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.



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

	Case No. ADJ11859979, ADJ11864576
DOB: 03/23/67	(IF APPLICATION HAS BEEN FILED, CASE NUMBER
AKA:	MUST BE INDICATED REGARDLESS OF DATE OF INJURY)
File:	
	SUBPOENA DUCES TECUM
Claimant/Applicant,	
	(When records are mailed, identify them by using above case
VS.	number or attaching a copy of subpoena)
IV.'. D	Where no application has been filed for injuries on or after
Kaiser Permanente	January 1, 1990 and before January 1, 1994, subpoena will
	be valid without a case number, but subpoena must be served
Employer/Insurance Carrier/Defendant.	on claimant and employer and/or insurance carrier.
Employer/insurance carren/Defendant.	See instructions below.*
	See instructions below.*
	_
	at 10:00 o'clock AM to testify in the above
on the <u>08/26/19</u> day of	, at 10:00 o'clock AM., to testify in the above-
on the 08/26/19day of entitled matter and to bring with you and produce the follo	owing described documents, papers, books and records.
on the 08/26/19 day of entitled matter and to bring with you and produce the follower Attachment for a list of records to be produced to be produced to the pr	owing described documents, papers, books and records. ed subject to this subpoena, to make available for
on the 08/26/19 day of entitled matter and to bring with you and produce the follower Attachment for a list of records to be produced to the p	owing described documents, papers, books and records. ed subject to this subpoena, to make available for
on the 08/26/19day of entitled matter and to bring with you and produce the follower that does not be produced as a spection and copying or transmit/transfer electrons.	owing described documents, papers, books and records. ed subject to this subpoena, to make available for
on the 08/26/19day of entitled matter and to bring with you and produce the followed the companion of the control of th	wing described documents, papers, books and records. red subject to this subpoena, to make available for eronically. ess specifically mentioned above.) y of a contempt and liable to pay to the parties aggrieved all
on the 08/26/19day of	wing described documents, papers, books and records. red subject to this subpoena, to make available for eronically. ess specifically mentioned above.) y of a contempt and liable to pay to the parties aggrieved all
on the 08/26/19day of	owing described documents, papers, books and records. ed subject to this subpoena, to make available for cronically. ess specifically mentioned above.) y of a contempt and liable to pay to the parties aggrieved all dred dollars in addition thereto. eg the declaration on the reverse hereof, or on the copy which is
on the 08/26/19day of entitled matter and to bring with you and produce the follower that the formula and copying or transmit/transfer elect (Do not produce X-rays unlesses and damages sustained thereby and forfeit one hund). This subpoena is issued at the request of the person making the follower than th	wing described documents, papers, books and records. red subject to this subpoena, to make available for cronically. ess specifically mentioned above.) y of a contempt and liable to pay to the parties aggrieved all dred dollars in addition thereto. g the declaration on the reverse hereof, or on the copy which is WORKERS' COMPENSATION APPEALS BOARD
on the 08/26/19day of entitled matter and to bring with you and produce the followed and copying or transmit/transfer elect (Do not produce X-rays unlesses and damages sustained thereby and forfeit one hund the subpoena is issued at the request of the person making served herewith.	owing described documents, papers, books and records. ed subject to this subpoena, to make available for cronically. ess specifically mentioned above.) y of a contempt and liable to pay to the parties aggrieved all dred dollars in addition thereto. eg the declaration on the reverse hereof, or on the copy which is
entitled matter and to bring with you and produce the followed Attachment for a list of records to be produce a spection and copying or transmit/transfer elect (Do not produce X-rays unlesses and damages sustained thereby and forfeit one hund this subpoena is issued at the request of the person making served herewith.	owing described documents, papers, books and records. Led subject to this subpoena, to make available for cronically. Less specifically mentioned above.) Less of a contempt and liable to pay to the parties aggrieved all dred dollars in addition thereto. Leg the declaration on the reverse hereof, or on the copy which is WORKERS' COMPENSATION APPEALS BOARD
on the 08/26/19day of entitled matter and to bring with you and produce the followed and copying or transmit/transfer elect (Do not produce X-rays unlesses and damages sustained thereby and forfeit one hund the subpoena is issued at the request of the person making served herewith.	owing described documents, papers, books and records. Led subject to this subpoena, to make available for cronically. Less specifically mentioned above.) Less of a contempt and liable to pay to the parties aggrieved all dred dollars in addition thereto. Leg the declaration on the reverse hereof, or on the copy which is WORKERS' COMPENSATION APPEALS BOARD



*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]

Control #: 19-25123-5

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

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.

Wann)	955 Overland Court, Suite 200, San Dimas, CA 91773	(626) 653-5160	
Signature Victor Landero, Operations	Address	Telephone	

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	<u>Date</u>	<u>Place</u>
I declare under penalty of perjury that the foregoi	ng 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:

- 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.
- Applicant's application for employment or contract for services and all employment documents regarding services performed by Applicant for or on behalf of employer.
- 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.
- All investigation reports, correspondence or memoranda regarding any claims alleged by Applicant, including printouts of electronically stored files of this category.
- Any and all subrosa video and related billings and logs.
- 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.
- All correspondence, memoranda, forms and notices transmitted to or received from Applicant, including printouts of electronically stored data, memos, emails and notes.
- 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. 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.

- 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. 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.

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	CASE NUMBER:
DEFENDANT/RESPONDENT: Kaiser Permanente	ADJ11859979

PROOF OF SERVICE

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	y 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: \$	
I received this subpoena for service on (date): 08/07	7/2019
Person serving:	
a Not a registered California process serv	rver.
b. California sheriff or marshal	
c. Registered California process server.	
d. Employee or independent contractor of	of a registered California process server.
e. Exempt from registration under Busines	ess and Professions Code Section 22350(b).
f. Registered professional photocopier.	
g. Exempt from registration under Busines	ess and Professions Code section 22451.
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
clare under penalty of perjury under the laws of the Sta fornia that the foregoing is true and correct.	rate of (For California sheriff or marshal use only) I certify that the foregoing is true and correct.
08/07/2019	Date:
/S/ Mark Gonzales	•
(SIGNATURE)	(SIGNATURE)
)(15.2) [Rev. January 2000] PRO	OOF OF SERVICE CS1827

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	
	ed Worker are being produced at the about the copies of the records by selecting one	ve record location and delivered to the opposing e of the following;
	vable Services. (A) services for records relevant mployer and the copy service provider.	nt to an injured worker's claim, except services under a
Electronic Se	t per Billing Codes WC026 or WC027	Send records:
Fees set by § 9983 Fees for Copy and Related Services (f)(2) Number of Sets		☐ Same as above
	illing Codes WC026 or WC027 983 Fees for Copy and Related Services (f)(2)	
		E-mail addresses required for the electronic sets:
5	Bill to My Office (Invoice will be sent	to the address on this notice.)
	☐ Bill to the Insurance Carrier	
	(Print your r	name)
(Signature red	(Sign your n	name) Control #: 19-25123-5

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



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...

Sincere

NHRSO Subpoena Desk

Hotline: 510-749-3034

National HR Service Center

Fax to: (877) 477-2329 Telephone: (877) 457-4772

Executives: Contact your Executive Benefits Specialist

7369 05/18/2016 1



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 Subpotena Des

National HR Service Center

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

7369 05/18/2016 1

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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

Victor Landero

Director of Operations



LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

Page 1 of 5

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 Nur	mber (###) ###-###	* 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 En	ployee Phone Number	(###).###-####	New or Revised Request	
		•	•	☐ New ☐ Revised	
* Leave Type:					
Medical	Union	•	Care	for Eligible Family Member	
Maternity	Personal		☐ Fami	ly Military Leave	
☐ Workers' Comp/Industrial	Military Service	e	Bond	ling	
Last Day Worked (mm/dd/yyyy)	* First Day of Leave	(mm/dd/yyyy)	Expected Return	n Date (mm/dd/yyyy)	
	09/02/2017				
Is this an intermittent or reduced work sched	lule Leave? X Inter	mittent Reduced	Work Schedule	Not Applicable	
Is this a Donor Leave? Yes	Unknown				
Estimated frequency and duration of absence	ces				
Freq 2 times per month				•	
Duration 1 day per episode					
If absence is for Care of Eligible Family N	lember or Bonding:	: •			
Name of Eligible Family Member		Relationship to Emple	oyee		
				•	
Is Family Member age 18 or under? If Yes	, enter age	Delivery/Adoption/Foster Care Placement Date (mm/dd/yyyy)			
Yes No		Actual Date Expected Date			
Is the child's other parent employed by Kaise	er Permanente?	If Yes, full name of other parent			
Yes No				•	
If absence is due to Family Member's Mili	tary Service please :	select the reason(s) th	at apply:		
Name of Eligible Family Member		Relationship to Empl	oyee		
		·			
Qualifying Exigency, (matters related to	deployment such as (Child Care issues, Fina	ncial Planning, an	d Family Support Sessions,	
Seeing off leaving or returning Service M		·	.		
Care for qualified Service Member who	incurred injury or il	iness in the line of du	ty		

National HR Service Center

Fax to: (877) 477-2329 Telephone: (877) 457-4772

Executives: Contact your Executive Benefits Specialist



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Page 1 of 5



LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

Page 2 of 5

* First Name	Middle Name	* Last	Name		
Da'r I ene		. Walls	Walls		
* Employee ID	* Contact Phone Number (###)	###-#### * Effec	tive Date (mm/dd/yyyy)		
00530105	(213) 401-8827	09/0	2/2017		
1. LEAVE INFORMATION - (Continu	ued)	· · · · · · · · · · · · · · · · · · ·			
If absence is for Employee's own healt	h condition (Medical, Maternity or V	Vorkers' Comp/Indu	strial)		
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 da	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 complete?	employee plan to take Bonding time	immediately after t	he pregnancy related absence is		
Yes No		<u> </u>	, 		
If absence is for Union Leave					
Type of Union Leave:	•				
Short Term (30 days or less)	Long Term (greater than 30 c	days) 🔲 Elec	cted 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	•	·	•		
	•				
·					
1					
	·				
Temporary Agency or Military Service					
Has the Employee worked for Kaiser Perr	manente less than one year?		•		
☐ Yes 🔀 No	· · · · · · · · · · · · · · · · · · ·		_ :_		
Has the Employee been on active Military	Duty in the past 12 months? Stan	Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)		
☐Yes ⊠No			· · · · · · · · · · · · · · · · · · ·		
Did the Employee work for Kaiser Perman	nente with a Temporary Agency in the	ne year before they	were hired?		
Yes No		·	<u>. </u>		

