subject to Workers' Compensation leave protection.

HR Policies, Collective Bargaining Agreements and other information regarding leaves of absence can be found on My HR at insidekp.kp.org/myhr.

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National HR Service Center

If you have any questions or concerns regarding the status of your request for an extension of family leave, please contact Work Absence Management (WAM) at the National HR Service Center at **877-4KP-HRSC (877-457-4772).** Please reference the case number located in the upper right-hand corner of this letter.

Sincerely,

Work Absence Management

Kaiser Permanente National HR Service Center

Enclosures:

☐ 1451 Employee - Certification of Physician

☐ 1452 Family Member - Certification of Physician

☐ Other:

KAISER PERMANENTE®

National HR Service Center

EMPLOYEE RIGHTS AND RESPONSIBILITIES
UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is a current member of the Armed forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the service member medically unfit to perform his or her duties for which the service member is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or 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.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility. Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

KAISER PERMANENTE®
National HR Service Center

April 10, 2018

Employee ID: 00530105
Case Number: 1850851

Darlene Walls
16323 cortuna ave # 8
Bellflower, CA 90706

REVISED

Subject: Designation for Family Leave under the Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA)

Dear Darlene,

On 09/02/17, we were informed that you needed leave beginning on 09/02/17 for:

☐ The birth of a child, or placement of a child with you for adoption or foster care.

☒ Your own serious health condition.

☐ Your need to care for your <spouse child parent domestic partner family member> due to his/her serious health condition.

☐ An exigency arising out of the fact that your <spouse son or daughter parent> is on active duty or call to active duty status.

☐ Your need to care for your <spouse son or daughter parent next of kin> due to his/her serious injury or illness incurred in the line of duty as a covered service member.

We reviewed your eligibility for leave under the FMLA/CFRA, and your supporting documentation, and determined that your <FMLA/CFRA> leave is approved. All leave taken for the reason checked above will be designated as <FMLA/CFRA> leave as long as you are eligible.

Your eligibility was determined based on the information available to us on 04/10/18. To qualify for FMLA/CFRA you must meet the eligibility requirements at the beginning of your leave. Should your employment status change prior to the start of your leave, you may not qualify for <FMLA/CFRA>. The FMLA/CFRA requires that you notify us as soon as practicable if dates of scheduled leave change or are extended, or were initially unknown.

Provided there is no deviation from your anticipated leave schedule, and based on the information available to date, you are eligible for <402.97 hours> which will be counted against your leave entitlement.

KAISER PERMANENTE®
National HR Service Center

☒ Our records indicate you have used <42.08 hours> during the immediately preceding 12 months. As of 09/02/17 your remaining <hours> are: 360.89

☐ Your continuous Family Leave begins on <Enter Date> and ends on <Enter Date>.

☒ Your intermittent Family Leave begins on 09/02/17 and ends on 06/23/17. You are approved for the following frequency and duration of leave:

Frequency: 2 episodes / month
Duration: 1 day / episode

Family Leave

- Family Leave entitles you to up to twelve (12) workweeks of leave in a twelve (12) month rolling period. Military Caregiver leave is limited to 26 workweeks in a single 12 month period.
- FMLA/CFRA runs concurrently with Occupational leaves of absence and time off under Kin Care/CESLA when it is for an FMLA/CFRA qualifying reason.
- CFRA leave to care for a domestic partner with a serious health condition does not run concurrently with FMLA leave.
- An employee's pay status during Family Leave is determined in accordance with applicable laws, regional policies, and collective bargaining agreements.
- When taking Family Leave for one's own non work-related and non pregnancy-related illness/injury, an employee is required to use any available Sick/Extended Sick leave benefits.
- An employee may elect, but is not required, to use ETO, vacation or FPD hours while on FMLA/CFRA leave to care for his/her own serious health condition, or to care for a child, spouse, domestic partner, or parent.
- Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations.
- Re-certification may be required every 30 calendar days or if there has been a significant change in circumstances.

If your Family Leave is related to Pregnancy

California Pregnancy Disability Leave (PDL) and FMLA run concurrently. You may be eligible for up to, an additional 12 workweeks of leave under the California Family Rights Act (CFRA) for bonding with your newborn child. Your time off for bonding will count towards your CFRA entitlement. Any remaining FMLA entitlement will run concurrently with your bonding time under CFRA.

KAISER PERMANENTE®
National HR Service Center

Intermittent Family Leave
As an eligible employee, you are entitled to take Family Leave in separate blocks of time or by a reduced work schedule for your own or a family member's serious health condition which requires continuing treatment by a health care provider and which is best accommodated through intermittent time or a reduced work schedule. Any intermittent leave taken under Family Leave shall reduce the amount of remaining Family Leave.

If you wish to take intermittent leave to care for and bond with a child within one year of the birth or placement of the child must take the leave in increments of two weeks or more at a time, with the exception that leaves of less than two weeks can be taken twice during the year.

Continuation of Benefits Under Family Leave
Kaiser Permanente will continue your health and dental benefits for a total of 12 workweeks while you are under Family Leave, whether your leave is paid or unpaid. If you are on Military Caregiver Leave, Kaiser Permanente will continue your health and dental benefits for a total of 26 workweeks in a single 12 month period. While on a paid Family Leave, your other elected benefits will continue, with the exception of the Dependent Care Spending Account.

For information regarding other Employer paid benefits while on an unpaid leave of absence, refer to your respective bargaining agreement or Summary Plan Description.

Life Insurance continues at the employer's expense for a minimum of 30 calendar days following commencement of **unpaid** Family Leave. Collective bargaining agreement provisions of represented employee groups maybe more generous than the Family Leave policy. **You may choose to continue Life Insurance coverage after this time at your own expense. If you wish to do so, you may contact the National HR Service Center (NHRSC) to make the necessary arrangements.**

Dependent enrollment for a newborn or adopted child
You will need to complete benefit enrollment within 31 days of the birth or adoption to ensure coverage for your new dependent.

Enroll on-line at: http://kp.org/myhr:

DAY 1	*Report your Qualifying Event/Family Status Change:* Go to the appropriate life event in the Home and Family section of the left-hand navigation, (i.e. getting married or having a baby) and enter the information requested.
DAY 2	Make benefit changes on-line: Log on and follow the online process to enroll your dependent.

DAY 3	Confirm Benefit change: To confirm that your enrollment was successfully completed, log on and print a confirmation statement for your records.
DAY 4	Submit supporting documents: Be sure to submit any required supporting documentation to the NHRSC.

A copy of your child's certified birth certificate will be required to complete the enrollment. Verification of your dependent's Social Security Number (SSN) may also be required.

DO NOT DELAY YOUR ENROLLMENT! If you need additional time to submit supporting documentation, contact the NHRSC.

If you do not notify the NHRSC within 31 days of the event, *you may have to wait until the next Open Enrollment period to enroll your child.*

Spending Accounts

If you enrolled in a Spending Account (Health Care, Dependent Care or Commuter) please go to the *Benefits, Pay & Employment* section on My HR at http://insidekp.kp.org/myhr/ for eligibility, contributions and any changes due to your leave of absence or return from leave.

If you need an extension of your leave

If you are unable to return to work on the specified return to work date, you are responsible for initiating a request for extension of leave. A request for extension of leave due to disability must be accompanied by a current physician certification from the health care provider. Any additional time off for this qualifying reason will be counted as FMLA up to the maximum time available, provided that sufficient certification is received. Remind your Manager to complete Form 1500 on My HR.

Returning to Work

You are encouraged to notify your supervisor of the intent to return to work at least 2 weeks prior to the expiration of the leave. In addition, if the family leave is due to your own serious health condition, you must provide a physician or practitioner certification form indicating that you are fit to return to work. Remind your Manager to complete Form 1510 on My HR.

The ***Employee Rights and Responsibilities*** under FMLA are attached for your review. Policies, bargaining agreements and other information regarding leaves of absence can be found on My HR at http://insidekp.kp.org/myhr/ or you may contact NHRSC at 877-4KP-HRSC (877-457-4772) and select Leaves of Absence.

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National HR Service Center

Please reference the case number located in the upper right corner of this letter.

Sincerely,

Work Absence Management

Enclosures:

- ☒ LOA Quick Reference Guide
- ☐ Supplement to Sick Leave Request - Form 2090
- ☐ Personal Data Change - Form 2520
- ☐ Other:

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EMPLOYEE RIGHTS AND RESPONSIBILITIES
UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is a current membe r o f the Armed forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or 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.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility. Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

1494 LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

Instructions:
1. To ensure efficient and effective service please, submit form online.
2. Items marked with an asterisk (*) are required fields.
3. Immediate confirmation will be sent to you upon receipt of your online submittal.
4. **Supervisor/Manager:** Complete Leave of Absence Form for employee. Review Attestations; include applicable notations in the Comments Section on the Request. Be sure to print a copy of Leave of Absence Form before submitting.

* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(323) 401-8827	08/13/2018
* First Name	Middle Name	* Last Name
Darlene		Walls

1. LEAVE INFORMATION

Employee E-mail Address	Alternate Employee Phone Number (###) ###-####	New or Revised Request
		☐ New ☐ Revised

*** Leave Type:**

☒ Medical	☐ Union	☐ Care for Eligible Family Member
☐ Maternity	☐ Personal	☐ Family Military Leave
☐ Workers' Comp/Industrial	☐ Military Service	☐ Bonding

Last Day Worked (mm/dd/yyyy)	* First Day of Leave (mm/dd/yyyy)	Expected Return Date (mm/dd/yyyy)
	08/13/2018	

Is this an intermittent or reduced work schedule Leave? ☒ Intermittent ☐ Reduced Work Schedule ☐ Not Applicable

Is this a Donor Leave? ☐ Yes ☒ No ☐ Unknown

Estimated frequency and duration of absences
Frequency 1 episode 2 times a month
Duration whole scheduled shift

If absence is for Care of Eligible Family Member or Bonding:

Name of Eligible Family Member	Relationship to Employee
Is Family Member age 18 or under? If Yes, enter age ☐ Yes ☐ No	Delivery/Adoption/Foster Care Placement Date (mm/dd/yyyy) ☐ Actual Date ☐ Expected Date
Is the child's other parent employed by Kaiser Permanente? ☐ Yes ☐ No	If Yes, full name of other parent

If absence is due to Family Member's Military Service please select the reason(s) that apply:

Name of Eligible Family Member	Relationship to Employee

☐ **Qualifying Exigency,** (matters related to deployment such as Child Care issues, Financial Planning, and Family Support Sessions, Seeing off leaving or returning Service Members.)

☐ **Care for qualified Service Member who incurred injury or illness in the line of duty**

National HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist

LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

* First Name	Middle Name	* Last Name
Darlene		Walls
*** Employee ID**	*** Contact Phone Number (###) ###-####**	*** Effective Date (mm/dd/yyyy)**
00530105	(323) 401-8827	08/13/2018

1. LEAVE INFORMATION - (Continued)

If absence is for Employee's own health condition (Medical, Maternity or Workers' Comp/Industrial)

Date of illness or injury (mm/dd/yyyy)	Was hospitalization required?	Date Hospitalized (mm/dd/yyyy)
08/13/2018	☐ Yes ☒ No ☐ Unknown	

Estimated/Actual hours worked on last day	If Leave is due to maternity	Delivery Date (mm/dd/yyyy)
8	☐ Actual Delivery Date ☐ Expected Delivery Date	

If absence is pregnancy related, does the employee plan to take Bonding time immediately after the pregnancy related absence is complete?

☐ Yes ☐ No

If absence is for Union Leave

Type of Union Leave:

☐ Short Term (30 days or less) ☐ Long Term (greater than 30 days) ☐ Elected Official

Name of Union

If absence is for Military Leave

Is this absence for Military Training or Active Duty?

☐ Military Training ☐ Active Duty

*** If for Personal Leave, indicate reason**

Temporary Agency or Military Service (asked for FMLA eligibility)

Has the Employee worked for Kaiser Permanente less than one year?

☐ Yes ☒ No

Has the Employee been on active Military Duty in the past 12 months?	Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)
☐ Yes ☒ No		

Did the Employee work for Kaiser Permanente with a Temporary Agency in the year before they were hired?

☐ Yes ☐ No

* First Name	Middle Name	* Last Name
Darlene		Walls
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(323) 401-8827	08/13/2018

1. LEAVE INFORMATION - (Continued)

Name of Agency		
Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)	Agency Phone Number (###) ###-####

2. COMMENTS

3. EMPLOYEE SCHEDULE

This information is essential for the NHRSC to prepare a worksheet to assist with TIME coding. This is required for employees absent for their own disability. Please use a 24 hr clock: 00:00 thru 24:00.

NOTE: This section is not applicable for the KRONOS regions.

Week 1

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start Time: (hh:mm)							
Hours:							

Week 2 (Only needed if schedule changes week to week)

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start Time: (hh:mm)							
Hours:							

4. REQUEST PAID TIME-OFF

Review your Collective Bargaining Agreement and/or Summary Plan Description Booklet before completing this section. Selections made here will not supersede conditions set in Collective Bargaining Agreements, Summary Plan Descriptions, KP and HR Policies, or applicable State and Federal Laws.

Did employee request EarnedTime Off (ETO)/Paid Time Off (PTO)/Vacation? ☒ Yes ☐ No	☒ Use all available hours ☐ Use selected hours	Number of hours
Did employee request to use Extended Sick Leave (ESL)/Sick Leave? ☒ Yes ☐ No	☒ Use all available hours ☐ Use selected hours	Number of hours
Did employee request to use Float Holidays? ☐ Yes ☒ No	Only available Float Holidays will be applied.	Number of days

National HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist

< Previous Page Next Page >

* First Name	Middle Name	* Last Name
Darlene		Walls
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(323) 401-8827	08/13/2018

4. REQUEST PAID TIME-OFF - (Continued)

Did employee request to use Flexible Personal Days? ☐ Yes ☐ No	Number of days	OR	Number of hours
Note: Flexible Personal Days can only be used in full day or two hour increments. Only available Flexible Personal Days will be applied.			
Did employee request Military Make-up Pay? ☐ Yes ☐ No			

5. SUBMITTED BY

* Name (First, MI, Last)	
Danny P Jimenez	
* Employee ID	* Title
00685629	
* E-mail Address	* Work Phone Number (###) ###-####
danny.p.jimenez@kp.org	(562) 657-8527

6. MANAGER INFORMATION DETAIL

* Name (First, MI, Last)	
Danny Jimenez	
Supervisor ID	* Title
* E-mail Address	* Work Phone Number (###) ###-####
danny.p.jimenez@kp.org	(562) 657-8527

7. ALTERNATE CONTACT INFORMATION - Someone, in addition to the Manager, who should receive leave communication (i.e. time coding, fmla status, etc)

* Name (First, MI, Last)	
* E-mail Address	* Work Phone Number (###) ###-####

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LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

* First Name	Middle Name	* Last Name
Darlene		Walls
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(323) 401-8827	08/13/2018

8. MANAGER ATTESTATION

* Checking these items acknowledges that you have read and understand each item.