National HR Service Center

Fax to: (877) 477-2329 Telephone: (877) 457-4772

Executives: Contact your Executive Benefits Specialist



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< Previous Page



LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

Page 3 of 5

* First Name		Middle I	Name		* Last Name	e .		
Darlene					Walls			
* Employee ID		* Conta	* Contact Phone Number (###) ###-####			# * Effective Date (mm/dd/yyyy)		
00530105		(213)	401-8827		09/02/20)17		
1. LEAVE INFORM	IATION - (Cont	tinued)		,				
Name of Agency		_						
Start Date (mm/dd/yy	/yy)	End Da	te (mm/dd/yyyy)		Agency Pho	one Number	(###) ###-###	
	•							
2. COMMENTS								
	-	<u> </u>				- "		
						,		
		· · · · · · · · · · · · · · · · · · ·		<u> </u>				
3. EMPLOYEE SC					<u> </u>	<u> </u>		
This information is employees absent f	essential for the or their own dis	e NHRSC to pre ability. Please	epare a worksh use a 24 hr clo	eet to assist wi ck: 00:00 thru 2	th TIME coding. 24:00.	This is requ	lired for	
NOTE: This section	is not applicable	le for the KROI	NOS regions.					
Week 1	10 110t app.110a2.			•				
	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	
Start Time: (hh:mm)						•		
Hours:							•	
Week 2 (Only n	eeded if schedu	<u>-</u>			,			
	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	
Start Time: (hh:mm)		•						
Hours:				<u> </u>	<u> </u>			
4. REQUEST PAID		· - ··						
Review your Collect Selections made he	tive Bargaining re will not supe	Agreement and rsede condition	d/or Summary I ns set in Collec	Plan Descriptio ctive Bargaining	n Booklet before n Agreements, S	e completing Summary Pla	g this section. an Descriptions,	
KP and HR Policies	, or applicable S	State and Fede	ral Laws.	· · · ·				
Did employee reques	st EarnedTime Of	ff (ETO)/Paid Ti	me Off (PTO)/V	acation?	Use all availa	able hours	Number of hours	
☐Yes ☐No					Use selected	hours		
Did employee reques	st to use Extende	d Sick Leave (E	SL)/Sick Leave	?	Use all availa	able hours	Number of hours	
☐Yes ☐ No					Use selected	hours		
Did employee reques	t to use Float Ho	olidays?			Only available F	loat	Number of days	
☐Yes ☐No					Holidays will be			
			· · · · · · · · · · · · · · · · · · ·		· · · · · · · · · · · · · · · · · · ·			

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

Page 4 of 5

* First Name		Middle Name	* Last Name		
Darlene			Walls		
* Employee ID		* Contact Phone Number (###) ###-###	*# * Effective Date (mm/dd/yyyy)		
00530105		(213) 401-8827	09/02/201	7	
4. REQUEST PAID TIM	IE-OFF - (Contin	ued)			·
Did employee request to u	se Flexible Persor	nal Days?	Number of days	OR	Number of hours
☐Yes ☐No				Un	
Note: Flexible Personal Da applied.	ays can only be us	ed in full day or two hour increments. On	ly available Flexible	Personal	Days will be
Did employee request Milit	tary 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@k	p.org		(5	62) 65	7-8527
6. MANAGER INFORM	ATION DETAIL		•		
* Name (First, MI, Last)					
Danny Jimenez					
Supervisor ID	* Title				
		•			
* E-mail Address		-	* Work Phone	Number	(###) ###-###
danny.p.jimenez@k	p.org		(5	62) 65	7 - 8527
7. ALTERNATE CONT. communication (i.e. time		FION - Someone, in addition to the Matus, etc)	anager, who sho	uld receiv	e leave
* Name (First, MI, Last)				_	
* E-mail Address		-	* Work Phone	Number	(###) ###-###
· · · · · · · · · · · · · · · · · · ·			-		

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* First Name

Darlene

LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

* Last Name Walls

Middle Name

Page 5 of 5

				•
* Employee ID		* Contact Phone Number (###) #	###-####	* Effective Date (mm/dd/yyyy)
00530105		(213) 401-8827		09/02/2017
8. MANAGER ATTE	STATION			
* Checking these items	s acknowledges that y	you have read and understand each	ch item.	
I agree to direct the Center.	employee requesting	Leave to submit any and all supp	oorting docur	mentation to me or the National HR Service
I agree to submit for to extend his or her terminated.	rm 1500 - Extend Lea leave beyond their ex	ve and any supporting documenta cpected return date or fails to return	ation at the t	ime I learn that the employee intends xpected date, fails to respond, and is not
☑ I agree to submit for	rm 1510 - Return from	n Leave when the employee return	ns to work.	
▼ TIME must be code	d for all paid and unp	aid leave taken by the employee.		
9. MANAGER SIGNA	ATURE - (Required	if not submitted online.)		
	_	•		
* Mana	ager Signature		* Da	ate (mm/dd/yyyy)
<u> </u>	·			

National HR Service Center

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Executives: Contact your Executive Benefits Specialist



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NEW HIRE DATASHEET

Page 1 of 4

Instructions:	 structions: 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 🔀 Hir		Ad	d ployee	☐Inter-Regional Transfer			Requisition	Requisition Number (If applicable. SB. 0701352	
If Rehire, provid	de last Reg	ion worked			If Transfer, pro	vide Sending Re	egion		
1. PRIMARY	NAME - (L	_egal Name)		· · · · · · · · · · · · · · · · · · ·	<u>ļ. </u>				
Prefix Mis	s Mr.	Mrs.	Ms.			· · · · · · · · · · · · · · · · · · ·			
* First Name	-		Mic	idle Name		* Last N	ame ⁻		
Darlene				•		Walls			
Suffix □Jr	□Sr				□ıv □v				
2. PREFERRI	D NAME								
First Name			Mic	idle Name		Last Na	me		
Darlene					•	Walls			
Suffix Jr	Sr	ים ים		III	_v				·
3. ADDRESS	- (P.O. Bo	ox not accept	ed as F	lome Address.)					
* Home	-				Mailing				_
* Address 1 15545 1/2	Eucalypt	us Ave.			Address 1				
Address 2					Address 2				
* City			State	* Zip Code	City	,	s	tate	Zip Code
Bellflower			CA	90706					
4. TELEPHO	NE NUMB	ERS	•					,	
* Home Numbe	r (###) ###	-###	Bus	siness Number (##	#) ###-###	Other No	umber (###)	###-##	##
+1 (562) 9:	25-5950			ı	•				
5. E-MAIL AD	DRESS								
Home									
			•						

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



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NEW HIRE DATASHEET

Page 3 of 4

Name (First, Middle, Last)				Effective Date (mm/dd/yyyy)			
Darlene Walls				02-25-2008			
11. PAYROLL							
* Employee Type			٠				
Mourly ☐ Salari	ed						
* Pay Group and De	scription						
AH1-NCAL Hospit		☐BC1-SCAL K		_	TS1-Texas CSC		
AM1-NCAL Medica	•	BM1-SCAL M	· ·	_	WH1-Northwest Hospital		
AP1-NCAL Health		BP1-SCAL H	ealth Plan		WP1-Northwest Health Plan		
⊠ BH1-SCAL Hospital							
12. SALARY PLAN	AND COMPENSA	·					
* Plan	* Grade	* Step	* Compensation	Rate (Provide Ho	ourly Compensation Rate in \$00.00)		
D2	10	01	13.0820				
Red-Circled/Green-C	Circled		If Red or Green	Circled - Enter Co	omp Rate End Date		
Red-Circled G	areen-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 1		License Number	r 1	Expiration Date 1 (mm/dd/yyyy)		
CRT / CA-CNA			00211001		03-23-2009		
License/Certification	Type 2		License Number	r 2	Expiration Date 2 (mm/dd/yyyy)		
COC / US-BLS					07-01-2008		
License/Certification	Type 3		License Number	r3 ·	Expiration Date 3 (mm/dd/yyyy)		
•							
License/Certification	Type 4		License Number	r 4	Expiration Date 4 (mm/dd/yyyy)		
License/Certification Type 5			License Number	r 5	Expiration Date 5 (mm/dd/yyyy)		
					·		
License/Certification	Type 6	-	License Number	r 6	Expiration Date 6 (mm/dd/yyyy)		
÷					.		
L					<u> </u>		

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NEW HIRE DATASHEET

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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 num	ber of hours (00.00)				
15. COMMENTS	· .				
	•				
16. PREPARED BY					
* Employee ID	* Name (First, Mid	ddle, Last)			
00260609	Joy A Kaiser	·			
* Title	-	* Work Phone Number (###) ###-###			
Recruitment Assistant		(562) 461-6646			
* Recruiter E-mail Address	<u>-</u>				
Joy.A.Kaiser@kp.org					
17. MANAGER INFORMATION DETAIL					
* Name (First, Middle, Last)		* Title			
Renato Razonable		Department Nurse Manager			
* Work Phone Number (###) ###-###	Work Phone Number (###) ###-### * Manager E-mail Address				
(310) 517-3042	Renato.L.Raz	conable@kp.org			



- After completing the form:

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

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

MEMBERSHIP APPLICATION (PLEASE PRINT CLEARLY)
First Name Darlene Walls
Gender (please check appropriately) Birthdate (month/day/year) Social Security Number Male Permale 03 23 67 5 5 8 3 7 5 6 7 9
Street Address Apt. No. 15545 /2 EU Calypt 45
City Bellflower CA Zip 90706
Home Email
Home Phone Personal Cell Phone Personal Pager 562925 5950 3/0346 8626
Employer Facility FOLSET PERMANENTE
Work Location/Campus Couting Boy Date of Hire 8
Department Job Classification R at + 2
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 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
 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;
 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 Calla Date Signed 1/30/08
Original Copy: Employer Yellow Copy: SEIU UHW - West Membership Dept Pink Copy: Employee
seiu uhw-west



CONFIDENTIALITY AGREEMENT

Page 1 of 2

Instructions:

- 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.

Darlene Walls	3/0) 5 17-3000	* Effective Date (mm/dd/yyyy) 2/25/08
* Employee / Physican First Name	Employee / Physician Middle Name	* Employee / Physician Last Name
* Job Title	*Location 5 outh B#	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:

- I will protect the confidentiality of our patients, members, employees and physicians.
- 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 fall to protect my password or other access to confidential information.
- 5. I will not use anyone else's password to access any Kalser 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 compiliance with the terms of any applicable software license agreements.
- I will not share and confidential information even if I no longer work for Kaiser Permanente.
- 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



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TD:Fax Server



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CONFIDENTIALITY AGREEMENT

Page 2 of 2

* First Name	Middle Name	* Last Name	
Darlene		walls	,
* Employee ID	* Work Phone Number (###)###		1/ yyyy)
530105	310)517-300	0 3/28/0	~

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 Kalser 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 Keiser Permanente will not tolerate any retaliation because I make such a report.

I understand that fallure to comply with this agreement may result in disciplinary action up to and including termination of employment or other relationship with Kalser 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 Kalser 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.

SIGNATURE (Required if not submitted online)



After completing the form:

- Print form to keep a copy for your records.
 Press the Submit buttion,

- 3. Walt for a pop-up screen to comfirm the form has been sub nitted. (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
- Volunteers, Students and Temporary Employees: Provide completed form to your Keiser Permanente Manager.
 SCPMG Physicians ONLY: To be administered and retained as part of credentiating process.

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CHILD ABUSE REPORTING REQUIREMENTS

310 257 5312

Page 1 of 1

Instructions: 1.To ensure efficient and effective service please, submit form online.

- 2. Items marked with an asterisk (") are required fields.

4. Immediate confin	r online submitt				
* Employee ID * Home Phone	(###) ### ####	* Work Phone (###)	 	* Effective Date (n	rm/dd/yyyy)
530/05 562) 96	25-5950	3/0)517	3000	2/28/	108
* First Name	Middle Na	ame		ast Name	
Darlene			(walls	
1. REQUIREMENTS					
Section 11166 of the Penal Code has knowledge of or observes a knows or reasonably suspects has suffering serious emotional dama instance of child abuse to a child send a written report thereof with	child in his or her profe as been the victim of c age or is at substantial protective agency im in 36 hours of receivir	essional capacity or with hild abuse or who he o risk of suffering seriou nedlately or as soon as ig the information conc	tin the scope of she knows or r s emotional dan practically poss ming the incide	his or her employmeasonably suspects nage to report the knistle by telephone a ent.	ent who he or she that a child is own or suspected nd to prepare and
The identity of all persons who re to the district attorney in a crimina from alleged child abuse, or to complete the county counsel or district attorney in a case or Section 300 of the Welfare and suspected, or when those person Health practitioner includes phenomenators, licensed nurses, dwith Section 500) of the Business paramedics, or other person cert psychological assistants registent counselor trainees as defined in the health employees who treat mind diagnose, examine, or treat child	al prosecution, or in all pursel appointed purse may in a proceeding of institutions Code, or as waive confidentiality sysicians and surgeon ental hyglenists, optor a and Professions Co- ified pursuant to Division de pursuant to Section subdivision (c) of Sections for venereal disease	n action Initiated under uant to subdivision (c) of under Part 4 (commence to a licensing agency way, or by court order. s, psychiatrists, psychometrists, or any other parties, or any other parties, marriage, family and ion 2.5 (commencing was 2913 of the Business ion 4980.44 of the Business ion 4980.44 of the Business ion 4980.44 of the Business in the subject in the subje	Section 602 of the fraction 317 of the section 317 of the section then abuse or no ogists, dentists reconsults and counselout Section 1797 and Professions ress and Professions	the Welfare and Instift the Welfare and Instift 1900) of Division 1. reglect in out-of-homic, residents, interns, pased under Divisions, emergency medit 19 of the Health and 19 Code, marriage, fassions Code; state of the Welfard 1900 of the Health and	tutions Code arising stitutions Code, or to 2 of the Family Code is care is reasonably podiatrists, 2 (commencing cal technicians I or II, Safety Code; mily and child r county public
Volunteers whose duties include report instances of child abuse a	nd neglect.	• •			
i understand and agree, if in a	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				
2, EMPLOYEE SIGNATURE	Warlere	walk w.		:	
Signature - (Required if not submitte	d onlinė).	Market State Commission Commission			and the state of t
Cholon *Employee Signal	me Wale	7	3 / * Date (n	3/5 <u>\$</u>	-
Facility / Department	ı <i>EP</i>				
South Bay 150	urg			·	

After completing the form:

1. Print form to keep a copy for your records.

2. Press the Submit buttlen.

3. Wait for a pop-up screan 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



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LANGUAGE PROFICENCY

Page 1 of 1

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.

⁴ Employee ID		* Contact Phon	e Numt	oer (###)	 - 	* Effective Date (mm/d	d/yyyy)	
530/05	· .	310)34	16 -1	8620		2/28/0	8	
* First Name		Middle Name				* Last Name		
Darlene	,					Walls		
1. LANGUAGE INF	ORMATION							
Foreign Language	•	<u> </u>		Foreign 1	anguage		٠,	
. "	•		1					
A. How well can you p	erform the following In	this language:		A. How w	ell can you p	erform the following in	this language:	
Speak	Read	Write		S	eak	Read	Write	
☐ Fluently	Fluently	Fluently		🔲 Fluent	y	☐ Fluently	☐ Fluently	ĺ
□ Adequately	□ Adequately	☐ Adequately		☐ Adequ	ately	Adequately	Adequately Adequately	
☐ Minimally	Minimally	Minimally		Minim	ally	Minimally	Minimally	
B. Is this your native to	anguage?	Yes	No	B. Is this	your native l	anguage?	☐Yes ☐N	40
C. Are you able to trai	nslate this language?	Yes	□No	C. Are yo	u able to trai	nslate this language?	☐Yes ☐N	40
D. Are you able to tea	ch in this language?	∐Yes	□No	D. Are yo	ou able to teach in this language?			VÓ
Foreign Language				Foreign	anguage			
					_			
A. How well can you p	perform the following in	this language:		A. How v	eli can you f	perform the following in	this language:	
Speak	Read	Write		S	peak	Read	Write	
Fluently	Fluently	☐ Fluently		Fluen	lý	Fluently	Fluently	
Adequately.	Adequately	Adequately Adequately		☐ Adeqi	rately	Adequately	Adequately	
Minimally	Minimally	Minimally		Minim	ally	Minimally	Minimally	
B. Is this your native language?		□No	B. Is this	your native language?		☐Yes ☐i	No	
C. Are you able to tra	nslate this language?	☐ Yes	□No	C. Are ye	ou able to translate this language?		Yes 🔲	No
D. Are you able to teach in this language? Yes No			∏ No	D. Are ye	u able to tea	ach in this language?	☐Yes ☐!	No
	Afte	r completing the f	lorm:	•		·		

Print form to keep a copy for your records.
 Press the Submit buttlon.

3. Weit 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



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STANDARDS OF ATTENDANCE

Page 1 of 1

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 o iginal and the fax receipt for your records.

5. Upon receipt, your form will be processed within 3 days.

	`		
* Employee ID	* Contact Phone Number (###)	144 444	* Effective Date (mm/dd/yyyy)
530105	310) 346-86	20	2/28/08
* First Name	Middle Name		* Last Name
Darlene	<u> </u>		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.

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



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ELDER AND DEPENDENT ADULT ABUSE REPORTING REQUIREMENTS Page 1 of 1

Instructions: 1. To ensure efficient and effective service please, submit form online.

- 2. Items marked with an asterisk (*) are required fields.

Remember to print copy of form before submitting. Immediate confirmation will be sent to you upon receipt of your			r online submitt			
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(b) to the State I	Department of Mental Healt					
(c) to the adult p	use is alteged to have occur protective services agency of					
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2. Press the Submit buttion.

3. Walt 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



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Page 1 of 1

Dartene Williams C.N.A 15545 ½ Eucalyptus Ave. Beliflower, 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 intuke
- Assisted with group therapy
- ADLS

KAISER PERMANENTE® APPLICATION FOR EMPLOYMENT



UAN 25 2008

FOR OFFICE USE

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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.

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PAGE 1 OF 5

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MAISER PERMANENTE.

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

PRINT NAME	Walls	Darl	ene.	DATE OF HIRE	
JOB TITLE	ng Attendend	FACILITY (MEDICAL CENTER) SOUTH BOY	DEPARTMENT Med/Surg	DATE OF TRANSFER	

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

HIPPAAS ecurity

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 INCORNATION HAS BEEN COVERED WITH ME DURING MY NEW EMPLOYEE ORIENTATION.

EMPLOYEE SIGNATURE WOLLOW WO	DATE 2 1 37 108
STAFF EDUCATION REPRESENTATIVE SIGNATURE	DATE
alle ocal	2127108

-1283 (8-03) WHITE HUMAN RESOURCES SERVICE CENTER CANARY - MANAGER PINK - EMPLOYEE

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

President Board of Trustee



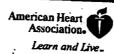
Hand Hygiene and Artificial Nail Policy Review and Distribution Documentation

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.

Walere wall

Employee signature



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

07/2008:

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AHA
Region _ W.S.R. = Los Angeles County .

Community
Training Center Little Company of Mary CTC

TRINITY VOCATIONAL CENTER

Instructor ZENAIDA MITU

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KAISER PERMANENTE		······································	Course Comp	oletion Form
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Instructions: To receive credit for th Number and Name fields, use the in	ils course, complete formation as it appea	the fleids below. Pars on your payche	rint clearly. To comp ck.	lete the I.D.
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Course Completion Attestation				
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I agree to abide by the Principles of Responsibility can result in discipling the addition to complete with the Description.	nary action, up to and I	ncludina termination.		-
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Please check your classification:	!			
EKP Employee (Employee, Per D		☐ PMG Physicia	an (Physician, Per D	lem, etc.)

Revision 01/02/09



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="" domestic="" family="" member="" parent="" partner=""> due to his/her serious health condition.</spouse>
An exigency arising out of the fact that your <spouse daughter="" or="" parent="" son=""> is on active duty or call to active duty status.</spouse>
Your need to care for your <spouse daughter="" kin="" next="" of="" or="" parent="" son=""> due to his/her serious injury or illness incurred in the line of duty as a covered servicemember.</spouse>
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 mos="" num=""> 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</enter>
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.</enter></mm>

HR Service Center

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

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You exhausted your <12 26>-week entitlement to leave under the <fmla cfra=""></fmla>
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="" care="" domestic="" foster="" marriage="" partner="" relationship="">.</birth>
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.



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 Pald 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.

HR Service Center

Fax to: (877) 477-2329 Telephone: (877) 457-4772 Executives: Contact your Executive Benefits Specialist 7087 08/19/2010 5

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DOWNEY SERVICE AREA

NEW EMPLOYEE ORIENTATION CHECKLIST

FINE FOLES OFFICE ATTICK OFF			1
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(FIRST)	DATE OF HIRE		

			J 43/00
PRINT NAME (LAST)	(FIRST)		DATE OF HIRE
WALLS	. DAR	LENE	3/5/12
JOB TITLE	FACILITY (MEDICAL CENTER)	DEPARTMENT	DATE OF TRANSFER
Nyrsing AT.	DMC	MEDISUEG	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.

EMPLOYER SIGNATURE Walled Wal	Lo.	DATE 3	17	1/2
STAFF EDUCATION DEFINE STATUTE SIGNATURE		DATE	17	1/2
NS-1293 (8/03)	WHITE - HUMAN RESOURCES SERVICE CENTER CANARY - MANAGER PINK - EMPLO	OYEE		

MASER PERMANENTE.	9		Course Completion Form
REGION: So Cal			
COURSE TITLE: General Compliance	e Training for New Em	ployees 2012	
CLASSROOM INSTRUCTOR: Fe	rdin Alon	50	
COMPLETION DATE: 3/4/	12		
instructions: To receive credit for this Number and Name fields, use the info			
Your Information EMPLOYEE/PHYSICIAN I.D. NUMBER		UID#, IF KNOWI	M
530105	<u>.</u>	(2351)65	
LAST NAME	FIRST NAME		MIDDLE INITIAL
WALLS	DARLE		WOED OUTODE
WORK PHONE NUMBER, TIELINE	W	OKK PHONE NO	JMBER, OUTSIDE
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Course Completion Attestation I understand that required compliance program. My signature General Compliance Training for N X SIGNATURE Principles of Responsibility Atte I have received, read, and I understand that I am expect compliance with the Principle comply with these principle I understand that I am also ethics concerns I become a lf I have any questions, I we	ince training is an ime indicates that I, and vew Employees 2012 estation familiarized myself we ected to conduct mysels of Responsibility as can result in discipate required, in good faware of, and that I all seek clarification from the control of the contro	portant part of no one on my 2 course. with a copy of the self in an ethic of at all times. It is all times are not an protected from protec	CPL:NACPL CNE 2012 ILT Kaiser Permanente's y behalf, have completed the ATE ATTENDED/COMPLETED The Principles of Responsibility. all and responsible manner in also acknowledge my failure to up to and including termination. my suspected compliance or rom retaliation for reporting.

Version 1.0 11/18/2011

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

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



CONFIDENTIALITY AGREEMENT

Page 1 of 3

- 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	MEDISURG	3/5/12
* Employee First Name	Employee Middle Name	* Employee Last Name
DARLENG		WALS
* 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)

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

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 Kalser Permanente to disclose confidential information, I will obtain approval from my supervisor before disclosing such information.
- 1 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.

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

Executives: Contact your Executive Benefits Specialist



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CONFIDENTIALITY AGREEMENT

Page 2 of 3

* First Name	Middle Name	* Last Name
DARLENE		WALLS
* Employee ID	* Work Phone Number (###)###-####	* Effective Date (mm/dd/yyyy)
530/05	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.

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

Executives: Contact your Executive Benefits Specialist

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CONFIDENTIALITY AGREEMENT

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	· · · · · · · · · · · · · · · · · · ·	
* First Name	Middle Name	* Last Name
DARLENE	·	WALLS
* Employee ID	* Work Phone Number (###)###-#####	* Effective Date (mm/dd/yyyy)
530105	MEDISURG	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)

Dalem walk	3/6/12	
* Employee Signature	* Date (mrh/dd/yy/y)	

Submit

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.)
- 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

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DRUG-FREE WORKPLACE - EMPLOYEE ACKNOWLEDGEMENT

Page 1 of 2

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 I	Number - Outside (###) ###-####	NUID # (if known)
MED/SURG	MED!	3URG	X835065
Location/Facility Name		Department	
PMC		DALL 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

Worlene Walls	3/7/12	3/7//2
* Employee Signature	m (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



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Page 1 of 2



DRUG-FREE WORKPLACE - EMPLOYEE ACKNOWLEDGEMENT

Page 2 of

* First Name	Middle Name	* Last Name
DARLENE		WALLS
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
536105	323) 674-5660	3/5/12
4. SUBMITTED BY		
* First Name	Middle Name	* Last Name
DARIENE		WALLS.
* Employee ID * Title		* Work Phone Number (###) ###-####
530/05 NUESING A	.77.	
5. MANAGER INFORMATION DETAIL		
* First Name	Middle Name	* Last Name

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

NURSING ATT.