☒ I agree to direct the employee requesting Leave to submit any and all supporting documentation to me or the National HR Service Center.

☒ I agree to submit form 1500 - Extend Leave and any supporting documentation at the time I learn that the employee intends to extend his or her leave beyond their expected return date or fails to return on their expected date, fails to respond, and is not terminated.

☒ I agree to submit form 1510 - Return from Leave when the employee returns to work.

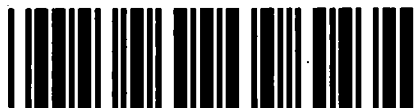
☒ TIME must be coded for all paid and unpaid leave taken by the employee.

9. MANAGER SIGNATURE - (Required if not submitted online.)

* Manager Signature

* Date (mm/dd/yyyy)

National HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist



LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

Instructions: 1. To ensure efficient and effective service please, submit form online.
2. Items marked with an asterisk (*) are required fields.
3. Immediate confirmation will be sent to you upon receipt of your online submittal.
4. **Supervisor/Manager:** Complete Leave of Absence Form for employee. Review Attestations; include applicable notations in the Comments Section on the Request. Be sure to print a copy of Leave of Absence Form before submitting.

* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(562) 657-8527	08/02/2018
* First Name	Middle Name	* Last Name
Darlene		Walls

1. LEAVE INFORMATION

Employee E-mail Address	Alternate Employee Phone Number (###) ###-####	New or Revised Request
		☒ New ☐ Revised

*** Leave Type:**

☒ Medical	☐ Union	☐ Care for Eligible Family Member
☐ Maternity	☐ Personal	☐ Family Military Leave
☐ Workers' Comp/Industrial	☐ Military Service	☐ Bonding

Last Day Worked (mm/dd/yyyy)	* First Day of Leave (mm/dd/yyyy)	Expected Return Date (mm/dd/yyyy)
	08/02/2018	

Is this an intermittent or reduced work schedule Leave? ☒ Intermittent ☐ Reduced Work Schedule ☐ Not Applicable

Is this a Donor Leave? ☐ Yes ☒ No ☐ Unknown

Estimated frequency and duration of absences
tbd by physician

If absence is for Care of Eligible Family Member or Bonding:

Name of Eligible Family Member	Relationship to Employee
Is Family Member age 18 or under? If Yes, enter age ☐ Yes ☐ No	Delivery/Adoption/Foster Care Placement Date (mm/dd/yyyy) ☐ Actual Date ☐ Expected Date
Is the child's other parent employed by Kaiser Permanente? ☐ Yes ☐ No	If Yes, full name of other parent

If absence is due to Family Member's Military Service please select the reason(s) that apply:

Name of Eligible Family Member	Relationship to Employee

☐ **Qualifying Exigency**, (matters related to deployment such as Child Care issues, Financial Planning, and Family Support Sessions, Seeing off leaving or returning Service Members.)

☐ **Care for qualified Service Member who incurred injury or illness in the line of duty**

National HR Service Center
Fax to: (877) 477-2329
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Next Page >

* First Name	Middle Name	* Last Name
Darlene		Walls
*** Employee ID**	*** Contact Phone Number (###) ###-####**	*** Effective Date (mm/dd/yyyy)**
00530105	(562) 657-8527	08/02/2018

1. LEAVE INFORMATION - (Continued)

If absence is for Employee's own health condition (Medical, Maternity or Workers' Comp/Industrial)

Date of illness or injury (mm/dd/yyyy)	Was hospitalization required?	Date Hospitalized (mm/dd/yyyy)
08/02/2018	☐ Yes ☒ No ☐ Unknown	

Estimated/Actual hours worked on last day	If Leave is due to maternity	Delivery Date (mm/dd/yyyy)
8	☐ Actual Delivery Date ☐ Expected Delivery Date	

If absence is pregnancy related, does the employee plan to take Bonding time immediately after the pregnancy related absence is complete?

☐ Yes ☐ No

If absence is for Union Leave

Type of Union Leave:

☐ Short Term (30 days or less) ☐ Long Term (greater than 30 days) ☐ Elected Official

Name of Union

If absence is for Military Leave

Is this absence for Military Training or Active Duty?

☐ Military Training ☐ Active Duty

*** If for Personal Leave, indicate reason**

Temporary Agency or Military Service (asked for FMLA eligibility)

Has the Employee worked for Kaiser Permanente less than one year?

☐ Yes ☒ No

Has the Employee been on active Military Duty in the past 12 months?	Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)
☐ Yes ☒ No		

Did the Employee work for Kaiser Permanente with a Temporary Agency in the year before they were hired?

☐ Yes ☐ No

National HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist

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LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

* First Name	Middle Name	* Last Name
Darlene		Walls
*** Employee ID**	*** Contact Phone Number (###) ###-####**	*** Effective Date (mm/dd/yyyy)**
00530105	(562) 657-8527	08/02/2018

1. LEAVE INFORMATION - (Continued)

Name of Agency		
Start Date (mm/dd/yyyy)	**End Date (mm/dd/yyyy)**	**Agency Phone Number (###) ###-####**

2. COMMENTS

AR 09/05/18-1480 submitted on behalf of manager. Eh

3. EMPLOYEE SCHEDULE

This information is essential for the NHRSC to prepare a worksheet to assist with TIME coding. This is required for employees absent for their own disability. Please use a 24 hr clock: 00:00 thru 24:00.

NOTE: This section is not applicable for the KRONOS regions.

Week 1

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start Time: (hh:mm)							
Hours:							

Week 2 (Only needed if schedule changes week to week)

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start Time: (hh:mm)							
Hours:							

4. REQUEST PAID TIME-OFF

Review your Collective Bargaining Agreement and/or Summary Plan Description Booklet before completing this section. Selections made here will not supersede conditions set in Collective Bargaining Agreements, Summary Plan Descriptions, KP and HR Policies, or applicable State and Federal Laws.

Did employee request EarnedTime Off (ETO)/Paid Time Off (PTO)/Vacation? ☐ Yes ☐ No	☐ Use all available hours ☐ Use selected hours	Number of hours
Did employee request to use Extended Sick Leave (ESL)/Sick Leave? ☐ Yes ☐ No	☐ Use all available hours ☐ Use selected hours	Number of hours
Did employee request to use Float Holidays? ☐ Yes ☐ No	Only available Float Holidays will be applied.	Number of days

National HR Service Center
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Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist

1494 LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

* First Name	Middle Name	* Last Name
Darlene		Walls
*** Employee ID**	*** Contact Phone Number (###) ###-####**	*** Effective Date (mm/dd/yyyy)**
00530105	(562) 657-8527	08/02/2018

4. REQUEST PAID TIME-OFF - (Continued)

Did employee request to use Flexible Personal Days? ☐ Yes ☐ No	Number of days	OR	Number of hours

Note: Flexible Personal Days can only be used in full day or two hour increments. Only available Flexible Personal Days will be applied.

Did employee request Military Make-up Pay?

☐ Yes ☐ No

5. SUBMITTED BY

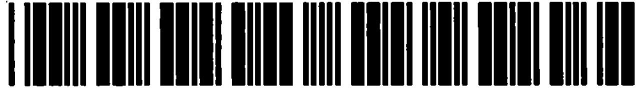
* Name (First, MI, Last)	
Erik A Humbert	
*** Employee ID**	*** Title**
00677786	
*** E-mail Address**	*** Work Phone Number (###) ###-####**
erik.ahumbert@kp.org	(562) 622-4029

6. MANAGER INFORMATION DETAIL

* Name (First, MI, Last)	
erik humbert	
Supervisor ID	*** Title**
*** E-mail Address**	*** Work Phone Number (###) ###-####**
erik.a.humbert@kp.org	(562) 657-8527

7. ALTERNATE CONTACT INFORMATION - Someone, in addition to the Manager, who should receive leave communication (i.e. time coding, fmla status, etc)

* Name (First, MI, Last)	
*** E-mail Address**	*** Work Phone Number (###) ###-####**



1494 LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

* First Name	Middle Name	* Last Name
Darlene		Walls
*** Employee ID**	*** Contact Phone Number (###) ###-####**	*** Effective Date (mm/dd/yyyy)**
00530105	(562) 657-8527	08/02/2018

8. MANAGER ATTESTATION

* Checking these items acknowledges that you have read and understand each item.

☒ I agree to direct the employee requesting Leave to submit any and all supporting documentation to me or the National HR Service Center.

☒ I agree to submit form 1500 - Extend Leave and any supporting documentation at the time I learn that the employee intends to extend his or her leave beyond their expected return date or fails to return on their expected date, fails to respond, and is not terminated.

☒ I agree to submit form 1510 - Return from Leave when the employee returns to work.

☒ TIME must be coded for all paid and unpaid leave taken by the employee.

9. MANAGER SIGNATURE - (Required if not submitted online.)

* Manager Signature	* Date (mm/dd/yyyy)

National HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist

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National HR Service Center

October 5, 2018

Employee ID: 00530105
Case Number: 3039373

Darlene Walls
16323 cortuna ave # 8
Bellflower, CA 90706

Subject: Notice of Eligibility - Under the Family and Medical Leave Act/California Family Rights Act (Family Leave)

Dear Darlene Walls,

On 09/25/18, we were informed that you needed leave beginning on 08/13/18 for:

☐ The birth of a child, or placement of a child with you for adoption or foster care.

☒ Your own serious health condition.

☐ Your need to care for your <spouse child parent domestic partner family member> due to his/her serious health condition.

☐ An exigency arising out of the fact that your <spouse son or daughter parent> is on active duty or call to active duty status.

☐ Your need to care for your <spouse son or daughter parent next of kin> due to his/her serious injury or illness incurred in the line of duty as a covered servicemember.

This notice is to inform you that you have met the eligibility requirements for FMLA/CFRA

Your eligibility was determined based on the information available to us on 10/05/18. To qualify for FMLA/CFRA you must meet the eligibility requirements at the beginning of your leave. Please refer to the attached *Employee Rights and Responsibilities* regarding eligibility criteria or requirements. Should your employment status change prior to the start of your leave, you may not qualify for FMLA/CFRA.

Approval of your request for leave under the FMLA/CFRA is pending receipt of the documentation indicated below. The documentation must be provided to the NHRSC by 10/23/18 or your leave may be denied.

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National HR Service Center

- [x] Sufficient certification to support your request for FMLA/CFRA leave.
  - [x] 1451 Employee - Certification of Physician
  - [ ] 1452 Family Member - Certification of Physician
  - [ ] 1453 Service Member - Certification of Physician
- [ ] Sufficient certification to indicate your adult child is incapable of self-care because of a physical or mental disability. Certification may be provided on the enclosed 1452 Family Member - Certification of Physician.
- [ ] Sufficient documentation to establish the required relationship between you and your family member; proof of <birth marriage adoption/foster care domestic partner relationship next of kin>.
- [ ] Military Orders
- [ ] 1454 - Military Exigency - Certification
- [ ] Other:

- [ ] The certification you provided is not complete and sufficient to determine whether the FMLA/CFRA applies to your leave request. You must provide the following information no later than <mm/dd/yyyy>, or your leave may be denied, unless it is not practicable under the particular circumstances despite your diligent good faith efforts.
  - [ ] The information provided on the Certification of Physician/Provider does not meet the definition of a serious health condition. A list of the definitions is attached for your reference.
  - [ ] The Certification of Physician/Provider does not include the Frequency and Duration for intermittent leave.
  - [ ] The Certification of Physician/Provider does not indicate your adult child is incapable of self-care because of a physical or mental disability.
  - [ ] The information provided failed to establish the required relationship between you and your family member; proof of <birth marriage adoption/foster care domestic partner relationship next of kin>.
  - [ ] Military Orders

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National HR Service Center

☐ 1453 - Service Member - Certification of Physician

☐ 1454 - Military Exigency - Certification

☐ Other:

Please fax the required document(s) to the National HR Service Center at **1-877-HRSC-FAX (1-877-477-2329).** Or mail the forms to:

Kaiser Permanente National HR Service Center
PO Box 2074
Oakland, CA 94604-2074

Once we obtain the information from you as specified above, we will inform you whether your leave will be designated as FMLA/CFRA leave and count towards your FMLA/CFRA leave entitlement.

Please note: Failure to provide the sufficient certification may result in delay or denial of your Family Leave.

The *Employee Rights and Responsibilities* and the definitions of a *Serious Health Condition* under the FMLA are attached for your review. Policies, bargaining agreements and other information regarding leaves of absence can be found on My HR.

If you have any questions or concerns regarding your request for family leave, please contact Work Absence Management (WAM) at the National HR Service Center at **877-4KP-HRSC (877-457-4772).** Please reference the case number located in the upper right-hand corner of this letter.

Sincerely,

Work Absence Management (WAM)
National HR Service Center

Enclosures:

☒ 1451 Employee - Certification of Physician
☐ 1452 Family Member - Certification of Physician
☐ 1453 Service Member - Certification of Physician
☐ 1454 - Military Exigency - Certification
☐ 2090 - Supplement to Sick Leave Request
☐ 2520 - Personal Data Change

KAISER PERMANENTE®
National HR Service Center

EMPLOYEE RIGHTS AND RESPONSIBILITIES
UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

Basic Leave Entitlement
FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:
- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements
Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is a current member of the Armed forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the service member medically unfit to perform his or her duties for which the service member is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections
During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements
Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition
A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or 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 t he qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave
An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave
Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities
Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities
Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility. Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA protected, the employer must notify the employee.

Unlawful Acts by Employers
FMLA makes it unlawful for any employer to:
- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement
An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

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National HR Service Center

Family and Medical Leave Act (FMLA)

"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.

Condition	Details
Inpatient Care	An overnight stay in a hospital, hospice, or residential medical-care facility, including any period of incapacity (i.e. inability to work, attend school, or perform other regular daily activities) or subsequent treatment in connection with such inpatient care.

Continuing treatment by a health care provider including one or more of the following:

a) Incapacity and Treatment	A period of incapacity lasting more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that **also** includes: • Treatment two or more times by or under the supervision of a health care provider (i.e. in-person visits, the first within 7 days and both within 30 days of the first day of incapacity); **or** One treatment by a health care provider (i.e., an in-person visit within 7 days of the first day of incapacity) with a continuing regimen of treatment (e.g., prescription medication, physical therapy).
b) Pregnancy	Any period of incapacity related to pregnancy or for prenatal care.
c) Chronic Conditions	Any period of incapacity or treatment for a chronic serious health condition. Requires periodic visits (at least twice a year) for treatment by, or under direct supervision of a health care provider. Continues over an extended period of time and may cause episodic rather than a continuing period of incapacity.
d) Permanent/Long-Term Conditions	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.
e) Conditions requiring multiple treatments	Any absences of incapacity to receive multiple treatments (including any period of recovery) 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 days if not treated.