Executives: Contact your Executive Benefits Specialist



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Work Phone Number (###) ### #### 562) 657-8527

Page 2 of 2





LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

Page 1 of 5

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.
- 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.

- Embloyee ID		ımber (###) ###-###	Effective Date	, , , , , , , , , , , , , , , , , , , ,
00530105	(562) 657-8	3527	09/19/201	2
* First Name	Middle Name	_	* Last Name	
Darlene			Walls	
1. LEAVE INFORMATION			•	
Employee E-mail Address	Alternate E	mployee Phone Number	r (###) ###-###	New or Revised Request
				New Revised
* Leave Type:				
Medical	Union		Care	for Eligible Family Member
Maternity	Personal	•	Fami	ly Military Leave
☐ Workers' Comp/Industrial	Military Serv	rice	Bond	ling
Last Day Worked (mm/dd/yyyy)	* First Day of Leave	e (mm/dd/yyyy)	Expected Return	n Date (mm/dd/yyyy)
	09/19/2012			
Is this an intermittent or reduced work sche	dule Leave? 🔀 Int	ermittent Reduced	Work Schedule [Not Applicable
Estimated frequency and duration of absen	ces			
UNKNOWN				
If absence is for Care of Eligible Family I	Member or Bonding			
Name of Eligible Family Member		Relationship to Employee		
				· · · · · · · · · · · · · · · · · · ·
Is Family Member age 18 or under? If Yes	s, enter age	Delivery/Adoption/Foster Care Placement Date (mm/dd/yyyy)		
Yes No		Actual Date Expected Date		
Is the child's other parent employed by Kaiser Permanente?		If Yes, full name of o	ther parent	
☐ Yes ☐ No	•			
If absence is due to Family Member's Mi	litary Service please	select the reason(s) th	nat apply:	
Name of Eligible Family Member		Relationship to Empl	loyee	
L				
Qualifying Exigency, (matters related to	deployment such as	Child Care issues, Fina	ncial Planning, an	d Family Support Sessions,
Seeing off leaving or returning Service N		Illmann in the line of d	.	
Care for qualified Service Member wh		iliness in the line of du	пу	

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

Page 2 of 5

* First Name	Mid	Middle Name				
Darlene		Walls				
* Employee ID	* Co	* Contact Phone Number (###) ###-####			Effective Date (mm/dd/yyyy)	
00530105	(56	(562) 657-8527 09/19/2012			2	
1. LEAVE INFORMATION - (Contin						
If absence is for Employee's own hea	lth condi	ition (Medical, Materni	ty or Workers' Cor	np/Industr	rial)	
Date of illness or injury (mm/dd/yyyy)	Was ho	spitalization required?		1	Date I	Hospitalized (mm/dd/yyyy)
09/19/2012	Yes	☐ No. 🏻 Unknov	vn			
Estimated/Actual hours worked on last of	lay	If Leave is due to ma	ternity			Delivery Date (mm/dd/yyyy)
8		Actual Delivery Da	ate Expected	Delivery D	ate	
If absence is pregnancy related, does th complete?	e employ	ee plan to take Bondin	g time immediatel	y after the	preg	nancy related absence is
☐ Yes ☐ No			·		`	
If absence is for Union Leave						
Type of Union Leave:						
Short Term (30 days or less)	.: 🔲 L	ong Term (greater tha	n 30 days)	Electe	ed Off	icial
Name of Union						
If absence is for Military Leave						
Is this absence for Military Training o	r Active	Duty? .				
Military Training		Active Duty				
* If for Personal Leave, indicate reaso	n					
Temporary Agency or Military Service	(asked f	or FMLA eligibility)				
Has the Employee worked for Kaiser Pe						
☐Yes ☑No		•				
Has the Employee been on active Militar	ry Duty in	the past 12 months?	Start Date (mm/c	ld/yyyy)	Ţi	End Date (mm/dd/yyyy)
☐ Yes No						3331
Did the Employee work for Kaiser Perma	anente wi	th a Temporary Agend	y in the year befor	e they we	ere hir	ed?
Yes No						

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

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t First Name		Middle I	Name :	•	* Last Name		
* First Name Da r I ene		ivildale i	vame		Walls		
			<u> </u>				
* Employee ID			* Contact Phone Number (###) ###-###		##		
00530105		(562)	657-8527		09/19/20)12	
1. LEAVE INFORM	IATION - (Con	tinued)					
Name of Agency							
Start Date (mm/dd/yy	/yy)	End Da	te (mm/dd/yyyy)		Agency Pho	one Number	(###) ###-####
2. COMMENTS		L					
LAUNCHING 1480	ON BEHALF	OF MICHELLE	E. L. LENABUR	G			
					•		
							·
						-	•
3. EMPLOYEE SC	HEDULE						
This information is absent for their own					TIME coding. T	his Is requi	red for employees
NOTE: This section							
Week 1	is not applicable	ie iui tile knoi	103 regions.				
	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start Time: (hh:mm)				<u> </u>	-		
Hours:							
	eeded if schedu	le changes wee	k to week)	1	<u>.</u>	L	
	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start Time: (hh:mm)							
Hours:							
4. REQUEST PAID	TIME-OFF			•		•	
Review your Collect Selections made he KP and HR Policies	re will not supe	rsede conditio	ns set in Collec	Plan Description ctive Bargaining	Booklet before Agreements, S	e completing summary Pla	g this section. In Descriptions,
Did employee reques	t EamedTime O	ff (ETO)/Paid Ti	me Off (PTO)/V	acation?	Use all availa	ble hours	Number of hours
☐Yes ⊠No			Use selected hours			·	
Did employee reques	it to use Extende	d Sick Leave (E	SL)/Sick Leave	?	Use all availa	ıble hours	Number of hours
⊠Yes					Use selected	hours	
Did employee reques	t to use Float Ho	olidays?			Only available F	loat	Number of days
☐Yes ⊠No					Holidays will be		

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

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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	09/19/2012	2		
4. REQUEST PAID TIM	E-OFF - (Contin	ued)				
Did employee request to use Flexible Personal Days?			Number of days	OR	Number of hours	
☐Yes ⊠No						
Note: Flexible Personal Da applied.	ays can only be us	ed in full day or two hour increments. On	ly available Flexible	Personal	Days will be	
Did employee request Milit	tary Make-ūp Pay?					
☐Yes ☐No						
5. SUBMITTED BY		-			• .	
* Name (First, MI, Last)						
Rosanne Torres						
* Employee ID	* Title	* Title				
00237713		\cdot .				
* E-mail Address			* Work Phone Number (###) ###-###			
ROSANNE.M.TORRES@	KP.ORG		(562) 461-5422			
6. MANAGER INFORM	ATION DETAIL					
* Name (First, MI, Last)		·	•			
MICHELLE L LEN	ABURG					
Supervisor ID	* Title					
		•				
* E-mail Address	E-mail Address * Work Phone Number (###) ###			(###) ###-###		
MICHELLE.L.LENABURG@KP.ORG (562) 657-852			7-8527			
7. ALTERNATE CONT	ACT INFORMAT	TION - (if manager is unavailable or v	will not manage the	e employ	ee 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



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* First Name

Darlene

LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

* Last Name Walls

Middle Name

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* Employee ID		* Contact Phone Number (###) ###-###	* Effective Date (mm/dd/yyyy)			
00530105		(562) 657-8527	09/19/2012			
8. MANAGER ATTESTAT	ION					
* Checking these items acknowledges that you have read and understand each item.						
☑ I agree to direct the employ	☑ I agree to direct the employee requesting Leave to submit any and all supporting documentation to me or the HR Service Center.					
		ve and any supporting documentation at the spected return date or fails to return on their				
☑ I agree to submit form 151	0 - Return from	Leave when the employee returns to work.				
		•				
▼ TIME must be coded for al	I paid and unpa	aid leave taken by the employee.	·			
9. MANAGER SIGNATURI	E - (Required	if not submitted online.)				
		The first state of the control of th				
			·			
* Manager Sig	nature	*1	Date (mm/dd/yyyy)			

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

Executives: Contact your Executive Benefits Specialist



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October 19, 2012

Employee ID: 00530105

Case Number: 35487487

Darlene Walls 16323 Cortuna Ave # 8 Bellflower, CA 90706

Dear Darlene Walls.

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

•
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="" domestic="" family="" member="" parent="" partner=""> due to his/her serious health condition.</spouse>
An exigency arising out of the fact that your <spouse daughter="" or="" parent="" son=""> is on active duty or call to active duty status.</spouse>
Your need to care for your <spouse daughter="" kin="" next="" of="" or="" parent="" son=""> due to his/her serious injury or illness incurred in the line of duty as a covered servicemember.</spouse>
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

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.

HR Service Center

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

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Sufficient certification to support your request for FMLA/CFRA leave.
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/CFR 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.</mm>
☐ 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 adoption="" care="" domestic="" foster="" kin="" marriage="" next="" of="" partner="" relationship="">.</birth> ☐ Military Orders

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

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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 <i>Employee Rights and Responsibilities</i> 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

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

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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

- 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

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
- 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.

HR Service Center

Fax to: (877) 477-2329 Telephone: (877) 457-4772

Executives: Contact your Executive Benefits Specialist

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November 10, 2012

Employee ID: 00530105

Case Number: 35487487

Darlene Walls 16323 Cortuna Ave # 8 Bellflower, CA 90706

Dear Darlene Walls,

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

Or	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.
\boxtimes	Your own serious health condition.
	Your need to care for your <spouse child="" domestic="" family="" member="" parent="" partner=""> due to his/her serious health condition.</spouse>
	An exigency arising out of the fact that your <spouse daughter="" or="" parent="" son=""> is on active duty or call to active duty status.</spouse>
	Your need to care for your <spouse daughter="" kin="" next="" of="" or="" parent="" son=""> due to his/her serious injury or illness incurred in the line of duty as a covered servicemember.</spouse>
Th	is 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 mos="" num=""> months towards this requirement. If you are still on leave at the completion of 12 months of service please contact the HRSC to</enter>
	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</enter></mm>
	requirement. You can check the number of hours worked by contacting the HRSC.

HR Service Center

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

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You exhausted your <12 26>-week entitlement to leave under the <fmla cfra=""></fmla>
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="" care="" domestic="" foster="" marriage="" partner="" relationship="">.</birth>
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.



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



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.

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

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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.