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National HR Service Center

October 8, 2018

Employee ID: 00530105
Case Number: 2863571

Darlene Walls
16323 cortuna ave # 8
Bellflower, CA 90706

Subject: Notice of Eligibility - Under the Family and Medical Leave Act/California Family Rights Act (Family Leave)

Dear Darlene Walls,

On 09/05/2018, we were informed that you needed leave beginning on 08/02/2018 for:

☐ The birth of a child, or placement of a child with you for adoption or foster care.

☒ Your own serious health condition.

☐ Your need to care for your <spouse child parent domestic partner family member> due to his/her serious health condition.

☐ An exigency arising out of the fact that your <spouse son or daughter parent> is on active duty or call to active duty status.

☐ Your need to care for your <spouse son or daughter parent next of kin> due to his/her serious injury or illness incurred in the line of duty as a covered servicemember.

This notice is to inform you that you have met the eligibility requirements for FMLA/CFRA

Your eligibility was determined based on the information available to us on 10/08/2018. To qualify for FMLA/CFRA you must meet the eligibility requirements at the beginning of your leave. Please refer to the attached *Employee Rights and Responsibilities* regarding eligibility criteria or requirements. Should your employment status change prior to the start of your leave, you may not qualify for FMLA/CFRA.

Approval of your request for leave under the FMLA/CFRA is pending receipt of the documentation indicated below. The documentation must be provided to the NHRSC by 10/26/2018 or your leave may be denied.

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National HR Service Center

☒ Sufficient certification to support your request for FMLA/CFRA leave.

☒ 1451 Employee - Certification of Physician

☐ 1452 Family Member - Certification of Physician

☐ 1453 Service Member - Certification of Physician

☐ Sufficient certification to indicate your adult child is incapable of self-care because of a physical or mental disability. Certification may be provided on the enclosed 1452 Family Member - Certification of Physician.

☐ Sufficient documentation to establish the required relationship between you and your family member; proof of <birth marriage adoption/foster care domestic partner relationship next of kin>.

☐ Military Orders

☐ 1454 - Military Exigency - Certification

☐ Other:

☐ The certification you provided is not complete and sufficient to determine whether the FMLA/CFRA applies to your leave request. You must provide the following information no later than <mm/dd/yyyy>, or your leave may be denied, unless it is not practicable under the particular circumstances despite your diligent good faith efforts.

☐ The information provided on the Certification of Physician/Provider does not meet the definition of a serious health condition. A list of the definitions is attached for your reference.

☐ The Certification of Physician/Provider does not include the Frequency and Duration for intermittent leave.

☐ The Certification of Physician/Provider does not indicate your adult child is incapable of self-care because of a physical or mental disability.

☐ The information provided failed to establish the required relationship between you and your family member; proof of <birth marriage adoption/foster care domestic partner relationship next of kin>.

☐ Military Orders

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☐ 1453 - Service Member - Certification of Physician

☐ 1454 - Military Exigency - Certification

☐ Other:

Please fax the required document(s) to the National HR Service Center at **1-877-HRSC-FAX (1-877-477-2329).** Or mail the forms to:

Kaiser Permanente National HR Service Center
PO Box 2074
Oakland, CA 94604-2074

Once we obtain the information from you as specified above, we will inform you whether your leave will be designated as FMLA/CFRA leave and count towards your FMLA/CFRA leave entitlement.

Please note: Failure to provide the sufficient certification may result in delay or denial of your Family Leave.

The *Employee Rights and Responsibilities* and the definitions of a *Serious Health Condition* under the FMLA are attached for your review. Policies, bargaining agreements and other information regarding leaves of absence can be found on My HR.

If you have any questions or concerns regarding your request for family leave, please contact Work Absence Management (WAM) at the National HR Service Center at **877-4KP-HRSC (877-457-4772).** Please reference the case number located in the upper right-hand corner of this letter.

Sincerely,

Work Absence Management (WAM)
National HR Service Center

Enclosures:

☒ 1451 Employee - Certification of Physician
☐ 1452 Family Member - Certification of Physician
☐ 1453 Service Member - Certification of Physician
☐ 1454 - Military Exigency - Certification
☐ 2090 - Supplement to Sick Leave Request
☐ 2520 - Personal Data Change

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National HR Service Center

EMPLOYEE RIGHTS AND RESPONSIBILITIES
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Benefits and Protections
During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements
Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition
A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or 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 t he qualified family member from participating in school or other daily activities.

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Use of Leave
An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

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Employee Responsibilities
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Employer Responsibilities
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Unlawful Acts by Employers
FMLA makes it unlawful for any employer to:
- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement
An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

KAISER PERMANENTE®
National HR Service Center

November 8, 2018

Employee ID: 00530105
Case Number: 2863571

Darlene Walls
16323 cortuna ave # 8
Bellflower, CA 90706

Subject: Designation for Family Leave under the Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA)

Dear Darlene,

On 09/05/2018, we were informed that you needed leave beginning on 08/02/2018 for:

☐ The birth of a child, or placement of a child with you for adoption or foster care.

☒ Your own serious health condition.

☐ Your need to care for your <spouse child parent domestic partner family member> due to his/her serious health condition.

☐ An exigency arising out of the fact that your <spouse son or daughter parent> is on active duty or call to active duty status.

☐ Your need to care for your <spouse son or daughter parent next of kin> due to his/her serious injury or illness incurred in the line of duty as a covered service member.

We reviewed your eligibility for leave under the FMLA/CFRA, and your supporting documentation, and determined that your FMLA/CFRA leave is approved. All leave taken for the reason checked above will be designated as FMLA/CFRA leave as long as you are eligible.

Your eligibility was determined based on the information available to us on 11/08/2018. To qualify for FMLA/CFRA you must meet the eligibility requirements at the beginning of your leave. Should your employment status change prior to the start of your leave, you may not qualify for FMLA/CFRA. The FMLA/CFRA requires that you notify us as soon as practicable if dates of scheduled leave change or are extended, or were initially unknown.

Provided there is no deviation from your anticipated leave schedule, and based on the information available to date, you are eligible for 372.96 hours which will be counted against your leave entitlement.

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☒ Our records indicate you have used 128 hours during the immediately preceding 12 months. As of 08/002/2018 your remaining hours are: 244.96

☐ Your continuous Family Leave begins on <Enter Date> and ends on <Enter Date>.

☒ Your intermittent Family Leave begins on 08/02/2018 and ends on 01/13/2019. You are approved for the following frequency and duration of leave:

Frequency: 2 episodes per month
Duration: 1 day per episode

Family Leave

- Family Leave entitles you to up to twelve (12) workweeks of leave in a twelve (12) month rolling period. Military Caregiver leave is limited to 26 workweeks in a single 12 month period.
- FMLA/CFRA runs concurrently with Occupational leaves of absence and time off under Kin Care/CESLA when it is for an FMLA/CFRA qualifying reason.
- CFRA leave to care for a domestic partner with a serious health condition does not run concurrently with FMLA leave.
- An employee's pay status during Family Leave is determined in accordance with applicable laws, regional policies, and collective bargaining agreements.
- When taking Family Leave for one's own non work-related and non pregnancy-related illness/injury, an employee is required to use any available Sick/Extended Sick leave benefits.
- An employee may elect, but is not required, to use ETO, vacation or FPD hours while on FMLA/CFRA leave to care for his/her own serious health condition, or to care for a child, spouse, domestic partner, or parent.
- Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations.
- Re-certification may be required every 30 calendar days or if there has been a significant change in circumstances.

If your Family Leave is related to Pregnancy

California Pregnancy Disability Leave (PDL) and FMLA run concurrently. You may be eligible for up to, an additional 12 workweeks of leave under the California Family Rights Act (CFRA) for bonding with your newborn child. Your time off for bonding will count towards your CFRA entitlement. Any remaining FMLA entitlement will run concurrently with your bonding time under CFRA.

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National HR Service Center

Intermittent Family Leave

As an eligible employee, you are entitled to take Family Leave in separate blocks of time or by a reduced work schedule for your own or a family member's serious health condition which requires continuing treatment by a health care provider and which is best accommodated through intermittent time or a reduced work schedule. Any intermittent leave taken under Family Leave shall reduce the amount of remaining Family Leave.

If you wish to take intermittent leave to care for and bond with a child within one year of the birth or placement of the child must take the leave in increments of two weeks or more at a time, with the exception that leaves of less than two weeks can be taken twice during the year.

Continuation of Benefits Under Family Leave

Kaiser Permanente will continue your health and dental benefits for a total of 12 workweeks while you are under Family Leave, whether your leave is paid or unpaid. If you are on Military Caregiver Leave, Kaiser Permanente will continue your health and dental benefits for a total of 26 workweeks in a single 12 month period. While on a paid Family Leave, your other elected benefits will continue, with the exception of the Dependent Care Spending Account.

For information regarding other Employer paid benefits while on an unpaid leave of absence, refer to your respective bargaining agreement or Summary Plan Description.

Life Insurance continues at the employer's expense for a minimum of 30 calendar days following commencement of **unpaid** Family Leave. Collective bargaining agreement provisions of represented employee groups maybe more generous than the Family Leave policy. **You may choose to continue Life Insurance coverage after this time at your own expense. If you wish to do so, you may contact the National HR Service Center (NHRSC) to make the necessary arrangements.**

Dependent enrollment for a newborn or adopted child

You will need to complete benefit enrollment within 31 days of the birth or adoption to ensure coverage for your new dependent.

Enroll on-line at: http://kp.org/myhr:

DAY 1	*Report your Qualifying Event/Family Status Change:* Go to the appropriate life event in the Home and Family section of the left-hand navigation, (i.e. getting married or having a baby) and enter the information requested.
DAY 2	Make benefit changes on-line: Log on and follow the online process to enroll your dependent.

DAY 3	Confirm Benefit change: To confirm that your enrollment was successfully completed, log on and print a confirmation statement for your records.
DAY 4	Submit supporting documents: Be sure to submit any required supporting documentation to the NHRSC.

A copy of your child's certified birth certificate will be required to complete the enrollment. Verification of your dependent's Social Security Number (SSN) may also be required.

DO NOT DELAY YOUR ENROLLMENT! If you need additional time to submit supporting documentation, contact the NHRSC.

If you do not notify the NHRSC within 31 days of the event, *you may have to wait until the next Open Enrollment period to enroll your child.*

Spending Accounts
If you enrolled in a Spending Account (Health Care, Dependent Care or Commuter) please go to the *Benefits, Pay & Employment* section on My HR at http://insidekp.kp.org/myhr/ for eligibility, contributions and any changes due to your leave of absence or return from leave.
If you need an extension of your leave
If you are unable to return to work on the specified return to work date, you are responsible for initiating a request for extension of leave. A request for extension of leave due to disability must be accompanied by a current physician certification from the health care provider. Any additional time off for this qualifying reason will be counted as FMLA up to the maximum time available, provided that sufficient certification is received. Remind your Manager to complete Form 1500 on My HR.

Returning to Work
You are encouraged to notify your supervisor of the intent to return to work at least 2 weeks prior to the expiration of the leave. In addition, if the family leave is due to your own serious health condition, you must provide a physician or practitioner certification form indicating that you are fit to return to work. Remind your Manager to complete Form 1510 on My HR.

The ***Employee Rights and Responsibilities*** under FMLA are attached for your review. Policies, bargaining agreements and other information regarding leaves of absence can be found on My HR at http://insidekp.kp.org/myhr/ or you may contact NHRSC at 877-4KP-HRSC (877-457-4772) and select Leaves of Absence.

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National HR Service Center

Please reference the case number located in the upper right corner of this letter.

Sincerely,

Work Absence Management

Enclosures:

☐ LOA Quick Reference Guide
☐ Supplement to Sick Leave Request - Form 2090
☐ Personal Data Change - Form 2520
☐ Other:

KAISER PERMANENTE®

National HR Service Center

EMPLOYEE RIGHTS AND RESPONSIBILITIES
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Basic Leave Entitlement

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Military Family Leave Entitlements

Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

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Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or 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.

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Use of Leave

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Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

1494 LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

Instructions:
1. To ensure efficient and effective service please, submit form online.
2. Items marked with an asterisk (*) are required fields.
3. Immediate confirmation will be sent to you upon receipt of your online submittal.
4. **Supervisor/Manager:** Complete Leave of Absence Form for employee. Review Attestations; include applicable notations in the Comments Section on the Request. Be sure to print a copy of Leave of Absence Form before submitting.

* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(213) 401-8827	01/17/2019
* First Name	Middle Name	* Last Name
Darlene		Walls

1. LEAVE INFORMATION

Employee E-mail Address	Alternate Employee Phone Number (###) ###-####	New or Revised Request
		☐ New ☐ Revised

*** Leave Type:**

☒ Medical	☐ Union	☐ Care for Eligible Family Member
☐ Maternity	☐ Personal	☐ Family Military Leave
☐ Workers' Comp/Industrial	☐ Military Service	☐ Bonding

Last Day Worked (mm/dd/yyyy)	* First Day of Leave (mm/dd/yyyy)	Expected Return Date (mm/dd/yyyy)
	01/17/2019	

Is this an intermittent or reduced work schedule Leave? ☒ Intermittent ☐ Reduced Work Schedule ☐ Not Applicable

Is this a Donor Leave? ☐ Yes ☐ No ☒ Unknown

Estimated frequency and duration of absences
Frequency 2 times per month
8 hours per episode

If absence is for Care of Eligible Family Member or Bonding:

Name of Eligible Family Member	Relationship to Employee
Is Family Member age 18 or under? If Yes, enter age ☐ Yes ☐ No	Delivery/Adoption/Foster Care Placement Date (mm/dd/yyyy) ☐ Actual Date ☐ Expected Date
Is the child's other parent employed by Kaiser Permanente? ☐ Yes ☐ No	If Yes, full name of other parent

If absence is due to Family Member's Military Service please select the reason(s) that apply:

Name of Eligible Family Member	Relationship to Employee

☐ **Qualifying Exigency,** (matters related to deployment such as Child Care issues, Financial Planning, and Family Support Sessions, Seeing off leaving or returning Service Members.)

☐ **Care for qualified Service Member who incurred injury or illness in the line of duty**

National HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist

Next Page >

LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

* First Name	Middle Name	* Last Name
Darlene		Walls
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(213) 401-8827	01/17/2019

1. LEAVE INFORMATION - (Continued)

If absence is for Employee's own health condition (Medical, Maternity or Workers' Comp/Industrial)

Date of illness or injury (mm/dd/yyyy)	Was hospitalization required?	Date Hospitalized (mm/dd/yyyy)
01/17/2019	☐ Yes ☐ No ☒ Unknown	

Estimated/Actual hours worked on last day	If Leave is due to maternity	Delivery Date (mm/dd/yyyy)
8	☐ Actual Delivery Date ☐ Expected Delivery Date	

If absence is pregnancy related, does the employee plan to take Bonding time immediately after the pregnancy related absence is complete?

☐ Yes ☐ No

If absence is for Union Leave

Type of Union Leave:

☐ Short Term (30 days or less) ☐ Long Term (greater than 30 days) ☐ Elected Official

Name of Union

If absence is for Military Leave

Is this absence for Military Training or Active Duty?

☐ Military Training ☐ Active Duty

*** If for Personal Leave, indicate reason**

Temporary Agency or Military Service (asked for FMLA eligibility)

Has the Employee worked for Kaiser Permanente less than one year?

☐ Yes ☒ No

Has the Employee been on active Military Duty in the past 12 months?	Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)
☐ Yes ☒ No		

Did the Employee work for Kaiser Permanente with a Temporary Agency in the year before they were hired?

☐ Yes ☐ No

National HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist

* First Name	Middle Name	* Last Name
Darlene		Walls
*** Employee ID**	*** Contact Phone Number (###) ###-####**	*** Effective Date (mm/dd/yyyy)**
00530105	(213) 401-8827	01/17/2019

1. LEAVE INFORMATION - (Continued)

Name of Agency		
Start Date (mm/dd/yyyy)	**End Date (mm/dd/yyyy)**	**Agency Phone Number (###) ###-####**

2. COMMENTS

3. EMPLOYEE SCHEDULE

This information is essential for the NHRSC to prepare a worksheet to assist with TIME coding. This is required for employees absent for their own disability. Please use a 24 hr clock: 00:00 thru 24:00.

NOTE: This section is not applicable for the KRONOS regions.

Week 1

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start Time: (hh:mm)							
Hours:							

Week 2 (Only needed if schedule changes week to week)

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start Time: (hh:mm)							
Hours:							

4. REQUEST PAID TIME-OFF

Review your Collective Bargaining Agreement and/or Summary Plan Description Booklet before completing this section. Selections made here will not supersede conditions set in Collective Bargaining Agreements, Summary Plan Descriptions, KP and HR Policies, or applicable State and Federal Laws.

Question	Option	Amount
Did employee request EarnedTime Off (ETO)/Paid Time Off (PTO)/Vacation? ☐ Yes ☐ No	☐ Use all available hours ☐ Use selected hours	Number of hours
Did employee request to use Extended Sick Leave (ESL)/Sick Leave? ☐ Yes ☐ No	☐ Use all available hours ☐ Use selected hours	Number of hours
Did employee request to use Float Holidays? ☐ Yes ☐ No	Only available Float Holidays will be applied.	Number of days

LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

* First Name	Middle Name	* Last Name
Darlene		Walls
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(213) 401-8827	01/17/2019

4. REQUEST PAID TIME-OFF - (Continued)

Did employee request to use Flexible Personal Days?	Number of days	OR	Number of hours
☐ Yes ☐ No			

Note: Flexible Personal Days can only be used in full day or two hour increments. Only available Flexible Personal Days will be applied.

Did employee request Military Make-up Pay?

☐ Yes ☐ No

5. SUBMITTED BY

* Name (First, MI, Last)	
Danny P Jimenez	
* Employee ID	* Title
00685629	
* E-mail Address	* Work Phone Number (###) ###-####
danny.p.jimenez@kp.org	(562) 657-8527

6. MANAGER INFORMATION DETAIL

* Name (First, MI, Last)	
Danny Jimenez	
Supervisor ID	* Title
* E-mail Address	* Work Phone Number (###) ###-####
danny.p.jimenez@kp.org	(562) 657-8527

7. ALTERNATE CONTACT INFORMATION - Someone, in addition to the Manager, who should receive leave communication (i.e. time coding, fmla status, etc)

* Name (First, MI, Last)	
* E-mail Address	* Work Phone Number (###) ###-####

National HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist

* First Name	Middle Name	* Last Name
Darlene		Walls
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(213) 401-8827	01/17/2019

8. MANAGER ATTESTATION

* Checking these items acknowledges that you have read and understand each item.

☒ I agree to direct the employee requesting Leave to submit any and all supporting documentation to me or the National HR Service Center.

☒ I agree to submit form 1500 - Extend Leave and any supporting documentation at the time I learn that the employee intends to extend his or her leave beyond their expected return date or fails to return on their expected date, fails to respond, and is not terminated.

☒ I agree to submit form 1510 - Return from Leave when the employee returns to work.

☒ TIME must be coded for all paid and unpaid leave taken by the employee.

9. MANAGER SIGNATURE - (Required if not submitted online.)

* Manager Signature	* Date (mm/dd/yyyy)

LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

Instructions: 1. To ensure efficient and effective service please, submit form online.
2. Items marked with an asterisk (*) are required fields.
3. Immediate confirmation will be sent to you upon receipt of your online submittal.
4. **Supervisor/Manager:** Complete Leave of Absence Form for employee. Review Attestations; include applicable notations in the Comments Section on the Request. Be sure to print a copy of Leave of Absence Form before submitting.

* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(213) 401-8827	01/16/2019
* First Name	Middle Name	* Last Name
Darlene		Walls.

1. LEAVE INFORMATION

Employee E-mail Address	Alternate Employee Phone Number (###) ###-####	New or Revised Request
		☐ New ☐ Revised

*** Leave Type:**

☒ Medical	☐ Union	☐ Care for Eligible Family Member
☐ Maternity	☐ Personal	☐ Family Military Leave
☐ Workers' Comp/Industrial	☐ Military Service	☐ Bonding

Last Day Worked (mm/dd/yyyy)	* First Day of Leave (mm/dd/yyyy)	Expected Return Date (mm/dd/yyyy)
	01/16/2019	

Is this an intermittent or reduced work schedule Leave? ☒ Intermittent ☐ Reduced Work Schedule ☐ Not Applicable

Is this a Donor Leave? ☐ Yes ☐ No ☒ Unknown

Estimated frequency and duration of absences
Frequency 2 times per 1 month
1 day per episode

If absence is for Care of Eligible Family Member or Bonding:

Name of Eligible Family Member	Relationship to Employee
Is Family Member age 18 or under? If Yes, enter age ☐ Yes ☐ No	Delivery/Adoption/Foster Care Placement Date (mm/dd/yyyy) ☐ Actual Date ☐ Expected Date
Is the child's other parent employed by Kaiser Permanente? ☐ Yes ☐ No	If Yes, full name of other parent

If absence is due to Family Member's Military Service please select the reason(s) that apply:

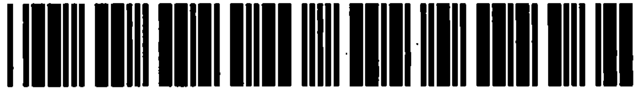
Name of Eligible Family Member	Relationship to Employee

☐ **Qualifying Exigency,** (matters related to deployment such as Child Care issues, Financial Planning, and Family Support Sessions, Seeing off leaving or returning Service Members.)

☐ **Care for qualified Service Member who incurred injury or illness in the line of duty**

National HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist

Next Page >



1494 LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

* First Name	Middle Name	* Last Name
Darlene		Walls
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(213) 401-8827	01/16/2019

1. LEAVE INFORMATION - (Continued)

If absence is for Employee's own health condition (Medical, Maternity or Workers' Comp/Industrial)

Date of illness or injury (mm/dd/yyyy)	Was hospitalization required?	Date Hospitalized (mm/dd/yyyy)
01/16/2019	☐ Yes ☒ No ☐ Unknown	

Estimated/Actual hours worked on last day	If Leave is due to maternity	Delivery Date (mm/dd/yyyy)
8	☐ Actual Delivery Date ☐ Expected Delivery Date	

If absence is pregnancy related, does the employee plan to take Bonding time immediately after the pregnancy related absence is complete?

☐ Yes ☐ No

If absence is for Union Leave

Type of Union Leave:

☐ Short Term (30 days or less) ☐ Long Term (greater than 30 days) ☐ Elected Official

Name of Union

If absence is for Military Leave

Is this absence for Military Training or Active Duty?

☐ Military Training ☐ Active Duty

*** If for Personal Leave, indicate reason**

Temporary Agency or Military Service (asked for FMLA eligibility)

Has the Employee worked for Kaiser Permanente less than one year?

☐ Yes ☒ No

Has the Employee been on active Military Duty in the past 12 months?	Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)
☐ Yes ☒ No		

Did the Employee work for Kaiser Permanente with a Temporary Agency in the year before they were hired?

☐ Yes ☐ No

National HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist

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1494 **LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT**

* First Name	Middle Name	* Last Name
Darlene		Walls
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(213) 401-8827	01/16/2019

1. LEAVE INFORMATION - (Continued)

Name of Agency		
Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)	Agency Phone Number (###) ###-####

2. COMMENTS

3. EMPLOYEE SCHEDULE

This information is essential for the NHRSC to prepare a worksheet to assist with TIME coding. This is required for employees absent for their own disability. Please use a 24 hr clock: 00:00 thru 24:00.

NOTE: This section is not applicable for the KRONOS regions.

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	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start Time: (hh:mm)							
Hours:							

Week 2 (Only needed if schedule changes week to week)

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start Time: (hh:mm)							
Hours:							

4. REQUEST PAID TIME-OFF

Review your Collective Bargaining Agreement and/or Summary Plan Description Booklet before completing this section. Selections made here will not supersede conditions set in Collective Bargaining Agreements, Summary Plan Descriptions, KP and HR Policies, or applicable State and Federal Laws.

Did employee request EarnedTime Off (ETO)/Paid Time Off (PTO)/Vacation? ☐ Yes ☐ No	☐ Use all available hours ☐ Use selected hours	Number of hours
Did employee request to use Extended Sick Leave (ESL)/Sick Leave? ☐ Yes ☐ No	☐ Use all available hours ☐ Use selected hours	Number of hours
Did employee request to use Float Holidays? ☐ Yes ☐ No	Only available Float Holidays will be applied.	Number of days

National HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist

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LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

* First Name	Middle Name	* Last Name
Darlene		Walls
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(213) 401-8827	01/16/2019

4. REQUEST PAID TIME-OFF - (Continued)

Did employee request to use Flexible Personal Days?	Number of days	OR	Number of hours
☐ Yes ☐ No			

Note: Flexible Personal Days can only be used in full day or two hour increments. Only available Flexible Personal Days will be applied.

Did employee request Military Make-up Pay?

☐ Yes ☐ No

5. SUBMITTED BY

* Name (First, MI, Last)	
Danny P Jimenez	
* Employee ID	* Title
00685629	
* E-mail Address	* Work Phone Number (###) ###-####
danny.p.jimenez@kp.org	(562) 657-8527

6. MANAGER INFORMATION DETAIL

* Name (First, MI, Last)	
Danny Jimenez	
Supervisor ID	* Title
* E-mail Address	* Work Phone Number (###) ###-####
danny.p.jimenez@kp.org	(562) 657-8527

7. ALTERNATE CONTACT INFORMATION - Someone, in addition to the Manager, who should receive leave communication (i.e. time coding, fmla status, etc)

* Name (First, MI, Last)	
* E-mail Address	* Work Phone Number (###) ###-####

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LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

* First Name	Middle Name	* Last Name
Darlene		Walls
*** Employee ID**	*** Contact Phone Number (###) ###-####**	*** Effective Date (mm/dd/yyyy)**
00530105	(213) 401-8827	01/16/2019

8. MANAGER ATTESTATION

* Checking these items acknowledges that you have read and understand each item.

☒ I agree to direct the employee requesting Leave to submit any and all supporting documentation to me or the National HR Service Center.

☒ I agree to submit form 1500 - Extend Leave and any supporting documentation at the time I learn that the employee intends to extend his or her leave beyond their expected return date or fails to return on their expected date, fails to respond, and is not terminated.

☒ I agree to submit form 1510 - Return from Leave when the employee returns to work.

☒ TIME must be coded for all paid and unpaid leave taken by the employee.

9. MANAGER SIGNATURE - (Required if not submitted online.)

* Manager Signature	* Date (mm/dd/yyyy)

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National HR Service Center

February 7, 2019

Employee ID: 00530105
Case Number: 3039373

Darlene Walls
16323 cortuna ave # 8
Bellflower, CA 90706

Subject: Designation for Family Leave under the Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA)

Dear Darlene,

On 09/25/2018, we were informed that you needed leave beginning on 08/13/2018 for:

☐ The birth of a child, or placement of a child with you for adoption or foster care.

☒ Your own serious health condition.

☐ Your need to care for your <spouse child parent domestic partner family member> due to his/her serious health condition.

☐ An exigency arising out of the fact that your <spouse son or daughter parent> is on active duty or call to active duty status.

☐ Your need to care for your <spouse son or daughter parent next of kin> due to his/her serious injury or illness incurred in the line of duty as a covered service member.

We reviewed your eligibility for leave under the FMLA/CFRA, and your supporting documentation, and determined that your FMLA/CFRA leave is approved. All leave taken for the reason checked above will be designated as FMLA/CFRA leave as long as you are eligible.

Your eligibility was determined based on the information available to us on 02/07/2019. To qualify for FMLA/CFRA you must meet the eligibility requirements at the beginning of your leave. Should your employment status change prior to the start of your leave, you may not qualify for FMLA/CFRA. The FMLA/CFRA requires that you notify us as soon as practicable if dates of scheduled leave change or are extended, or were initially unknown.

Provided there is no deviation from your anticipated leave schedule, and based on the information available to date, you are eligible for 368.96 hours which will be counted against your leave entitlement.

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☒ Our records indicate you have used 128.00 hours during the immediately preceding 12 months. As of 08/13/2018 your remaining hours are: 240.96 hours.

☐ Your continuous Family Leave begins on <Enter Date> and ends on <Enter Date>.

☒ Your intermittent Family Leave begins on 08/13/2018 and ends on 01/13/2019. You are approved for the following frequency and duration of leave:

Frequency: < 2 episodes per month >
Duration: < 1 day per episode >

Family Leave

- Family Leave entitles you to up to twelve (12) workweeks of leave in a twelve (12) month rolling period. Military Caregiver leave is limited to 26 workweeks in a single 12 month period.
- FMLA/CFRA runs concurrently with Occupational leaves of absence and time off under Kin Care/CESLA when it is for an FMLA/CFRA qualifying reason.
- CFRA leave to care for a domestic partner with a serious health condition does not run concurrently with FMLA leave.
- An employee's pay status during Family Leave is determined in accordance with applicable laws, regional policies, and collective bargaining agreements.
- When taking Family Leave for one's own non work-related and non pregnancy-related illness/injury, an employee is required to use any available Sick/Extended Sick leave benefits.
- An employee may elect, but is not required, to use ETO, vacation or FPD hours while on FMLA/CFRA leave to care for his/her own serious health condition, or to care for a child, spouse, domestic partner, or parent.
- Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations.
- Re-certification may be required every 30 calendar days or if there has been a significant change in circumstances.

If your Family Leave is related to Pregnancy

California Pregnancy Disability Leave (PDL) and FMLA run concurrently. You may be eligible for up to, an additional 12 workweeks of leave under the California Family Rights Act (CFRA) for bonding with your newborn child. Your time off for bonding will count towards your CFRA entitlement. Any remaining FMLA entitlement will run concurrently with your bonding time under CFRA.

Intermittent Family Leave
As an eligible employee, you are entitled to take Family Leave in separate blocks of time or by a reduced work schedule for your own or a family member's serious health condition which requires continuing treatment by a health care provider and which is best accommodated through intermittent time or a reduced work schedule. Any intermittent leave taken under Family Leave shall reduce the amount of remaining Family Leave.