Care for qualified Service Member who incurred injury or illness in the line of duty					
Qualifying Exigency, (matters related to Seeing off leaving or returning Service Me	embers.)			d Family Support Sessions,	
Name of Eligible Family Member		Relationship to Emple	oyee		
If absence is due to Family Member's Mili	tary Service please s	~			
Yes No		,			
Is the child's other parent employed by Kaise	er Permanente?	If Yes, full name of ot	ther parent		
Yes No	•	Actual Date Expected Date			
Is Family Member age 18 or under? If Yes	, enter age	Delivery/Adoption/For	ster Care Placeme	ent Date (mm/dd/yyyy)	
Name of Eligible Family Member		Relationship to Emplo	oyee		
If absence is for Care of Eligible Family N	lember or Bonding:	T=-:-:			
	· .				
Estimated frequency and duration of absence To be determined by Physician					
Is this an intermittent or reduced work sched	. ————————————————————————————————————	mittent Reduced	Work Schedule	Not Applicable	
·	06/17/2013				
Last Day Worked (mm/dd/yyyy)	* First Day of Leave (mm/dd/yyyy)	Expected Return	n Date (mm/dd/yyyy)	
☐ Workers' Comp/Industrial	Military Servic	е	Bond	ling	
Maternity	Personal		Fami	ly Military Leave	
Medical	Union		Care	for Eligible Family Member	
* Leave Type:		•		<u>, </u>	
,		, ,	. ,	New Revised	
Employee E-mail Address	Alternate Em	ployee Phone Number	(###) ###-####	New or Revised Request	
1. LEAVE INFORMATION					
Darlene	Middle Name		Walls		
* First Name	Middle Name	· - ·	* Last Name		
00530105	* Contact Phone Number (###) ###-#### (562) 657 - 8527		06/17/2013		
* Employee ID	* Contact Phone Num	nher (###) ###-###	* Effective Date	(mm/dd/www)	

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

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* First Name	Mide	dle Name		* Last Name				
Darlene				Walls				
* Employee ID	ntact Phone Number	(###) ###-###	* Effective Date (mm/dd/yyyy)					
00530105	(562) 657-8527			06/17/2013		3		
1. LEAVE INFORMATION - (Continued)					·			
If absence is for Employee's own healt	h condi	tion (Medical, Matern	ity or Workers' Con	np/Indust	trial)	· · · · · · · · · · · · · · · · · · ·		
Date of illness or injury (mm/dd/yyyy)	Was ho	Vas hospitalization required?				Date Hospitalized (mm/dd/yyyy)		
06/17/2013	Yes No Unknown							
Estimated/Actual hours worked on last da	y.	If Leave is due to ma	aternity			Delivery Date (mm/dd/yyyy)		
8		Actual Delivery D						
If absence is pregnancy related, does the complete?	employ	ee plan to take Bondir	ng time immediately	y after the	e preg	nancy related absence is		
☐Yes ☐No								
If absence is for Union Leave								
Type of Union Leave:								
Short Term (30 days or less)		ong Term (greater tha	an 30 days)	Elect	ed Of	ficial		
Name of Union								
If absence is for Military Leave								
Is this absence for Military Training or	Active I	Duty?						
Military Training		Active Duty		i				
* If for Personal Leave, Indicate reason	ŀ							
				•				
Temporary Agency or Military Service	asked f	or FMLA eligibility)						
Has the Employee worked for Kaiser Perr	nanente	less than one year?						
☐Yes ☑No						- 		
Has the Employee been on active Military	Duty in	the past 12 months?	Start Date (mm/d	d/yyyy)		End Date (mm/dd/yyyy)		
Yes No								
Did the Employee work for Kaiser Permar	nente wi	th a Temporary Agend	cy in the year befor	e they we	ere hir	red?		
∏Yes ∏No								

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LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

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* First Name		Middle N	Jame	•	* Last Name	e		
Darlene	I Wildaic I	Tarric		Walls	•			
			et Phone Numbe	or (###) ###-###				
* Employee ID 00530105		657-8527) (<i>пип) пип-пип</i>	06/17/20	•	<i>(</i>		
	l`			007.17720		· · · · · · · · · · · · · · · · · · ·		
1. LEAVE INFORM	ATION - (Con	tinued)						
Name of Agency								
Start Date (mm/dd/yy	dd/yyyy) End Date (mm/dd/yyyy)				Agency Phone Number (###) ###-####			
2. COMMENTS		<u> </u>						
Attendance Revi	iew 07/09/1	3- 1480 sub	mitted on	behalf of M	anager Mich	elle Len	aburg. am	
		,		_	J		J	
3. EMPLOYEE SCI	HEDULE			•				
This information is eabsent for their own					TIME coding. T	'his is requi	red for employee	
		156 nze 9 74 ili		ru 24:00.				
absent for their own	dioability: 1 lot		0.0011.					
NOTE: This section	•							
	is not applicab	le for the KRON	IOS regions.		· ·	·		
NOTE: This section Week 1	•			Wednesday	Thursday	Friday	Saturday	
NOTE: This section Week 1 Start Time: (hh:mm)	is not applicab	le for the KRON	IOS regions.		Thursday	Friday	Saturday	
NOTE: This section Week 1 Start Time: (hh:mm) Hours:	is not applicab	le for the KRON	Tuesday		Thursday	Friday	Saturday	
NOTE: This section Week 1 Start Time: (hh:mm)	is not applicab Sunday eeded if schedu	Monday le changes weel	Tuesday	Wednesday				
NOTE: This section Week 1 Start Time: (hh:mm) Hours: Week 2 (Only no	is not applicab	le for the KRON	Tuesday		Thursday Thursday	Friday		
NOTE: This section Week 1 Start Time: (hh:mm) Hours: Week 2 (Only note) Start Time: (hh:mm)	is not applicab Sunday eeded if schedu	Monday le changes weel	Tuesday	Wednesday				
NOTE: This section Week 1 Start Time: (hh:mm) Hours: Week 2 (Only note) Start Time: (hh:mm) Hours:	Sunday eeded if schedu Sunday	Monday le changes weel	Tuesday	Wednesday				
NOTE: This section Week 1 Start Time: (hh:mm) Hours: Week 2 (Only note) Start Time: (hh:mm) Hours: 4. REQUEST PAID	Sunday eeded if schedu Sunday	Monday le changes weel Monday	Tuesday (to week) Tuesday	Wednesday	Thursday	Friday	Saturday	
NOTE: This section Week 1 Start Time: (hh:mm) Hours: Week 2 (Only note) Start Time: (hh:mm) Hours: 4. REQUEST PAID Review your Collect Selections made her	Sunday eeded if schedu Sunday TIME-OFF ive Bargaining re will not supe	Monday le changes weel Monday Agreement and ersede condition	Tuesday (to week) Tuesday	Wednesday Wednesday Plan Description	Thursday Booklet before	Friday	Saturday g this section.	
NOTE: This section Week 1 Start Time: (hh:mm) Hours: Week 2 (Only note) Start Time: (hh:mm) Hours: 4. REQUEST PAID Review your Collect Selections made her KP and HR Policies,	Sunday eeded if schedu Sunday TIME-OFF ive Bargaining re will not supe or applicable	Monday le changes weel Monday Agreement and resede condition state and Feder	Tuesday (to week) Tuesday d/or Summary ns set in Collect al Laws.	Wednesday Wednesday Plan Description	Thursday Booklet before Agreements, S	Friday e completing	Saturday g this section. an Descriptions,	
NOTE: This section Week 1 Start Time: (hh:mm) Hours: Week 2 (Only note) Start Time: (hh:mm) Hours: 4. REQUEST PAID Review your Collect Selections made her KP and HR Policies, Did employee request	Sunday eeded if schedu Sunday TIME-OFF ive Bargaining re will not supe or applicable	Monday le changes weel Monday Agreement and resede condition state and Feder	Tuesday (to week) Tuesday d/or Summary ns set in Collect al Laws.	Wednesday Wednesday Plan Description	Thursday Booklet before Agreements, S Use all availa	Friday e completing	Saturday g this section.	
NOTE: This section Week 1 Start Time: (hh:mm) Hours: Week 2 (Only note) Start Time: (hh:mm) Hours: 4. REQUEST PAID Review your Collect Selections made her KP and HR Policies, Did employee request Yes No	Sunday eeded if schedu Sunday TIME-OFF ive Bargaining re will not supe or applicable s	Monday le changes weel Monday Agreement and resede condition State and Federal Times of the condition of	Tuesday Tuesday Tuesday Tuesday Tuesday Tuesday Liver Summary Tuesday Tuesday Tuesday Tuesday Tuesday Tuesday Tuesday	Wednesday Wednesday Plan Description etive Bargaining acation?	Thursday Booklet before Agreements, S Use all availa Use selected	Friday e completing gummary Pla able hours	Saturday g this section. an Descriptions,	
NOTE: This section Week 1 Start Time: (hh:mm) Hours: Week 2 (Only note) Start Time: (hh:mm) Hours: 4. REQUEST PAID Review your Collect Selections made her KP and HR Policies, Did employee request Yes No Did employee request	Sunday eeded if schedu Sunday TIME-OFF ive Bargaining re will not supe or applicable s	Monday le changes weel Monday Agreement and resede condition State and Federal Times of the condition of	Tuesday Tuesday Tuesday Tuesday Tuesday Tuesday Liver Summary Tuesday Tuesday Tuesday Tuesday Tuesday Tuesday Tuesday	Wednesday Wednesday Plan Description etive Bargaining acation?	Thursday Booklet before Agreements, S Use all availa Use selected Use all availa	Friday e completing gummary Pla able hours hours	Saturday g this section. an Descriptions,	
NOTE: This section Week 1 Start Time: (hh:mm) Hours: Week 2 (Only note to be a constant	Sunday eeded if schedu Sunday TIME-OFF ive Bargaining re will not supe or applicable s t EarnedTime O	Monday le changes weel Monday Agreement and ersede condition State and Feder (ETO)/Paid Tired Sick Leave (Education Control of the Control	Tuesday Tuesday Tuesday Tuesday Tuesday Tuesday Liver Summary Tuesday Tuesday Tuesday Tuesday Tuesday Tuesday Tuesday	Wednesday Wednesday Plan Description etive Bargaining acation?	Thursday Booklet before Agreements, S Use all availa Use selected	Friday e completing gummary Pla able hours hours	g this section. an Descriptions, Number of hour	
NOTE: This section Week 1 Start Time: (hh:mm) Hours: Week 2 (Only note) Start Time: (hh:mm) Hours: 4. REQUEST PAID Review your Collect Selections made her KP and HR Policies, Did employee request Yes No Did employee request	Sunday eeded if schedu Sunday TIME-OFF ive Bargaining re will not supe or applicable s t EarnedTime O	Monday le changes weel Monday Agreement and ersede condition State and Feder (ETO)/Paid Tired Sick Leave (Education Control of the Control	Tuesday Tuesday Tuesday Tuesday Tuesday Tuesday Liver Summary Tuesday Tuesday Tuesday Tuesday Tuesday Tuesday Tuesday	Wednesday Wednesday Plan Description ctive Bargaining acation?	Thursday Booklet before Agreements, S Use all availa Use selected Use all availa	Friday e completing summary Pla able hours hours hours hours	Saturday g this section. an Descriptions,	

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LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

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* First Name		Middle Name	* Last Name			
Darlene		•	Walls			
* Employee ID		* Contact Phone Number (###) ###-###	# * Effective Dat	* Effective Date (mm/dd/yyyy)		
00530105	•	(562) 657-8527	06/17/2013	06/17/2013		
4. REQUEST PAID TIM	IE-OFF - (Contin	ued)				
Did employee request to u	se Flexible Persor	nal Days?	Number of days	OR	Number of hours	
☐Yes ☐No			01	·		
Note: Flexible Personal Da applied.	ays can only be us	ed in full day or two hour increments. On	ly available Flexible	Personal	Days will be	
Did employee request Milit	tary 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.Martine	z@kp.org		(562) 461-6808			
6. MANAGER INFORM	ATION DETAIL					
* Name (First, MI, Last)						
Michelle L. Ler	naburg					
Supervisor ID	* Title					
·						
* E-mail Address			* Work Phone Number (###) ###-###			
Michelle.L.Lenaburg@kp.org			(562) 657-8527			
7. ALTERNATE CONT.	ACT INFORMAT	TION - (if manager is unavailable or w	vill not manage the	employ	ee while on leave)	
* Name (First, MI, Last)	•					
Barbara Lesproi	า			•		
* E-mail Address			* Work Phone Number (###) ###-###			
Barbara.X.Lespron	@kp.org		(562) 657-9624			
					· -	

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* First Name

LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

* Last Name

Walls

Middle Name

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Darlene		·	Walls
* Employee ID		* Contact Phone Number (###) ###-###	* Effective Date (mm/dd/yyyy)
00530105	•	(562) 657-8527	06/17/2013
8. MANAGER A	TTESTATION		
* Checking these	items acknowledges that y	you have read and understand each item.	
X I agree to direc	ct the employee requesting	Leave to submit any and all supporting doc	umentation to me or the HR Service Center.
I agree to subr to extend his o terminated.	nit form 1500 - Extend Lea r her leave beyond their ex	eve and any supporting documentation at the expected return date or fails to return on their	time I learn that the employee intends expected date, fails to respond, and is not
☑ I agree to subr	nit form 1510 - Return from	n Leave when the employee returns to work.	
☑ TIME must be	coded for all paid and unp	aid leave taken by the employee.	
9. MANAGER S	IGNATURE - (Required	if not submitted online.)	
	·		
]	Manager Signature	• 1	Date (mm/dd/yyyy)
		Alternative Commence	

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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="" domestic="" family="" member="" parent="" partner=""> due to his/her serious health condition.</spouse>
An exigency arising out of the fact that your <spouse daughter="" or="" parent="" son=""> is on active duty of call to active duty status.</spouse>
Your need to care for your <spouse daughter="" kin="" next="" of="" or="" parent="" son=""> due to his/her serious injury or illness incurred in the line of duty as a covered servicemember.</spouse>
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.

HR Service Center

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



Sufficient certification to support your request for FMLA/CFRA leave.
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/CFR/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.</mm>
☐ 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 adoption="" care="" domestic="" foster="" kin="" marriage="" next="" of="" partner="" relationship="">. □ Military Orders</birth>

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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 yo Family Leave.	ur
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 World Absence Management (WAM) at the HR Service Center at 877-4KP-HRSC (877-457-4772). Pleas reference the case number located in the upper right-hand corner of this letter.	
Sincerely,	
WAM .	
Kaiser Permanente HR Service Center	
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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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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LEAVE OF ABSENCE - MEDICAL LEAVE

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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.
- 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 Num	nber (###) ###-#	###	* Effective Date	(mm/dd/yyyy)
00530105	(323) 674-56	60		02/24/2014	
* First Name	Middle Name	Middle Name		* Last Name	
Darlene				Walls	•
1. LEAVE INFORMATION				1	
Employee E-mail Address	Alternate Em	ployee Phone N	lumber	(###) ###-###	New or Revised Request
					New ☐ Revised
* Leave Type:	· · · · · · · · · · · · · · · · · · ·				
Medical	Union			☐ Care	for Eligible Family Member
Maternity	Personal			Famil	ly Military Leave
Workers' Comp/Industrial	Military Service	e .		Bond	ing
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?					
Estimated frequency and duration of absence	ces		-		
·					
If absence is for Care of Eligible Family N	lember or Bonding:				
Name of Eligible Family Member		Relationship to	o Emplo	oyee	
Is Family Member age 18 or under? If Yes	, enter age	Delivery/Adopt	tion/Fos	ster Care Placeme	ent Date (mm/dd/yyyy)
Yes No		Actual Date	• 🗆 E	xpected Date	
Is the child's other parent employed by Kaise	er Permanente?	If Yes, full nam	ne of ot	her parent	
☐Yes ☐No					
If absence is due to Family Member's Mili	itary Service please s	elect the reaso	n(s) th	at apply:	
Name of Eligible Family Member		Relationship to	o Emplo	oyee	
Qualifying Exigency, (matters related to Seeing off leaving or returning Service Mo	deployment such as Cembers.)	Child Care issues	s, Finar	ncial Planning, and	d Family Support Sessions,
Care for qualified Service Member who		ness in the line	e of du	tv	
Care isi damina asirisa mambai ana				·,	

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LEAVE OF ABSENCE - MEDICAL LEAVE

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- First Name	Mia	die Name		Lastr	vame	•
Darlene _.				Walls	} 	
* Employee ID	* Co	ontact Phone Number	(###) ###-###	* Effect	ffective Date (mm/dd/yyyy)	
00530105	(32	23) 674-5660		02/24	/201	4
1. LEAVE INFORMATION - (Contin	ued)					
If absence is for Employee's own heal	th condi	tion (Medical, Materni	ty or Workers' Co	mp/Indus	trial)	
Date of illness or injury (mm/dd/yyyy)	ate of illness or injury (mm/dd/yyyy) Was hospitalization required? Date Hospitalized (mm/dd/yyyy)					
02/24/2014	Yes	No Unknov	vn			
Estimated/Actual hours worked on last d	lay	If Leave is due to ma	ternity			Delivery Date (mm/dd/yyyy)
8		Actual Delivery Da	ate Expected	Delivery	Date	
If absence is pregnancy related, does the complete?	e employ	ee plan to take Bondin	g time immediate	ely after th	e preg	nancy related absence is
Yes No						···
If absence is for Union Leave						
Type of Union Leave:						
Short Term (30 days or less)	<u>_</u>	ong Term (greater tha	n 30 days)	Elec	ted Of	ficial
Name of Union	٠					
If absence is for Military Leave						
Is this absence for Military Training or	r Active	Duty?				
Military Training		Active Duty				
* If for Personal Leave, indicate reaso	n					
Temporary Agency or Military Service	(asked f	or FMLA eligibility)				
Has the Employee worked for Kaiser Per	rmanente	e less than one year?				
☐ Yes ☑ No						
Has the Employee been on active Militar	y Duty in	the past 12 months?	Start Date (mm/	/dd/yyyy)		End Date (mm/dd/yyyy)
☐ Yes ☑ No						
Did the Employee work for Kaiser Perma	anente wi	th a Temporary Agend	y in the year befo	ore they w	ere hi	red?
Yes No		· · · · · · · · · · · · · · · · · · ·				· · · · · · · · · · · · · · · · · · ·

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* First Name		Middle N	Jame		* Last Name			
Darlene		ivildule 1	Tarric		Walls	•		
		* Conto	et Dhono Numbo	· / · / · · · · · · · · · · · · · · · ·		Data /mm/dd	hann	
* Employee ID 00530105			1			* Effective Date (mm/dd/yyyy) 02/24/2014		
		<u></u>	074-3000		02/24/20	714		
1. LEAVE INFORM	IATION - (Con	tinued)				<u>. </u>		
Name of Agency								
Start Date (mm/dd/yy	уу)	End Dat	e (mm/dd/yyyy)		Agency Pho	one Number	(###) ###-###	
2. COMMENTS		•					 · · · · · · · · · · · · · · · · 	
NON-INDUSTRIAL	/PROVISIONA	ıL.						
3. EMPLOYEE SC	HEDULE		•					
This information is absent for their own					TIME coding. T	his is requi	red for employees	
NOTE: This section	is not applicab	le for the KRON	IOS regions.					
Week 1								
	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	
Start Time: (hh:mm)	_			·		<u> </u>		
Hours:					•			
Week 2 (Only n			,		·			
	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	
Start Time: (hh:mm)								
Hours:		~		L		<u> </u>		
4. REQUEST PAID	TIME-OFF		· ————					
Review your Collect Selections made he KP and HR Policies	re will not supe	ersede conditio	ns set in Collec	Plan Description ctive Bargaining	n Booklet before Agreements, S	e completing Summary Pla	g this section. an Descriptions,	
Did employee reques	· · · · · · · · · · · · · · · · · · ·			acation?	Use all availa	able hours	Number of hours	
	Lameurine O	ii (LIO)/i aid iii		acation:	Use selected			
Yes No	A An Liga Codanada	od Ciole I acres /5	(C) \/Q;ak aass=1		Use all availa		Number of hours	
Did employee reques	t to use Extende	ed Sick Leave (E	SL)/SICK Leave	·			·	
Yes No					Use selected	nours	. Alimahar of da	
Did employee reques	t to use Float Ho	olidays?			Only available F		Number of days	
Yes No					Holidays will be	аррпеа.		
UP Sarvice Center			-, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		=1			

Fax to: (877) 477-2329 Telephone: (877) 457-4772

Executives: Contact your Executive Benefits Specialist



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LEAVE OF ABSENCE - MEDICAL LEAVE

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* First Name		Middle Name	* Last Na	me		
Darlene			Walls			
* Employee ID		* Contact Phone Number (###) ###-###		* Effective Date (mm/dd/yyyy)		
· ·		(323) 674-5660		02/24/2014		
00530105			02/24/2			
4. REQUEST PAID TIME-	OFF - (Continu	ued)		<u> </u>	,	
Did employee request to use	Flexible Person	al Days?	Number of day	/s OR	Number of hours	
☐ Yes 🖾 No						
Note: Flexible Personal Days applied.	can only be use	ed in full day or two hour increments. Onl	y available Fle	kible Personal	Days will be	
Did employee request Military	y Make-up Pay?					
☐ Yes ¹☐ No						
5. SUBMITTED BY				•		
* Name (First, MI, Last)						
Michelle Lenaburg						
* Employee ID * *	Title					
00256143						
* E-mail Address			* Work Ph	one Number ((###) ###-###	
Michelle, L. Lenaburg@	@kp.org	·		(562) 65	7-8527	
6. MANAGER INFORMATION DETAIL						
* Name (First, MI, Last)						
Michelle.L.Lenab	ourg@kp.or	rg ·			•	
Supervisor ID * *	Title					
		••				
* E-mail Address		· · · · · · · · · · · · · · · · · · ·	* Work Pi	one Number	(###) ###-###	
Michelle.L.Lenaburg@	@kp.org			(562) 65	7-8527	
7. ALTERNATE CONTAC	T INFORMAT	ION - (if manager is unavailable or w	vill not manag	e the employ	ee while on leave)	
* Name (First, MI, Last)						
Barbara X. Lespr	on		,			
* E-mail Address			* Work Pi	one Number	(###) ###-###	
Barbara.X.Lespron@k	p.org			(562) 65	7-9624	

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* First Name

Darlene

LEAVE OF ABSENCE - MEDICAL LEAVE

* Last Name

Walls

Middle Name

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* Employee ID	<u></u>	* Contact Phone Number (###) ###-###	* Effective Date (mm/dd/yyyy)
00530105		(323) 674-5660	02/24/2014
8. MANAGER	ATTESTATION		
* Checking thes	se items acknowledges that y	you have read and understand each item.	
☑ I agree to dir	ect the employee requesting	Leave to submit any and all supporting doct	umentation to me or the HR Service Center.
		ve and any supporting documentation at the spected return date or fails to return on their	
☑ I agree to su	bmit form 1510 - Return fron	Leave when the employee returns to work.	
TIME must b	e coded for all paid and unp	aid leave taken by the employee.	
9. MANAGER	SIGNATURE - (Required	if not submitted online.)	
		· · · · · · · · · · · · · · · · · · ·	
	* Manager Signature		Pate (mm/dd/yyyy)

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Executives: Contact your Executive Benefits Specialist



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LEAVE OF ABSENCE - RETURN

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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).
- 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 N	lumber (##	!#) ###-###	* Return to Work Date (mm/dd/yyyy)	
00530105		323674-566	323674-5660		03/08/2014	
* First Name	·	Middle Name			* Last Name	
dARLENE					Walls	
1. RETURN FROM LE	AVE INFORMAT	TION	<u> </u>			
		ployee working a	Yes	Schedule and	Duration	
work restrictions? reductions?		ced work dule?	□No	PT-days	·	
2. COMMENTS						
·						
3. SUBMITTED BY						
* First Name		Middle Name			* Last Name	
Michelle		L.			Lenaburg	
* Employee ID	* Title					
00256143	NURSING DEF	PT MANAGER, RN				
* E-mail Address					* Work Phone Number (###) ###-###	
Michelle.L.Lenabu	urg@kp.org		•	•	(562)657-8527 ⁻	
4. MANAGER INFORM	MATION DETAIL	•				
* First Name		Middle Name			* Last Name	
Michelle					Lenaburg	
Supervisor ID	* Title					
00256143	ACCD				·	
* E-mail Address	-			_	* Work Phone Number (###) ###-###	
lichelle.L.Lenaburg@kp.org (562)657-8527						

(Press the Submit button ONCE only)

After completing the form:

- Press the Submit button once to submit request.
 The system will then provide confirmation.
- 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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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)

De	ear Dariene Walls,
Oı	n 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="" domestic="" family="" member="" parent="" partner=""> due to his/her serious health condition.</spouse>
	An exigency arising out of the fact that your <spouse daughter="" or="" parent="" son=""> is on active duty or call to active duty status.</spouse>
	Your need to care for your <spouse daughter="" kin="" next="" of="" or="" parent="" son=""> due to his/her serious injury or illness incurred in the line of duty as a covered servicemember.</spouse>

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.