If you wish to take intermittent leave to care for and bond with a child within one year of the birth or placement of the child must take the leave in increments of two weeks or more at a time, with the exception that leaves of less than two weeks can be taken twice during the year.

Continuation of Benefits Under Family Leave
Kaiser Permanente will continue your health and dental benefits for a total of 12 workweeks while you are under Family Leave, whether your leave is paid or unpaid. If you are on Military Caregiver Leave, Kaiser Permanente will continue your health and dental benefits for a total of 26 workweeks in a single 12 month period. While on a paid Family Leave, your other elected benefits will continue, with the exception of the Dependent Care Spending Account.

For information regarding other Employer paid benefits while on an unpaid leave of absence, refer to your respective bargaining agreement or Summary Plan Description.

Life Insurance continues at the employer's expense for a minimum of 30 calendar days following commencement of **unpaid** Family Leave. Collective bargaining agreement provisions of represented employee groups maybe more generous than the Family Leave policy. **You may choose to continue Life Insurance coverage after this time at your own expense. If you wish to do so, you may contact the National HR Service Center (NHRSC) to make the necessary arrangements.**

Dependent enrollment for a newborn or adopted child
You will need to complete benefit enrollment within 31 days of the birth or adoption to ensure coverage for your new dependent.

Enroll on-line at: http://kp.org/myhr:

DAY 1	*Report your Qualifying Event/Family Status Change:* Go to the appropriate life event in the Home and Family section of the left-hand navigation, (i.e. getting married or having a baby) and enter the information requested.
DAY 2	Make benefit changes on-line: Log on and follow the online process to enroll your dependent.

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National HR Service Center

DAY 3	Confirm Benefit change: To confirm that your enrollment was successfully completed, log on and print a confirmation statement for your records.
DAY 4	Submit supporting documents: Be sure to submit any required supporting documentation to the NHRSC.

A copy of your child's certified birth certificate will be required to complete the enrollment. Verification of your dependent's Social Security Number (SSN) may also be required.

DO NOT DELAY YOUR ENROLLMENT! If you need additional time to submit supporting documentation, contact the NHRSC.

If you do not notify the NHRSC within 31 days of the event, *you may have to wait until the next Open Enrollment period to enroll your child.*

Spending Accounts

If you enrolled in a Spending Account (Health Care, Dependent Care or Commuter) please go to the *Benefits, Pay & Employment* section on My HR at http://insidekp.kp.org/myhr/ for eligibility, contributions and any changes due to your leave of absence or return from leave.

If you need an extension of your leave

If you are unable to return to work on the specified return to work date, you are responsible for initiating a request for extension of leave. A request for extension of leave due to disability must be accompanied by a current physician certification from the health care provider. Any additional time off for this qualifying reason will be counted as FMLA up to the maximum time available, provided that sufficient certification is received. Remind your Manager to complete Form 1500 on My HR.

Returning to Work

You are encouraged to notify your supervisor of the intent to return to work at least 2 weeks prior to the expiration of the leave. In addition, if the family leave is due to your own serious health condition, you must provide a physician or practitioner certification form indicating that you are fit to return to work. Remind your Manager to complete Form 1510 on My HR.

The ***Employee Rights and Responsibilities*** under FMLA are attached for your review. Policies, bargaining agreements and other information regarding leaves of absence can be found on My HR at http://insidekp.kp.org/myhr/ or you may contact NHRSC at 877-4KP-HRSC (877-457-4772) and select Leaves of Absence.

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Please reference the case number located in the upper right corner of this letter.

Sincerely,

Work Absence Management

Enclosures:

- [x] LOA Quick Reference Guide
- [ ] Supplement to Sick Leave Request - Form 2090
- [ ] Personal Data Change - Form 2520
- [ ] Other:

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National HR Service Center

EMPLOYEE RIGHTS AND RESPONSIBILITIES
UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

Basic Leave Entitlement
FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:
- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements
Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is a current membe r o f the Armed forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections
During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements
Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition
A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or 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.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave
An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave
Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities
Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities
Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility. Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA protected, the employer must notify the employee.

Unlawful Acts by Employers
FMLA makes it unlawful for any employer to:
- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement
An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

KAISER PERMANENTE®
National HR Service Center

February 7, 2019

Employee ID: 00530105
Case Number: 3039373

Darlene Walls
16323 cortuna ave # 8
Bellflower, CA 90706

Subject: Family Leave Extension under the Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA)

Dear Darlene Walls,

On 02/04/2019, we were informed that you requested an extension of your leave that began on 08/13/2018 for:

☐ The birth of a child, or placement of a child with you for adoption or foster care.

☒ Your own serious health condition.

☐ Your need to care for your <spouse child parent domestic partner family member> due to his/her serious health condition.

☐ An exigency arising out of the fact that your <spouse son or daughter parent> is on active duty or call to active duty status.

☐ Your need to care for your <spouse son or daughter parent next of kin> due to his/her serious injury or illness incurred in the line of duty as a covered servicemember.

☒ This Notice is to inform you that your request for an extension has been approved for the period: 01/16/2019 to 07/16/2019. Additionally, your FMLA/CFRA will be exhausted effective 08/12/2019.

You were approved for intermittent FMLA/CFRA, for the approved frequency 2 episodes per month and duration 1 day per episode of your absences.

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National HR Service Center

☐ This Notice is to inform you that, while you remain eligible for leave under the FMLA/CFRA, approval of your request is pending receipt of sufficient certification to support your request for FMLA/CFRA leave, as indicated below. The documentation must be provided to the NHRSC by <Enter Date>, or your request for an extension may be denied.

- ☐ 1451 Employee - Certification of Physician
- ☐ 1452 Family Member - Certification of Physician
- ☐ Other:

☐ This Notice is to inform you that your request for an extension is **denied** because:

- ☐ You exhausted your <12 26>-workweek entitlement to leave under <FMLA/CFRA CFRA> effective <Enter Date>.
- ☐ A Health Care Provider Certification form was not received.
- ☐ The certification document you submitted was not sufficient to support your request.
- ☐ Other:

The *Employee Rights and Responsibilities* under the FMLA are attached for your review.

If your request for an extension of family leave is denied, your time off is not protected under FMLA/CFRA. Please refer to the *Employee Rights and Responsibilities* for eligibility criteria and requirements. You may be eligible for other types of leave under Kaiser's HR Policies or under an applicable Collective Bargaining Agreement. If your leave is the result of a work-related injury, it may be subject to Workers' Compensation leave protection.

HR Policies, Collective Bargaining Agreements and other information regarding leaves of absence can be found on My HR at insidekp.kp.org/myhr.

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If you have any questions or concerns regarding the status of your request for an extension of family leave, please contact Work Absence Management (WAM) at the National HR Service Center at **877-4KP-HRSC (877-457-4772).** Please reference the case number located in the upper right-hand corner of this letter.

Sincerely,

Work Absence Management
Kaiser Permanente National HR Service Center

Enclosures:

☐ 1451 Employee - Certification of Physician
☐ 1452 Family Member - Certification of Physician
☐ Other:

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EMPLOYEE RIGHTS AND RESPONSIBILITIES
UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

Basic Leave Entitlement
FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:
- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements
Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is a current member of the Armed forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the service member medically unfit to perform his or her duties for which the service member is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections
During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements
Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition
A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or 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.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave
An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave
Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities
Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities
Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility. Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA protected, the employer must notify the employee.

Unlawful Acts by Employers
FMLA makes it unlawful for any employer to:
- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement
An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

Instructions: 1. To ensure efficient and effective service please, submit form online.
2. Items marked with an asterisk (*) are required fields.
3. Immediate confirmation will be sent to you upon receipt of your online submittal.
4. **Supervisor/Manager:** Complete Leave of Absence Form for employee. Review Attestations; include applicable notations in the Comments Section on the Request. Be sure to print a copy of Leave of Absence Form before submitting.

* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(562) 657-8527	04/11/2019
* First Name	Middle Name	* Last Name
Darlene		Walls

1. LEAVE INFORMATION

Employee E-mail Address	Alternate Employee Phone Number (###) ###-####	New or Revised Request
		☒ New ☐ Revised

*** Leave Type:**

☒ Medical	☐ Union	☐ Care for Eligible Family Member
☐ Maternity	☐ Personal	☐ Family Military Leave
☐ Workers' Comp/Industrial	☐ Military Service	☐ Bonding

Last Day Worked (mm/dd/yyyy)	* First Day of Leave (mm/dd/yyyy)	Expected Return Date (mm/dd/yyyy)
	04/11/2019	

Is this an intermittent or reduced work schedule Leave? ☒ Intermittent ☐ Reduced Work Schedule ☐ Not Applicable

Is this a Donor Leave? ☐ Yes ☒ No ☐ Unknown

Estimated frequency and duration of absences
tbd by physician

If absence is for Care of Eligible Family Member or Bonding:

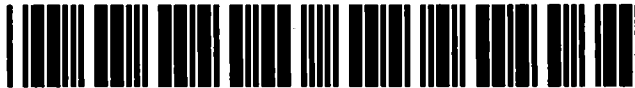
Name of Eligible Family Member	Relationship to Employee
Is Family Member age 18 or under? If Yes, enter age ☐ Yes ☐ No	Delivery/Adoption/Foster Care Placement Date (mm/dd/yyyy) ☐ Actual Date ☐ Expected Date
Is the child's other parent employed by Kaiser Permanente? ☐ Yes ☐ No	If Yes, full name of other parent

If absence is due to Family Member's Military Service please select the reason(s) that apply:

Name of Eligible Family Member	Relationship to Employee

☐ **Qualifying Exigency**, (matters related to deployment such as Child Care issues, Financial Planning, and Family Support Sessions, Seeing off leaving or returning Service Members.)

☐ **Care for qualified Service Member who incurred injury or illness in the line of duty**



* First Name	Middle Name	* Last Name
Darlene		Walls
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(562) 657-8527	04/11/2019

1. LEAVE INFORMATION - (Continued)

If absence is for Employee's own health condition (Medical, Maternity or Workers' Comp/Industrial)

Date of illness or injury (mm/dd/yyyy)	Was hospitalization required?	Date Hospitalized (mm/dd/yyyy)
04/11/2019	☐ Yes ☒ No ☐ Unknown	

Estimated/Actual hours worked on last day	If Leave is due to maternity	Delivery Date (mm/dd/yyyy)
8	☐ Actual Delivery Date ☐ Expected Delivery Date	

If absence is pregnancy related, does the employee plan to take Bonding time immediately after the pregnancy related absence is complete?

☐ Yes ☐ No

If absence is for Union Leave

Type of Union Leave:

☐ Short Term (30 days or less) ☐ Long Term (greater than 30 days) ☐ Elected Official

Name of Union

If absence is for Military Leave

Is this absence for Military Training or Active Duty?

☐ Military Training ☐ Active Duty

*** If for Personal Leave, indicate reason**

Temporary Agency or Military Service (asked for FMLA eligibility)

Has the Employee worked for Kaiser Permanente less than one year?

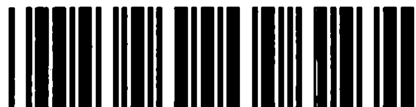
☐ Yes ☒ No

Has the Employee been on active Military Duty in the past 12 months?	Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)
☐ Yes ☒ No		

Did the Employee work for Kaiser Permanente with a Temporary Agency in the year before they were hired?

☐ Yes ☐ No

National HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist



LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

* First Name	Middle Name	* Last Name
Darlene		Walls
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(562) 657-8527	04/11/2019

1. LEAVE INFORMATION - (Continued)

Name of Agency		
Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)	Agency Phone Number (###) ###-####

2. COMMENTS

AR 06/04/19-1480 submitted on behalf of manager. EH

3. EMPLOYEE SCHEDULE

This information is essential for the NHRSC to prepare a worksheet to assist with TIME coding. This is required for employees absent for their own disability. Please use a 24 hr clock: 00:00 thru 24:00.

NOTE: This section is not applicable for the KRONOS regions.

Week 1

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start Time: (hh:mm)							
Hours:							

Week 2 (Only needed if schedule changes week to week)

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start Time: (hh:mm)							
Hours:							

4. REQUEST PAID TIME-OFF

Review your Collective Bargaining Agreement and/or Summary Plan Description Booklet before completing this section. Selections made here will not supersede conditions set in Collective Bargaining Agreements, Summary Plan Descriptions, KP and HR Policies, or applicable State and Federal Laws.

Did employee request EarnedTime Off (ETO)/Paid Time Off (PTO)/Vacation? ☐ Yes ☐ No	☐ Use all available hours ☐ Use selected hours	Number of hours
Did employee request to use Extended Sick Leave (ESL)/Sick Leave? ☐ Yes ☐ No	☐ Use all available hours ☐ Use selected hours	Number of hours
Did employee request to use Float Holidays? ☐ Yes ☐ No	Only available Float Holidays will be applied.	Number of days

* First Name	Middle Name	* Last Name
Darlene		Walls
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(562) 657-8527	04/11/2019

4. REQUEST PAID TIME-OFF - (Continued)

Did employee request to use Flexible Personal Days? ☐ Yes ☐ No	Number of days	OR	Number of hours
Note: Flexible Personal Days can only be used in full day or two hour increments. Only available Flexible Personal Days will be applied.			
Did employee request Military Make-up Pay? ☐ Yes ☐ No			

5. SUBMITTED BY

* Name (First, MI, Last)	
Erik A Humbert	
* Employee ID: 00677786	* Title:
* E-mail Address: erik.a.humbert@kp.org	* Work Phone Number (###) ###-####: (562) 622-4029

6. MANAGER INFORMATION DETAIL

* Name (First, MI, Last)	
danny jimenez	
Supervisor ID:	* Title:
* E-mail Address: danny.p.jimenez@kp.org	* Work Phone Number (###) ###-####: (562) 657-8527

7. ALTERNATE CONTACT INFORMATION - Someone, in addition to the Manager, who should receive leave communication (i.e. time coding, fmla status, etc)

* Name (First, MI, Last)	
* E-mail Address	* Work Phone Number (###) ###-####

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* First Name	Middle Name	* Last Name
Darlene		Walls
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(562) 657-8527	04/11/2019

8. MANAGER ATTESTATION

* Checking these items acknowledges that you have read and understand each item.

☒ I agree to direct the employee requesting Leave to submit any and all supporting documentation to me or the National HR Service Center.

☒ I agree to submit form 1500 - Extend Leave and any supporting documentation at the time I learn that the employee intends to extend his or her leave beyond their expected return date or fails to return on their expected date, fails to respond, and is not terminated.

☒ I agree to submit form 1510 - Return from Leave when the employee returns to work.

☒ TIME must be coded for all paid and unpaid leave taken by the employee.