HR Service Center

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Executives: Contact your Executive Benefits Specialist

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ur records indicate you have used 0 workweeks during the immediately preceding 12 mor 02/24/2014 your remaining workweeks are: 12	itns. As
our continuous Family Leave begins on 02/24/2014 and ends on 03/07/2014	
our intermittent Family Leave begins on <enter date=""> and ends on <enter date="">. \ oproved for the following frequency and duration of leave: equency: <enter frequency=""></enter></enter></enter>	ou are
uration: <enter duration=""></enter>	

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.

HR Service Center

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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, 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.

HR Service Center

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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 <u>unpaid</u> leave of absence, as applicable. For information regarding accrual date adjustments while on a leave of absence, refer to your respective bargaining agreement or Summary Plan Description.



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

Sincerely,

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.

KP000082

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

VAM Agent
IR Specialist II
aiser Permanente HR Service Center
Enclosures:
LOA Quick Reference Guide
Supplement to Sick Leave Request - Form 2090
Personal Data Change - Form 2520
Other:

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Executives: Contact your Executive Benefits Specialist



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 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 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 Pald 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.

HR Service Center

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

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September 2, 2016

Employee ID: 00530105 Case Number: 39708183

Darlene Walls 16323 cortuna ave # 8 Beliflower, 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="" domestic="" family="" member="" parent="" partner=""> due to his/her serious health condition.</spouse>
An exigency arising out of the fact that your <spouse daughter="" or="" parent="" son=""> is on active duty o call to active duty status.</spouse>
Your need to care for your <spouse daughter="" kin="" next="" of="" or="" parent="" son=""> due to his/her serious injury or illness incurred in the line of duty as a covered servicemember.</spouse>
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.

National HR Service Center

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

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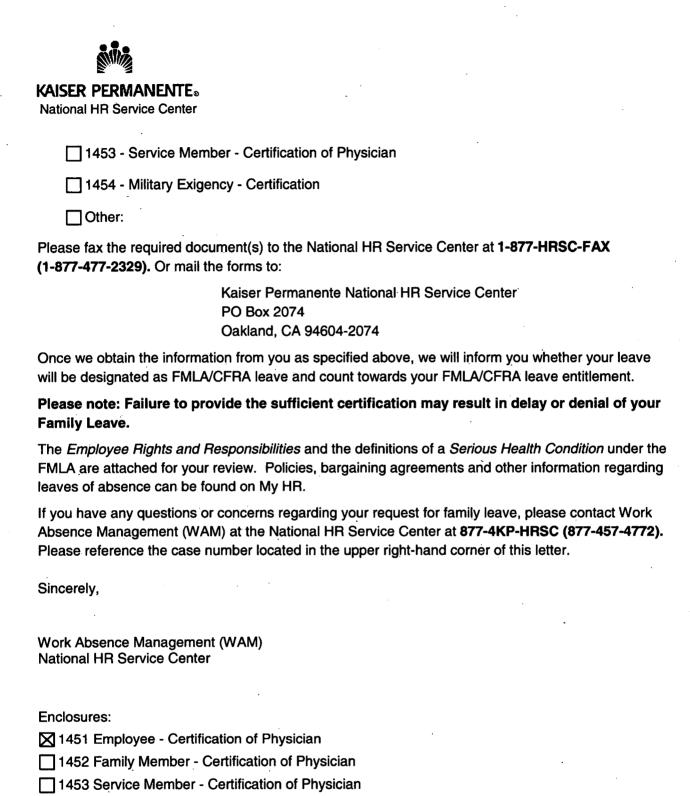


574454 Employee Contitionation of Physician	
1452 Family Member - Certification of Physician	
1453 Service Member - Certification of Physician	
Sufficient certification to indicate your adult child is incapable of self-care because of a physical or mental disability. Certification may be provided on the enclosed 1452 Family Member - Certification of Physician.	
Sufficient documentation to establish the required relationship between you and your family member; proof of <bir> </bir>	•
☐ Military Orders	
1454 - Military Exigency - Certification	
Other:	
The certification you provided is not complete and sufficient to determine whether the FMLA/CFF applies to your leave request. You must provide the following information no later than	₹A
<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</mm>	
<mm dd="" yyyy="">, or your leave may be denied, unless it is not practicable under the particular circumstances despite your diligent good faith efforts.</mm>	
<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</mm>	
<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</mm>	
<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</mm>	
<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</mm>	

National HR Service Center
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Executives: Contact your Executive Benefits Specialist

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2520 - Personal Data Change

Fax to: (877) 477-2329 Telephone: (877) 457-4772

1454 - Military Exigency - Certification

2090 - Supplement to Sick Leave Request

Executives: Contact your Executive Benefits Specialist

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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.

National HR Service Center

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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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LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

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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.
- 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 Num	ber (###) ###-###	* Effective Date	(mm/dd/yyyy)
00530105	(562) 657-85	27	09/13/2015	
* First Name	Middle Name		* Last Name	
Darlene		·	Walls	
1. LEAVE INFORMATION			-	-
Employee E-mail Address	Alternate Em	ployee Phone Number	(###) ###-###	New or Revised Request
				New ☐ Revised
* Leave Type:			- ,,	-
Medical	Union		Care	for Eligible Family Member
Maternity	Personal		Famil	y Military Leave
Workers' Comp/Industrial	Military Service	9	Bond	ing
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 sched	lule Leave? X Inter	mittent Reduced V	Vork 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 Emplo	oyee ·	
			·	
Is Family Member age 18 or under? If Yes	, enter age	Delivery/Adoption/Foster Care Placement Date (mm/dd/yyyy)		
Yes No		Actual Date Expected Date		
Is the child's other parent employed by Kaiser Permanente?		If Yes, full name of otl	her parent	
Yes No			•	
If absence is due to Family Member's Military Service please select the reason(s) that apply:				
Name of Eligible Family Member	•	Relationship to Emplo	oyee	
Qualifying Exigency, (matters related to Seeing off leaving or returning Service Mo	deployment such as C embers.)	hild Care issues, Finar	ncial Planning, and	d Family Support Sessions,
Care for qualified Service Member who	incurred injury or ill	ness in the line of dut	y	

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L'EAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

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* First Name	Middle Name	* Last N	* Last Name		
Darlene		Walls	Walls		
* Employee ID	* Contact Phone Number (###) ###-###	# * Effect	* Effective Date (mm/dd/yyyy)		
00530105	(562) 657-8527	09/13	/2015		
1. LEAVE INFORMATION - (Continue	ed)				
If absence is for Employee's own health	condition (Medical, Maternity or Workers'	Comp/Indus	trial)		
Date of illness or injury (mm/dd/yyyy)	Vas 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 Expect	ed Delivery	Date		
If absence is pregnancy related, does the ecomplete?	employee plan to take Bonding time immedia	ately after th	e pregnancy related absence is		
☐Yes ☐No					
If absence is for Union Leave					
Type of Union Leave:					
Short Term (30 days or less)	Long Term (greater than 30 days)	Elec	ted Official		
Name of Union					
If absence is for Military Leave		•			
Is this absence for Military Training or A					
Military Training	Active Duty				
* If for Personal Leave, indicate reason					
İ					
1.			·		
· .			•		
Temporary Agency or Military Service (a	asked for FMLA eligibility)		. .		
Has the Employee worked for Kaiser Perm	anente less than one year?				
☐Yes ⊠No			,		
Has the Employee been on active Military	Duty in the past 12 months? Start Date (m	m/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?				
Did the Employee work for Kaiser Permane	ente with a Temporary Agency in the year be	efore they w	ere hired?		

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LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

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* First Name Dar I ene		Middle 1	lame		* Last Name	9	
			- Dhana Niverb	(444) 444 444		2-1 ((-	
* Employee ID		į.		er (###) ###-###	# 09/13/20	Date (mm/dd.	· (уууу) -
00530105			657-8527		09/13/20		j
1. LEAVE INFORM	IATION - (Con	inued)					
Name of Agency				•			
Start Date (mm/dd/yy	уу)	End Dat	End Date (mm/dd/yyyy)		Agency Phone Number (###) ###-###		
2. COMMENTS							
Attendance Rev	iew 11/12/1	5: 1480 sub	mitted on-	behalf of M	fanager Mich	elle L.	Lenaburg.am
3. EMPLOYEE SC	HEDULE		•	-			
This information is employees absent for NOTE: This section	or their own dis	ability. Please	use a 24 hr clo	eet to assist wii ck: 00:00 thru 2	th TIME coding. 24:00.	This is requ	iired for
Week 1	· · · · · · · · · · · · · · · · · · ·			T .		•	
	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start Time: (hh:mm)		· -					
Hours:				<u> </u>		<u> </u>	
Week 2 (Only n			· · · · · · · · · · · · · · · · · · ·	Wednesday	Thursday	Friday	Saturday
Start Time: (hh:mm)	Sunday	Monday	Tuesday	wednesday	Thursday	Friday	Saturday
Hours:				<u> </u>			-
4. REQUEST PAID	TIME-OFF			<u> </u>	<u> </u>		
Review your Collect Selections made he KP and HR Policies,	tive Bargaining re will not supe	rsede conditio	ns set in Collec	Plan Description	n Booklet before g Agreements, S	e completing summary Pla	g this section. In Descriptions,
Did employee request EarnedTime Off (ETO)/Paid Time Off (PTO)/Vacation? Use all available hours Number of hours					Number of hours		
☐ Yes ☐ No ☐ Use selected hours							
Did employee request to use Extended Sick Leave (ESL)/Sick Leave?			ble hours	Number of hours			
☐Yes ☐No		•			Use selected	hours	
Did employee reques	t to use Float Ho	olidays?	· .	. :	Only available F	loat	Number of days
☐Yes ☐No					Holidays will be		

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Executives: Contact your Executive Benefits Specialist



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LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

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* First Name		Middle Name	* Last Name		
Darlene			Walls		·
* Employee ID		* Contact Phone Number (###) ###-###	# * Effective Dat	e (mm/dd	/уууу)
00530105		(562) 657-8527	09/13/201	5	
4. REQUEST PAID TIM	E-OFF - (Contin	ued)			
Did employee request to us	se Flexible Persor	nal Days?	Number of days	0.0	Number of hours
☐Yes ☐No				OR	
Note: Flexible Personal Da applied.	ys can only be us	ed in full day or two hour increments. Onl	y available Flexible	Personal	Days will be
Did employee request Milit	ary Make-up Pay?	?			
∐Yes					
5. SUBMITTED BY	· · · · · · · · · · · · · · · · · · ·		<u> </u>		
* 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 INFORM	ATION DETAIL				
* Name (First, MI, Last)				•	
Michelle Lenabu	ırg			•	
Supervisor ID	* Title				
		•			
* E-mail Address			* Work Phone	Number ((###) ###-###
Michelle.L.Lenaburg@kp.org			(562) 657-8527		
7. ALTERNATE CONTA		TION - Someone, in addition to the Matus, etc.)	anager, who shou	ıld receiv	e leave
* Name (First, MI, Last)					
Barbara X Lespi	ron				
* E-mail Address			* Work Phone Number (###) ###-###		
Barbara.X.Lespron@kp.org			(562) 657-9624		
<u> </u>					