9. MANAGER SIGNATURE - (Required if not submitted online.)

* Manager Signature	* Date (mm/dd/yyyy)

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National HR Service Center

July 2, 2019

Employee ID: 00530105
Case Number: 4550201

Darlene Walls
16323 cortuna ave # 8
Bellflower, CA 90706

Subject: Notice of Eligibility - Under the Family and Medical Leave Act/California Family Rights Act (Family Leave)

Dear Darlene Walls,

On 06/04/19 we were informed that you needed leave beginning on 04/11/19 for:

☐ The birth of a child, or placement of a child with you for adoption or foster care.

☒ Your own serious health condition.

☐ Your need to care for your <spouse child parent domestic partner family member> due to his/her serious health condition.

☐ An exigency arising out of the fact that your <spouse son or daughter parent> is on active duty or call to active duty status.

☐ Your need to care for your <spouse son or daughter parent next of kin> due to his/her serious injury or illness incurred in the line of duty as a covered servicemember.

This notice is to inform you that you have met the eligibility requirements for FMLA/CFRA

Your eligibility was determined based on the information available to us on 07/02/19.

To qualify for FMLA/CFRA you must meet the eligibility requirements at the beginning of your leave. Please refer to the attached *Employee Rights and Responsibilities* regarding eligibility criteria or requirements. Should your employment status change prior to the start of your leave, you may not qualify for FMLA/CFRA.

Approval of your request for leave under the FMLA/CFRA is pending receipt of the documentation indicated below. The documentation must be provided to the NHRSC by 07/20/19 or your leave may be denied.

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National HR Service Center

- ☒ Sufficient certification to support your request for FMLA/CFRA leave.
  - ☒ 1451 Employee - Certification of Physician
  - ☐ 1452 Family Member - Certification of Physician
  - ☐ 1453 Service Member - Certification of Physician
- ☐ Sufficient certification to indicate your adult child is incapable of self-care because of a physical or mental disability. Certification may be provided on the enclosed 1452 Family Member - Certification of Physician.
- ☐ Sufficient documentation to establish the required relationship between you and your family member; proof of <birth marriage adoption/foster care domestic partner relationship next of kin>.
- ☐ Military Orders
- ☐ 1454 - Military Exigency - Certification
- ☐ Other:

☐ The certification you provided is not complete and sufficient to determine whether the FMLA/ CFRA applies to your leave request. You must provide the following information no later than <mm/dd/yyyy>, or your leave may be denied, unless it is not practicable under the particular circumstances despite your diligent good faith efforts.

- ☐ The information provided on the Certification of Physician/Provider does not meet the definition of a serious health condition. A list of the definitions is attached for your reference.
- ☐ The Certification of Physician/Provider does not include the Frequency and Duration for intermittent leave.
- ☐ The Certification of Physician/Provider did not indicate the start and/or end date of the condition.
- ☐ The Certification of Physician/Provider is missing the Signature, Signature Date or the Location of the provider.
- ☐ The Certification of Physician/Provider does not indicate your adult child is incapable of self-care because of a physical or mental disability.
- ☐ The information provided failed to establish the required relationship between you and your family member; proof of <birth marriage adoption/foster care domestic partner relationship next of kin>.
- ☐ Military Orders

- ☐ 1453 - Service Member - Certification of Physician
- ☐ 1454 - Military Exigency - Certification
- ☐ Other:

Please fax the required document(s) to the National HR Service Center at **1-877-HRSC-FAX (1-877-477-2329).** Or mail the forms to:

Kaiser Permanente National HR Service Center
PO Box 2074
Oakland, CA 94604-2074

Once we obtain the information from you as specified above, we will inform you whether your leave will be designated as FMLA/CFRA leave and count towards your FMLA/CFRA leave entitlement.

Please note: Failure to provide the sufficient certification may result in delay or denial of your Family Leave.

The *Employee Rights and Responsibilities* and the definitions of a *Serious Health Condition* under the FMLA are attached for your review. Policies, bargaining agreements and other information regarding leaves of absence can be found on My HR.

If you have any questions or concerns regarding your request for family leave, please contact Work Absence Management (WAM) at the National HR Service Center at **877-4KP-HRSC (877-457-4772).** Please reference the case number located in the upper right-hand corner of this letter.

Sincerely,

Work Absence Management (WAM)
National HR Service Center

Enclosures:

- ☒ 1451 Employee - Certification of Physician
- ☐ 1452 Family Member - Certification of Physician
- ☐ 1453 Service Member - Certification of Physician
- ☐ 1454 - Military Exigency - Certification
- ☐ 2090 - Supplement to Sick Leave Request
- ☐ 2520 - Personal Data Change

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National HR Service Center

EMPLOYEE RIGHTS AND RESPONSIBILITIES
UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

Leave Entitlements

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within one year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse,child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

Benefits and Protections

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

Eligibility Requirements

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

Requesting Leave

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Employer Responsibilities

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Enforcement

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersed any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE(1-866-487-9243) TTY:1-877-889-5627

www.dol.gov/whd

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National HR Service Center

Family and Medical Leave Act (FMLA)

"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.

Condition	Details
Inpatient Care	An overnight stay in a hospital, hospice, or residential medical-care facility, including any period of incapacity (i.e. inability to work, attend school, or perform other regular daily activities) or subsequent treatment in connection with such inpatient care.

Continuing treatment by a health care provider including one or more of the following:

a) Incapacity and Treatment	A period of incapacity lasting more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that **also** includes: • Treatment two or more times by or under the supervision of a health care provider (i.e. in-person visits, the first within 7 days and both within 30 days of the first day of incapacity); **or** One treatment by a health care provider (i.e., an in-person visit within 7 days of the first day of incapacity) with a continuing regimen of treatment (e.g., prescription medication, physical therapy).
b) Pregnancy	Any period of incapacity related to pregnancy or for prenatal care.
c) Chronic Conditions	Any period of incapacity or treatment for a chronic serious health condition. Requires periodic visits (at least twice a year) for treatment by, or under direct supervision of a health care provider. Continues over an extended period of time and may cause episodic rather than a continuing period of incapacity.
d) Permanent/Long-Term Conditions	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.
e) Conditions requiring multiple treatments	Any absences of incapacity to receive multiple treatments (including any period of recovery) 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 days if not treated.

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National HR Service Center

July 23, 2019

Employee ID: 00530105
Case Number: 4550201

Darlene Walls
16323 Cortuna Ave # 8
Bellflower, CA 90706

Subject: Denial Notice - Under the Family and Medical Leave Act/California Family Rights Act (Family Leave)

Dear Darlene Walls,

On 06/04/2019, we were informed that you needed leave beginning on 04/11/2019 for:

☐ The birth of a child, or placement of a child with you for adoption or foster care.

☒ Your own serious health condition.

☐ Your need to care for your <spouse child parent domestic partner family member> due to his/her serious health condition.

☐ An exigency arising out of the fact that your <spouse son or daughter parent> is on active duty or call to active duty status.

☐ Your need to care for your <spouse son or daughter parent next of kin> due to his/her serious injury or illness incurred in the line of duty as a covered servicemember.

This Notice is to inform you that you are not eligible for FMLA/CFRA leave, because:

☐ You have not met the 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately <Enter Num Mos> months towards this requirement. If you are still on leave at the completion of 12 months of service please contact the NHRSC to request your eligibility for FMLA/CFRA. For more information please see the attached notice of Employee Rights and Responsibilities.

☐ You have not met the 1,250 hours worked requirement within the 12 months preceding the start of your leave. As of <mm/dd/yyyy> you have worked <Enter Hours> hours towards the eligibility requirement. You can check the number of hours worked by contacting the NHRSC.

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National HR Service Center

☐ You exhausted your <12 26>-week entitlement to leave under the <FMLA/CFRA>

☐ Your request is for a non-qualified family member.

☒ You failed to provide sufficient certification to support your request.

- ☒ A Health Care Provider Certification form was not received.
- ☐ The information provided on the Health Care Provider Certification did not meet the definition of a serious health condition.
- ☐ The Health Care Provider Certification did not include the Frequency and Duration for an intermittent leave.
- ☐ The Health Care Provider Certification did not indicate your adult child is incapable of self-care because of a physical or mental disability.
- ☐ You failed to provide sufficient documentation to establish the required relationship between you and your family member; proof of <birth adoption/foster care domestic partner relationship marriage>.
- ☐ Military Orders
- ☐ <Certification of Exigency Certification of an injured/ill servicemember>

☐ Other:

The *Employee Rights and Responsibilities* under the FMLA are attached for your review.

While your time off is not currently protected under the FMLA and CFRA; you may become eligible for FMLA/CFRA during your leave. Please refer to the *Employee Rights and Responsibilities* for eligibility criteria or requirements. You may also be eligible for other forms of leave under Kaiser's leave policies or under an applicable collective bargaining agreement. If your leave is the result of a work-related injury, it may be subject to Workers' Compensation leave protection.

Policies, bargaining agreements and other information regarding leaves of absence can be found on My HR.

KAISER PERMANENTE®
National HR Service Center

If you have any questions or concerns regarding the denial of your request for family leave, please contact Work Absence Management (WAM) at the National HR Service Center at **877-4KP-HRSC (877-457-4772).** Please reference the case number located in the upper right-hand corner of this letter.

Sincerely,

Work Absence Management (WAM)
Kaiser Permanente National HR Service Center

KAISER PERMANENTE®

National HR Service Center

EMPLOYEE RIGHTS AND RESPONSIBILITIES
UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

Leave Entitlements

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within one year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse,child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

Benefits and Protections

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

Eligibility Requirements

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

Requesting Leave

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Employer Responsibilities

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Enforcement

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersed any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE(1-866-487-9243) TTY:1-877-889-5627

www.dol.gov/whd

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PERFORMANCE EVALUATION COVER SHEET

Instructions:
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3. Items marked with asterisk (*) are required fields.
4. When complete – fax to the number below. Be sure to retain the original and the fax receipt for your records.

*Employee ID	*Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyy)
530105	323-674-5660	6/18/2013
* First Name	Middle Name	* Last Name
Darlene		Walls

1. EMPLOYEE INFORMATION

Job Title	G/L Location
CNA	0801-80101-0100

2. PERFORMANCE EVALUATION

1. ☒ Annual ☐ Introductory/Probationary
2. Date range covered by this performance evaluation: From (mm/dd/yyy) 07/01/12 To (mm/dd/yyy 6/30/13
3. Date evaluation was given (mm/dd/yyy) June 18, 2013
4. Rating of Performance Evaluation (please select one.)

☐ Expert	Preceptor, teaches others, deemed independent (Exemplary: 8.6-10-PMP; exceeds requirements).
☒ Independent	Performed all critical core elements without supervision (Fully effective [+/-]; 4.6-8.5-PMP; meets requirements [+/-])
☐ LOA	Employee on Leave of Absence
☐ Not Met	Not met (must attach corrective action plan) (Development required; 1-4.5-PMP; Improvement required)
☐ Novice	New to the organization, new to service, new grad, unable to perform all critical core elements without supervision or mentorship (e.g. interim permitee, student, interns).

3. REQUIREMENTS COVERED BY THE PERFORMANCE EVALUATION

Note: Check boxes below if applicable and attach all documentation verifying completion of the evaluation / observation of the items selected.

Initial / First Time Requirements
The report is done from the actual document received. All initial first-time documents have their own document type and are listed in the appropriate tab individually. (Orientation)

☐ Medical Center - General Orientation	☐ Sexual Abuse	☐ Initial Assessment
☐ Department-Specific Orientation	☐ Abuse Reporting: Child	☐ Abuse Reporting: Dependent/Elder
☐ Confidentiality Agreement	☐ Other	☐ Abuse Reporting: Domestic Abuse

Annual Requirements

☒ Infection Control	☒ Emergency/Disaster Management	☒ Corporate Compliance
☒ Hazardous Materials/ Waste Management	☒ Age Specific Care (interacts with members)	☒ Health Screen -
☒ Fire Safety	☐ Other	

Clinical Position Annual Requirements

☒ Department-Specific Competencies	☐ Procedural Sedation Education	☒ Patient Safety Training
☐ Pain Management	☒ Clinical Competency	☐ Team Dynamics Training
☒ Restraint Education	☐ Other	☐ Waived Testing Competency

National HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772

DOWNEY MEDICAL CENTER
2012 – 2013 Performance Evaluation

Name ~ Job Title: Walls, Darlene ~ CNA	Unit ~ Shift: 6EAST ~ DAY
Employee Number: 530105	License Number ~ Expiration: 688083 ~ 3/23/2015
ACLS Expiration:	BLS Expiration: 8/31/2014

METHODS OF EVALUATION

WA: Writing Assessment	RS: Routine Supervision
OBS: Observation	PCS: Patient Care Scenarios

SKILLS

N=Novice E=Expert I=Independent NM=Not Met NA=Not Applicable

Service	Clinical	Quality	Financial	Attendance	Interpersonal Skills
I	I	I	I	I	I

Manager's Comments:

GENERAL OPPORTUNITIES FOR IMPROVEMENT:

- Eliminate Incremental Overtime
  - You are expected to clock in and clock out on time every day you are scheduled to be at work
- Customer Service
  - Hourly Rounds
  - Nurse Knowledge Exchange (NKE)
  - Call Bells

MINIMUM PERFORMANCE EXPECTATIONS

CUSTOMER SERVICE:

HOURLY ROUNDS

- Hourly Rounds are to be performed and documented in KP Health Connect. Rounds are performed each hour during the hours of 6:00am to 10:00pm. Rounds are performed every 2 hours between 10:00pm and 6:00am.
- During Purposeful Hourly Rounds, you will:
  1. Assess the 4 Ps (pain, potty, position, and plan)
  2. Perform an environmental "Be Safe" check (bed alarm plugged in, call light in reach, floor uncluttered, etc)
  3. Ask the patient, and/or visitor(s) "Is there anything I can do for you before I leave? I have time."
  4. Inform the patient, family member(s), and/or visitor(s) that you or someone on the team will be back to check on them again in 1 hour (2 hours between 10:00pm and 6:00am)

NURSE KNOWLEDGE EXCHANGE (NKE)

* NKE + is to be performed at the change of shift without exception.

1. Bedside Rounds include; the outgoing and incoming CNA's will meet at the patient's bedside to perform change of shift report. During the bedside rounds, the outgoing CNA will:
   - Introduce the incoming CNA
   - Provide full report to the incoming CNA while involving the patient in the report
     - Both CNA's will check the patient's bed for incontinence, offer assistance to the restroom, and ensure the patient's environment is safe.
     - During Bedside rounds, you will ask the patient:

       "What time would you like to have your bath?"
       "When would you like to have your bed changed?"
       "Do you need help brushing your teeth?"
       "Do you need help with your meals?"
2. Update the Care Board: The Care Board should be updated with the following:
   - Day, Date, Name of the incoming CNA, and any other pertinent information (hearing impaired, visually impaired, fall risk, etc.)

CALL BELLS

- All call bells will be answered in the patient's room when possible.
- When answering call bells over the intercom, the CNA will use the following script:
  - "Hello (patient's preferred name). This is Darlene. How can I help you?"

WORK PLACE SAFETY

- Observe and adhere to all "Safety Always" rules.

TEAMWORK:

- Promote teamwork by offering to help your co-workers throughout your workday. Ask for assistance when you need it and offer assistance every chance you get.
- As a staff member of Downey Medical Center, you are committed to:
  - Avoiding the 3Bs (bickering, back-biting and blame).
  - Practicing the 3Cs (Caring, Committing and collaborating).

DELEGATION

- The RN has primary responsibility for the patient's overall care. As a result, the RN has the ability to delegate work to you. Therefore, you are expected to:
  - Take direction and delegation from the RN
  - Provide routine updates to the RN throughout your shift so that she/he can update the patient's plan of care.

PRIORITIZATION:

- Direct patient care is the #1 priority. Entering data into the computer is a lower priority
- Adheres to the Regional Attendance Policy. Reports to assigned area promptly, being present and available for report at the beginning of your assigned shift

PATIENT PROBLEMS:

AS A STAFF MEMBER AT DOWNEY MEDICAL CENTER, YOU ARE COMMITTED TO:

- The Falls prevention program
- Dedicated to the safety of all members and staff.
- The prevention of Hospital acquired pressure ulcers
- Ensuring hand hygiene

EVALUATOR'S SIGNATURE: M Lenaburg DATE: 6/18/13
Michelle Lenaburg, RN, BS – Assistant Clinical Director

EMPLOYEE SIGNATURE: Darlene Walls DATE: 6/18/13
Darlene Walls ~ CNA

KP – DOWNEY MEDICAL CENTER
6TH FLOOR/TELEMETRY 2013-2014 - FUTURE OBJECTIVES AND EVALUATION

EMPLOYEE NAME/NUMBER: Walls, Darlene CNA/530105 DAY

OVERALL PERFORMANCE RATING: Independent

KP Mission: Our Mission is to provide high-quality, affordable health care services to improve the health of our members and the communities we serve.

A. Action Plan to address Skill, Experience or Knowledge Needs

Skill, Experience, or Knowledge Needed	Action To Be Taken	Target Date
SERVICE	Ensure every effort is made to address patients' concerns/issues in a timely manner. Answer call bells at the bedside within 10 seconds or less. Demonstrate consistent application of the Caring Model and the Nurse Knowledge Exchange.	Ongoing June 30, 2013
CLINICAL	Maintain job description requirements, including BLS certification. Successfully complete competencies for ~~Monitor Technician~~ CNA job classification.	Ongoing June 30, 2013
QUALITY	Demonstrate compliance with Kaiser policies and procedures. Participate in all Performance Improvement activities. Ensure regulatory guidelines are adhered to (crash cart, refrigerator, etc).	Ongoing June 30, 2013
FINANCIAL	Prioritize work to ensure all tasks are performed within established timeframes. Follow the Automated Timekeeping System policy and procedure. Eliminate incidental overtime.	Ongoing June 30, 2013
ATTENDANCE	Adhere to the Kaiser Permanente Attendance Program. Participate in attendance reviews with your manager. During this evaluation period (7/1/2012 – 6/30/2013) you had the following absences: • 7.65 absences coded SCL/SCK • 0 tardies	Ongoing June 30, 2013

Progress Checkpoint: 3 mos.__ 6 mos.__ 9 mos.

B. EMPLOYEE'S DESIRED FUTURE OBJECTIVES/IMPROVEMENT ACTIVITIES.

Objective (Optional)	Target Date
Try to go to school for H.D. tech	2014

MM. COMMENTS:

Darlene is independent in her duties as a Certified Nursing Attendant. She gets along well with her co-workers. The staff appreciates the fact that you are helpful and a team player.

An area for improvement would be to eliminate any incidental overtime. It is the organization expectation that you complete your work in the established time frames. Darlene is aware of the impact incidental overtime has on the operation of the Unit and the organization.

Darlene is a hard worker; attentive to her patient's needs The patients compliment your care and compassion. As an important part of the healthcare team, Darlene recognizes that despite the patients she is assigned, all patient's lights need to be answered in a timely manner. All patients on he Unit are everyone's responsibility.

Darlene is dedicated to improve processes and systems on 6 East. She is a member of the RN/CNA communication team. Darlene also informs her Manager regarding opportunities for improvement on the unit as well.

NN. EMPLOYEE'S SUGGESTIONS REGARDING DEPARTMENTAL EDUCATION / QUALITY IMPROVEMENT ACTIVITIES: (LEADERSHIP, PARTNERSHIP, QUALITY OF SERVICE, DEPT. IN-SERVICES, ETC.)

49. ______

50. ______

51. ______

52. ______

Evaluator's Signature:	Date:	Employee's Signature:	Date:
M Lenaburg	6/18/13	Darlene Walls	6/18/13

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ee#00530105

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PERFORMANCE EVALUATION COVER SHEET

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4. When complete - fax to the number below. Be sure to retain the original and the fax receipt for your records.

* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
530105	(213) 570-9242	02/25/2008
* First Name	Middle Name	* Last Name
Darlene		Walls

1. EMPLOYEE INFORMATION

Job Title	G/L Location
CNA	Unit 3000

2. PERFORMANCE EVALUATION

1. ☒ Annual ☐ Introductory / Probationary

2. Date range covered by this performance evaluation: From (mm/dd/yyyy) 07/01/2010 To (mm/dd/yyyy) 06/30/2011

3. Date evaluation was given (mm/dd/yyyy): 07/27/2011

4. Rating of Performance Evaluation (please select one.)

☐ Expert	Preceptor, teaches others, deemed independent (Exemplary; 8.6-10-PMP; exceeds requirements).
☒ Independent	Performed all critical core elements without supervision (Fully effective [+/-]; 4.6-8.5-PMP; meets requirements [+/-]).
☐ LOA	Employee on Leave of Absence.
☐ Not Met	Not met (must attach corrective action plan) (Development required; 1-4.5-PMP; improvement required).
☐ Novice	New to the organization, new to service, new grad, unable to perform all critical core elements without supervision or mentorship (e.g. interim permitee, student, interns).

3. REQUIREMENTS COVERED BY THE PERFORMANCE EVALUATION

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☒ Medical Center - General Orientation	☒ Sexual Abuse	☒ Initial Assessment
☒ Department-Specific Orientation	☒ Abuse Reporting: Child	☒ Abuse Reporting: Dependent/Elder
☒ Confidentiality Agreement	☐ Other: ________	☒ Abuse Reporting: Domestic Abuse

Annual Requirements

☒ Infection Control	☒ Emergency/Disaster Management	☒ Corporate Compliance
☒ Hazardous Materials/ Waste Management	☒ Age Specific Care (interacts with members)	☒ Health Screen
☒ Fire Safety	☐ Other: ________	

Clinical Position Annual Requirements

☒ Department-Specific Competencies	☐ Procedural Sedation Education	☒ Patient Safety Training
☒ Pain Management	☒ Clinical Competency	☒ Team Dynamics Training
☒ Restraint Education	☐ Other: ________	☐ Waived Testing Competency

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KAISER PERMANENTE

VCH 00530105

PERFORMANCE EVALUATION

Name: Darlene Walls	Department: 0103 Acutecare-Med/Surg-D
EE #:	☐ Initial Assessment/Dept. Orientation Date
☐ Unrepresented ☒ Represented Union	☑ Probationary Evaluation Date
Reports to: Department Administrator and/or Assistant Department Administrator	✓ ☒ Annual Evaluation Year 2010
Medical Center: South Bay	Final Competency Rating (I)

RATING KEY

Validation Method: C = case study response, O = observation in the real setting, M = mock event, demonstration, P = paper and pencil test, R = record review, E = exercises (written), V = verbal response/discussion (for customer service skills only).

Competency Rating: Not met - unable to perform the criteria even with coaching. ***Novice*** - able to perform the criteria with coaching. ***Independent*** - able to perform the criteria independently without any coaching. ***Expert*** - able to perform the criteria independently and able to teach or mentor others in this area.

Self Assessment				Note: Initial and date each assessment/evaluation column	Assessment/ Competency Validation if required			Evaluation		
Expert	Independent	Novice	Not Met	Accountabilities	Expert – E Independent – I Novice – N* Not Met*	Needs Action Plan*	Method of Validation	Improvement Needed*	Meets Expectations	Exceeds Expectation
☐	☒	☐	☐	Consistently demonstrates support of the KP mission, promise, strategic goals and the Labor Management Partnership that positively impacts affordable, quality health care, performance, access and service, community benefit and health outcomes.	I	☐	O	☐	☒	☐
☐	☒	☐	☐	Consistently responsive to the needs of others, supporting a culturally diverse workforce that complies with the changing needs of the local markets. Maintains a professional, respectful behavior towards members and co-workers; creating a positive image for the organization by willingly taking the initiative to resolve member/co-worker issues dealing with complaints in a positive manner.	I	☐	O	☐	☒	☐
☐	☒	☐	☐	Consistently supports the precepts of Corporate Compliance and Principles of Responsibility by maintaining confidentiality, protecting the assets of the organization, acting with integrity, reporting observed fraud and abuse and complying with applicable state, federal and local laws and program policies and procedures.	I	☐	O	☐	☒	☐
☐	☐	☐	☐			☐		☐	☐	☐
☐	☐	☐	☐			☐		☐	☐	☐
☐	☐	☐	☐			☐		☐	☐	☐
☐	☐	☐	☐			☐		☐	☐	☐

bl#00530105

PERFORMANCE EVALUATION

Goal Accomplishment in the Past Year: (not applicable for probationary evaluation)

Goal	Threshold**	Target**	Stretch**	Actual Outcome
Hourly Rounding	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	

Final Rating

- ☐ **Not met** – On corrective action plan.
- ☐ **Novice** – New to the organization, new to service, new grad, unable to perform all critical core elements without supervision or mentoring. Needs development.
- ☒ **Independent** – Consistently meets and occasionally exceeds position expectations. Performs all critical core elements without supervision.
- ☐ **Expert** – Performs core elements independently. Precepts and/or teaches others. Consistently exceeds position expectations.

Goals for Coming Year:

Goal			
Workplace Safety			
Attendance			
HCAHPS (service)			

** If applicable

Verification signature ______________________

Employee Signature: [signature] **Date:** 7/27/11

CNS/Preceptor Signature: ______________________ **Date:** ____________
(Required only for Orientation Competency)

DA/ADA Signature [signature] **Date:** 04/27/2011

Form based on the State of California DWC Form RU-91 (1/95) Description of Job Duties

Kaiser Permanente Medical Center - South Bay
Educational Assessment and Needs Evaluation for Year 2007 KC#0053010S

Employee Name:	DARLENE WALLS		
Employee ID #:	530105	Date of Hire:	02/25/2008
Job Title:	CNA	Facility: South Bay Department: **Acutecare-Med/Surg-D**	

Please complete each section to indicate work related education that you have taken in the last year and educational needs you have identified for yourself.

A. Educational classes provided both in and outside of the organization to enhance your role as a healthcare worker. (do not include BLS / ACLS / PALS or NRP unless it is the first time you have been certified).

The name of the class / seminar, etc.	Class was given by (Sponsor)	Date
1.		
2.		
3.		
4.		
5.		

B. Employee's desired future objectives / improvement activities.
Employee's suggestions regarding departmental education / quality improvement activities: (leadership, partnership, quality of service, dept. In-services, etc.)

1. Bariatric Service TRAING	1 2 3 4
2. Survy	1 2 3 4
3.	1 2 3 4
4.	1 2 3 4
5.	1 2 3 4
Manager Comments:	Please circle one for each suggestion

Key
1 = Not part of core job, will not be addressed
2 = Will consider if enough interest in the department (75% plus)
3 = Will arrange
4 = Refer to learning well
5 = Refer to external resources

Evaluator's Signature: [signature]	Date: 07/27/2011	Employee's Signature: Darlene Walls	Date: 7/27/11

Personnel Representative Signature: ____________ Date: ________

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PERFORMANCE EVALUATION COVER SHEET

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*Employee ID	*Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyy)
530105	323-674-5660	6/13/12
*** First Name**	**Middle Name**	*** Last Name**
Darlene		Walls

1. EMPLOYEE INFORMATION

Job Title	G/L Location
CNA	0801-80101-0100

2. PERFORMANCE EVALUATION

1. ☒ Annual ☐ Introductory/Probationary
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3. Date evaluation was given (mm/dd/yyy) 6/13/12
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3. REQUIREMENTS COVERED BY THE PERFORMANCE EVALUATION

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☒ Infection Control	☒ Emergency/Disaster Management	☒ Corporate Compliance
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☒ Fire Safety	☐ Other:	

Clinical Position Annual Requirements

☒ Department-Specific Competencies	☒ Procedural Sedation Education	☒ Patient Safety Training
☒ Pain Management	☒ Clinical Competency	☐ Team Dynamics Training
☒ Restraint Education	☐ Other:	☐ Waived Testing Competency

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KAISER PERMANENTE
Southern California Region

DOWNEY MEDICAL CENTER
Telemetry/6East CNA 2011 – 2012 Performance Evaluation

Name ~ Job Title:	Unit ~ Shift:
Walls, Darlene ~ CNA	Telemetry/6East ~ DAY
Employee Number: 530105	**License Number ~ Expiration:** 688083 ~ 3/23/2013
ACLS Expiration:	**BLS Expiration:** 8/31/2012

METHODS OF EVALUATION	
WA: Writing Assessment	RS: Routine Supervision
OBS: Observation	PCS: Patient Care Scenarios

SKILLS

N=Novice E=Expert I=Independent NM=Not Met NA=Not Applicable

Service	Clinical	Quality	Financial	Attendance	Interpersonal Skills
I	I	I	I	I	I

Manager's Comments:

GENERAL OPPORTUNITIES FOR IMPROVEMENT:

- Eliminate Incremental Overtime
  - You are expected to clock in and clock out on time every day you are scheduled to be at work
- Customer Service
  - Hourly Rounds
  - Nurse Knowledge Exchange (NKE)
  - Call Bells

MINIMUM PERFORMANCE EXPECTATIONS

CUSTOMER SERVICE:

HOURLY ROUNDS

- Hourly Rounds are to be performed and documented in KP Health Connect. Rounds are performed each hour during the hours of 6:00am to 10:00pm. Rounds are performed every 2 hours between 10:00pm and 6:00am.
- During Hourly Rounds, you will:
  1. Assess the 4 Ps (pain, potty, position, and plan)
  2. Perform an environmental and safety check (call light, bedside table, etc)
  3. Ask the patient, and/or visitor(s) "Is there anything I can do for you before I leave? I have time."
  4. Inform the patient, family member(s), and/or visitor(s) that you or someone on the team will be back to check on them again in 1 hour (2 hours between 10:00pm and 6:00am)

NURSE KNOWLEDGE EXCHANGE (NKE)

- The NKE is to be performed at the change of shift without exception. The three steps to the NKE are:
  1. Assignments: The Charge RN will make assignments for the oncoming shift
  2. Bedside Rounds: The outgoing and incoming CNA's will meet at the patient's bedside to perform change of shift report. During the bedside rounds, the outgoing CNA will:
     - Introduce the incoming CNA
     - Provide full report to the incoming CNA while involving the patient in the report
       - Both CNA's will check the patient's bed for incontinence, offer assistance to the restroom, and ensure the patient's environment is safe.
       - During Bedside rounds, you will ask the patient:
         "What time would you like to have your bath?"
         "When would you like to have your bed changed?"
         "Do you need help brushing your teeth?"
         "Do you need help with your meals?"
  3. Update the Care Board: The Care Board should be updated with the following:
     - Day, Date, Name of the incoming CNA, and any other pertinent information (hearing impaired, visually impaired, fall risk, etc.)

CALL BELLS

- All call bells will be answered in the patient's room when possible.
- When answering call bells over the intercom, the CNA will use the following script:
  - "Hello (patient's preferred name). This is Darlene. How can I help you?"

TEAMWORK:

- Promote teamwork by offering to help your co-workers throughout your workday. Ask for assistance when you need it and offer assistance every chance you get.

DELEGATION

- The RN has primary responsibility for the patient's overall care. As a result, the RN has the ability to delegate work to you. Therefore, you are expected to:
  - Take direction and delegation from the RN
  - Provide routine updates to the RN throughout your shift so that she/he can update the patient's plan of care.

PRIORITIZATION:

- Direct patient care is the #1 priority. Entering data into the computer is a lower priority

EVALUATOR'S SIGNATURE: M Lenaburg RN **DATE:** 6/13/12
Michelle Lenaburg, RN, BS - Assistant Clinical Director

EMPLOYEE SIGNATURE: Darlene Walls **DATE:** 6/13/12
Darlene Walls ~ CNA

KP – DOWNEY MEDICAL CENTER

TELEMETRY/6EAST CNA 2011-2012 - FUTURE OBJECTIVES AND EVALUATION

EMPLOYEE NAME/NUMBER: Walls, Darlene CNA/530105 DAY

OVERALL PERFORMANCE RATING: Independent

KP Mission: Our Mission is to provide high-quality, affordable health care services to improve the health of our members and the communities we serve.

A. Action Plan to address Skill, Experience or Knowledge Needs		
Skill, Experience, or Knowledge Needed	Action To Be Taken	Target Date
SERVICE	Ensure every effort is made to address patients' concerns/issues in a timely manner. Answer call bells at the bedside within 10 seconds or less. Demonstrate consistent application of the Caring Model and the Nurse Knowledge Exchange.	Ongoing June 30, 2012
CLINICAL	Maintain job description requirements, including BLS certification. Successfully complete competencies for Monitor Technician job classification.	Ongoing June 30, 2012
QUALITY	Demonstrate compliance with Kaiser policies and procedures. Participate in all Performance Improvement activities. Ensure regulatory guidelines are adhered to (crash cart, refrigerator, etc).	Ongoing June 30, 2012
FINANCIAL	Prioritize work to ensure all tasks are performed within established timeframes. Follow the Automated Timekeeping System policy and procedure. Eliminate incidental overtime.	Ongoing June 30, 2012
ATTENDANCE	Adhere to the Kaiser Permanente Attendance Program. Participate in attendance reviews with your manager. During this evaluation period (7/1/2011 – 6/30/2012) you had the following absences: • 0 absences coded SCL/SCK • 1 tardies	Ongoing June 30, 2012

Progress Checkpoint: 3 mos. ___ 6 mos. ___ 9 mos.

B. EMPLOYEE'S DESIRED FUTURE OBJECTIVES/IMPROVEMENT ACTIVITIES.

Objective (Optional)	Target Date

C. COMMENTS:

Darlene is independent in her duties as a Certified Nursing Attendant.

She gets along well with her co-workers.

The staff appreciates the fact that Darlene is helpful and a team player.

Darlene is a hard worker, attentive to her patient's needs

The patient's compliment her care and compassion while on duty.

Darlene exemplifies the KP values for service and quality.

Darlene has contributed to performance in our Unit by participating in NKE Plus roll out and kick off. Darlene is interested in enhancing our performance on 6 East by contributing ideas for improvement to our UBT members and WPS. She has been working with the other CNAs to improve safe practices for patient handling.

Darlene needs to adhere to our timekeeping policy by clocking in and out as scheduled and for her breaks.

An area for improvement would be to eliminate any incidental overtime.

D. EMPLOYEE'S SUGGESTIONS REGARDING DEPARTMENTAL EDUCATION / QUALITY IMPROVEMENT ACTIVITIES: (LEADERSHIP, PARTNERSHIP, QUALITY OF SERVICE, DEPT. IN-SERVICES, ETC.)

1. ______
2. ______
3. ______
4. ______

Evaluator's Signature:	Date:	Employee's Signature:	Date:
M Lanaburg	6/13/12	Darlene Walls	6/13/12

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(5)

KAISER PERMANENTE.

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PERFORMANCE EVALUATION COVER SHEET

Instructions:
45. This form cannot be submitted on-line
46. Either complete on-line and print or print and complete by hand – print clearly using blue or black ink.
47. Items marked with asterisk (*) are required fields.
48. When complete – fax to the number below. Be sure to retain the original and the fax receipt for your records.

*Employee ID	*Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyy)
530105	213-401-8827	6/2/2014
*** First Name**	**Middle Name**	*** Last Name**
Darlene		Walls

34. EMPLOYEE INFORMATION

Job Title	G/L Location
CNA	0801-80101-0100

35. PERFORMANCE EVALUATION

45. ☒ Annual ☐ Introductory/Probationary

46. Date range covered by this performance evaluation: From (mm/dd/yyy) 6/30/13 To (mm/dd/yyy) 7/1/14

47. Date evaluation was given (mm/dd/yyy) 6/2/14

48. Rating of Performance Evaluation (please select one.)

☐ Expert	Preceptor, teaches others, deemed independent (Exemplary; 8.6-10-PMP; exceeds requirements).
☒ Independent	Performed all critical core elements without supervision (Fully effective [+/-]; 4.6-8.5-PMP; meets requirements [+/-])
☐ LOA	Employee on Leave of Absence
☐ Not Met	Not met (must attach corrective action plan) (Development required; 1-4.5-PMP; Improvement required)
☐ Novice	New to the organization, new to service, new grad, unable to perform all critical core elements without supervision or mentorship (e.g. interim permitee, student, interns).

36. REQUIREMENTS COVERED BY THE PERFORMANCE EVALUATION

Note: Check boxes below if applicable and attach all documentation verifying completion of the evaluation / observation of the items selected.

Initial / First Time Requirements
The report is done from the actual document received. All initial first-time documents have their own document type and are listed in the appropriate tab individually. (Orientation)

☐ Medical Center - General Orientation	☐ Sexual Abuse	☐ Initial Assessment
☐ Department-Specific Orientation	☐ Abuse Reporting: Child	☐ Abuse Reporting: Dependent/Elder
☐ Confidentiality Agreement	☐ Other:	☐ Abuse Reporting: Domestic Abuse

Annual Requirements

☒ Infection Control	☒ Emergency/Disaster Management	☒ Corporate Compliance
☒ Hazardous Materials/ Waste Management	☒ Age Specific Care (interacts with members)	☒ Health Screen -
☒ Fire Safety	☐ Other:	

Clinical Position Annual Requirements

☒ Department-Specific Competencies	☐ Procedural Sedation Education	☒ Patient Safety Training
☐ Pain Management	☒ Clinical Competency	☐ Team Dynamics Training
☒ Restraint Education	☐ Other:	☐ Waived Testing Competency

National HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772

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DOWNEY MEDICAL CENTER
2013 – 2014 Performance Evaluation

Name ~ Job Title:	Unit ~ Shift:
Walls, Darlene ~ CNA	6East Telemetry ~ DAY
Employee Number: 530105	**License Number ~ Expiration:** 688083 ~ 3/23/2015
ACLS Expiration:	**BLS Expiration:** 8/31/2014

METHODS OF EVALUATION	
WA: Writing Assessment	RS: Routine Supervision
OBS: Observation	PCS: Patient Care Scenarios

SKILLS

N=Novice E=Expert I=Independent NM=Not Met NA=Not Applicable

Service	Clinical	Quality	Financial	Attendance	Interpersonal Skills
I	I	I	I	I	I

Manager's Comments:

GENERAL OPPORTUNITIES FOR IMPROVEMENT:

- Eliminate Incremental Overtime
  - You are expected to clock in and clock out on time every day you are scheduled to be at work
- Customer Service
  - Hourly Rounds
  - Nurse Knowledge Exchange (NKE)
  - Call Lights

MINIMUM PERFORMANCE EXPECTATIONS

CUSTOMER SERVICE:

PURPOSEFUL HOURLY ROUNDS

- Hourly Rounds are to be performed and documented in KP Health Connect. Rounds are performed each hour during the hours of 6:00am to 10:00pm. Rounds are performed every 2 hours between 10:00pm and 6:00am.
- During Purposeful Hourly Rounds, you will:
  45. Assess the 4 Ps (pain, potty, position, and plan)
  46. Perform an environmental "Be Safe" check (bed alarm plugged in, call light in reach, floor uncluttered, etc)
  47. Ask the patient, and/or visitor(s) "Is there anything I can do for you before I leave? I have time."
  48. Inform the patient, family member(s), and/or visitor(s) that you or someone on the team will be back to check on them again in 1 hour (2 hours between 10:00pm and 6:00am)

NURSE KNOWLEDGE EXCHANGE (NKE)

* NKE + is to be performed at the change of shift without exception.

23. Bedside Rounds include; the outgoing and incoming CNA's will meet at the patient's bedside to perform change of shift report. During the bedside rounds, the outgoing CNA will:
    - Introduce the incoming CNA
    - Provide full report to the incoming CNA while involving the patient in the report
      - Both CNA's will check the patient's bed for incontinence, offer assistance to the restroom, and ensure the patient's environment is safe.
      - During Bedside rounds, you will ask the patient:

        "What time would you like to have your bath?"
        "When would you like to have your bed changed?"
        "Do you need help brushing your teeth?"
        "Do you need help with your meals?"
24. Update the Care Board: The Care Board should be updated with the following:
    - Day, Date, Name of the incoming CNA, and any other pertinent information (hearing impaired, visually impaired, fall risk, etc.)

CALL LIGHTS

- All call lights will be answered in the patient's room when possible.
- When answering call bells over the intercom, the CNA will use the following script:
  - "Hello (patient's preferred name). This is Darlene. How can I help you?"

WORK PLACE SAFETY

- Observe and adhere to all "Safety Always" rules.
- Utilize safety equipment at all times in the movement of patients. Adhere to "Safe Patient Handling" by never lifting alone.
- Patients at risk for falls must never walk alone or be left unattended in the bathroom.

TEAMWORK

- Promote teamwork by offering to help your co-workers throughout your workday. Ask for assistance when you need it and offer assistance every chance you get.
- As a staff member of Downey Medical Center, you are committed to:
  - Avoiding the 3Bs (bickering, back-biting and blame).
  - Practicing the 3Cs (Caring, Committing and collaborating).

DELEGATION

- The RN has primary responsibility for the patient's overall care. As a result, the RN has the ability to delegate work to you. Therefore, you are expected to:
  - Take direction and delegation from the RN
  - Provide routine updates to the RN throughout your shift so that she/he can update the patient's plan of care.

PRIORITIZATION

- Direct patient care is the #1 priority. Entering data into the computer is a lower priority
- Adheres to the Regional Attendance Policy. Reports to assigned area promptly, being present and available for report at the beginning of your assigned shift

PATIENT PROBLEMS:

AS A STAFF MEMBER AT DOWNEY MEDICAL CENTER, YOU ARE COMMITTED TO:

- The Falls prevention program
- Dedicated to the safety of all members and staff.
- The prevention of Hospital acquired pressure ulcers
- Ensuring hand hygiene is performed

EVALUATOR'S SIGNATURE: M Lonaburg
Assistant Clinical Director
DATE: 6/2/14

EMPLOYEE SIGNATURE: Darlene Walls
Darlene Walls ~ CNA
DATE: 6/2/14

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KP – Downey Medical Center
Future Objectives and Evaluation

Employee Name/Number: Walls, Darlene CNA/530105 DAY

Overall Performance Rating: Independent

KP Mission: Our Mission is to provide high-quality, affordable health care services to improve the health of our members and the communities we serve.

A. Action Plan to address Skill, Experience or Knowledge Needs		
Skill, Experience, or Knowledge Needed	**Action To Be Taken**	**Target Date**
SERVICE	Ensure every effort is made to address patients' concerns/issues in a timely manner. Answer call bells at the bedside within 10 seconds or less. Demonstrate consistent application of the Caring Model and the Nurse Knowledge Exchange.	Ongoing June 30, 2015
CLINICAL	Maintain job description requirements, including BLS certification. Successfully complete competencies for Monitor Technician job classification.	Ongoing June 30, 2015
QUALITY	Demonstrate compliance with Kaiser policies and procedures. Participate in all Performance Improvement activities. Ensure regulatory guidelines are adhered to (crash cart, refrigerator, etc).	Ongoing June 30, 2015
FINANCIAL	Prioritize work to ensure all tasks are performed within established timeframes. Follow the Automated Timekeeping System policy and procedure. Eliminate incidental overtime.	Ongoing June 30, 2015
ATTENDANCE	Adhere to the Kaiser Permanente Attendance Program. Participate in attendance reviews with your manager. During this evaluation period (7/1/2013 – 6/30/2014) you had the following absences: • 7 absences coded SCL/SCK • 3 tardies	Ongoing June 30, 2015
Progress Checkpoint: 3 mos. ___ 6 mos. ___ 9 mos.		

B. Employee's desired future objectives/improvement activities.

1. **What professional aspirations do you have in the next year?**
2. **What professional development are you seeking to achieve in the next 2 years?**
3. **Where do you see yourself professionally in 5 years?**

Objective	Target Date
1. Successful completion of Anesthesia tech examination	2015
2. Being an anesthia tech	2017
3. Start my own business in home care	2019

C. COMMENTS:

Darlene is independent in her duties as a Certified Nursing Attendant.

Darlene is a hard worker; attentive to her patient's needs The patients compliment your care and compassion. As an important part of the healthcare team, Darlene recognizes that despite the patients she is assigned, all patient's lights need to be answered in a timely manner. All patients on he Unit are everyone's responsibility.

Darlene is dedicated to improve processes and systems on 6 East. Darlene also informs her Manager regarding opportunities for improvement on the unit as well.

D. EMPLOYEE'S SUGGESTIONS REGARDING DEPARTMENTAL EDUCATION / QUALITY IMPROVEMENT ACTIVITIES: (LEADERSHIP, PARTNERSHIP, QUALITY OF SERVICE, DEPT. IN-SERVICES, ETC.)

1. More education directed at Nursing assistance job duties versus being directed at staff nurses
2.
3.
4.

Evaluator's Signature:	Date:	Employee's Signature:	Date:
M Lenaburg	6/2/14	Darlene Walls	6/2/14