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* First Name

Darlene

LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

Middle Name

* Last Name

Walls

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* 5 ID	 	t Contact Bhone Number (444) 444 4444	* Effective Date (mm/dd/sees)
* Employee ID		* Contact Phone Number (###) ###-###	
00530105		(562) 657-8527	09/13/2015
8. MANAGER	ATTESTATION	·	
 Checking these 	e items acknowledges that	you have read and understand each item.	
		•	cumentation to me or the National HR Service
I agree to sub to extend his terminated.	omit form 1500 - Extend Lea or her leave beyond their ex	eve and any supporting documentation at the expected return date or fails to return on their	e time I learn that the employee intends r expected date, fails to respond, and is not
☑I agree to sub	mit form 1510 - Return fron	n Leave when the employee returns to work	(.
TIME must be	e coded for all paid and unp	aid leave taken by the employee.	
9. MANAGER	SIGNATURE - (Required	if not submitted online.)	
Santa Contract	····		
	*M		Date (mm/dd/yyyy)
	* Manager Signature		Date (IIIII/IIII/IIII/IIII/III

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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="" domestic="" family="" member="" parent="" partner=""> due to his/her serious health condition.</spouse>
An exigency arising out of the fact that your <spouse daughter="" or="" parent="" son=""> is on active duty or call to active duty status.</spouse>
Your need to care for your <spouse daughter="" kin="" next="" of="" or="" parent="" son=""> due to his/her serious injury or illness incurred in the line of duty as a covered servicemember.</spouse>
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 <i>Employee Rights and Responsibilities</i> 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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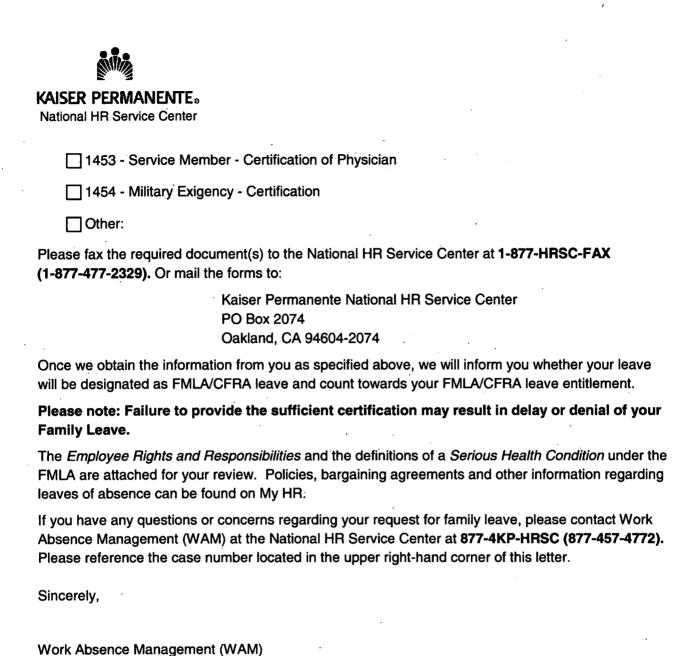


Sufficient certification to support your request for FMLA/CFRA leave.
☑ 1451 Employee - Certification of Physician
1452 Family Member - Certification of Physician
1453 Service Member - Certification of Physician
Sufficient certification to indicate your adult child is incapable of self-care because of 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 <bir>birth marriage adoption/foster care domestic partner relationship next of kin>.</bir>
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.</mm>
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 <bir>birth marriage adoption/foster care domestic partner relationship next of kin>.</bir>
☐Military Orders

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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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KAISER PERMANENTES

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 reacons:

- 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
b)	Pregnancy	of treatment (e.g., prescription medication, physical therapy). Any period of incapacity related to pregnancy or for prenatal care.
- 6	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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Executives: Contact your Executive Benefits Specialist

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December 16, 2015

Employee ID: 00530105.

Case Number: 38807656

Darlene Walls 16323 cortuna ave # 8 Bellflower, CA 90706

Dear Darlene Walls.

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

	·
Or	n 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.
X	Your own serious health condition.
	Your need to care for your <spouse child="" domestic="" family="" member="" parent="" partner=""> due to his/her serious health condition.</spouse>
	An exigency arising out of the fact that your <spouse daughter="" or="" parent="" son=""> is on active duty or call to active duty status.</spouse>
	Your need to care for your <spouse daughter="" kin="" next="" of="" or="" parent="" son=""> due to his/her serious injury or illness incurred in the line of duty as a covered servicemember.</spouse>
Th	is 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 mos="" num=""> months towards this requirement. If you are still on leave at the completion of 12 months of service please contact the NHRSC to</enter>
	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</enter></mm>
	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=""></fmla>
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="" care="" domestic="" foster="" marriage="" partner="" relationship="">.</birth>
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.



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



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.

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

Page 1 of 5

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 Num	nber (###) ###-###	* Effective Date (mm/dd/yyyy)		
00530105	(562) 657-85	27	01/30/201	6	
* First Name	Middle Name	-	* Last Name		
Darlene	!		Walls		
1. LEAVE INFORMATION					
Employee E-mail Address	Alternate Em	ployee Phone Number	(###) ###-####	New or Revised Request	
	·			New ☐ Revised	
* Leave Type:					
Medical ·	Union		☐ Care	for Eligible Family Member	
Maternity	Personal		Fami	ly Military Leave	
Workers' Comp/Industrial	Military Servic	е	Bond	ing	
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 sched	lule Leave? 🔀 Inter	mittent Reduced V	Vork Schedule	Not Applicable	
Is this a Donor Leave? Yes No	Unknown				
Estimated frequency and duration of absence				<u>.</u>	
To be determined by physician					
If absence is for Care of Eligible Family N	lember or Bonding:	+			
Name of Eligible Family Member		Relationship to Emplo	oyee		
	. <u></u>		<u> </u>		
Is Family Member age 18 or under? If Yes	Delivery/Adoption/Fos	ster Care Placeme	ent Date (mm/dd/yyyy)		
Yes No		Actual Date	xpected Date		
Is the child's other parent employed by Kaiser Permanente?		If Yes, full name of ot	her parent		
☐ Yes ☐ No					
If absence is due to Family Member's Mili	tary Service please s	T			
Name of Eligible Family Member		Relationship to Emplo	oyee		
·					
Qualifying Exigency, (matters related to deployment such as Child Care issues, Financial Planning, and Family Support Sessions, Seeing off leaving or returning Service Members.)					
		ness in the line of dut	v .		
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



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LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

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- First Name	Mia	die Name		Last	vame		
Darlene				Walls	3		
* Employee ID	* C	ontact Phone Number	(###) ###-###	## * Effective Date (mm/dd/yyyy)			
00530105	(562) 657-8527 01/30/2016				6		
1. LEAVE INFORMATION - (Contin	nued)			•			
If absence is for Employee's own hea	lth cond	ition (Medical, Materni	ty or Workers' Co	mp/Indus	strial)	· · · · · · · · · · · · · · · · · · ·	
Date of illness or injury (mm/dd/yyyy)	Was ho	spitalization required?			Date	Hospitalized (mm/dd/yyyy)	
01/30/2016	Yes	No. Unknow	vn				
Estimated/Actual hours worked on last of	lay	If Leave is due to ma	ternity			Delivery Date (mm/dd/yyyy)	
8		Actual Delivery D	ate Expected	Delivery	Date	'	
If absence is pregnancy related, does the complete?	e employ	ee plan to take Bondir	g time immediate	ly after th	ne pre	gnancy related absence is	
Yes No.			······································				
If absence is for Union Leave							
Type of Union Leave:						·	
Short Term (30 days or less)	<u></u>	ong Term (greater tha	ın 30 days)	Elec	cted O	fficial	
Name of Union							
If absence is for Military Leave							
Is this absence for Military Training o	r Active	Duty?					
Military Training		Active Duty					
* If for Personal Leave, indicate reaso	n						
			•	_			
Temporary Agency or Military Service							
Has the Employee worked for Kaiser Pe	rmanente	e less than one year?		•		•	
Yes No							
Has the Employee been on active Milita	ry Duty in	the past 12 months?	Start Date (mm/	dd/yyyy)		End Date (mm/dd/yyyy)	
☐ Yes Xi No						· · ·	
Did the Employee work for Kaiser Perma	anente w	ith a Temporary Agend	y in the year befo	ore they w	vere hi	red?	
Yes No					_	·	
	•						

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LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

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* First Name		Middle I	Name		* Last Nam	` Ө			
Darlene			·			Walls .			
* Employee ID		* Contac	* Contact Phone Number (###) ###-##			### * Effective Date (mm/dd/yyyy)			
00530105		i .	657-8527		01/30/20				
1. LEAVE INFORM	IATION - (Cont	tinued)					· · · · · · · · · · · · · · · · · · ·		
Name of Agency					•	•			
·									
Start Date (mm/dd/yy		End Dat	te (mm/dd/yyyy)		Agency Pho	nne Number	(###\ ###_####		
Start Date (Illinouty)	'yy)		te (IIIII/dd/yyyy)		Agency Phone Number (###) ###-#				
									
2. COMMENTS									
Attendance Rev	iew 03/08/1	6: 1480 sut	omitted on	behalf of M	anager Mich	ielle Len	aburg.am		
	· · · ·	•							
3. EMPLOYEE SCI		-				•			
This information is employees absent for	essential for the or their own dis	e NHRSC to pre ability. Please	epare a worksh use a 24 hr clo	eet to assist wit ock: 00:00 thru 2	h TIME coding. 4:00.	This is requ	uired for		
, ,		•							
NOTE: This section	is not applicab	le for the KHO	NOS regions.						
Week 1	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday		
Start Time: (hh:mm)	Sullday	Wildingay	Tuesuay	Wednesday	Thursday	Filluay	Saturday		
Hours:				<u> </u>					
• Week 2 (Only n	eeded if schedu	le changes weel	k to week)		<u> </u>	l			
Week 2 (Only ii	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday		
Start Time: (hh:mm)	- "			<u> </u>					
Hours:				· · · · · · · · · · · · · · · · · · ·			-		
4. REQUEST PAID TIME-OFF									
Review your Collect		Agreement and	d/or Summary	Plan Description	Booklet before	e completin	a this section.		
Selections made he	re will not supe	rsede conditio	ns set in Collec						
KP and HR Policies,	- ' '						· · · · · · · · · · · · · · · · · · ·		
Did employee request EamedTime Off (ETO)/Paid Time Off (PTO)/Vacation?						Number of hours			
Yes No Use selected hours									
Did employee reques	?	Use all available hours Number of hou							
☐ Yes ☐ No		Use selected hours							
Did employee request to use Float Holidays? Only available Float Number of							<u> </u>		
Did employee reques	t to use Float Ho	olidays?			Only available F	loat	Number of days		
Did employee reques ☐ Yes ☐ No	t to use Float Ho	olidays?			Only available F Holidays will be		Number of days		

National HR Service Center

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Executives: Contact your Executive Benefits Specialist



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LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

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* First Name	1 mg 1	Middle Name	* Last Name				
Darlene	•	Walls					
* Employee ID		* Contact Phone Number (###) ###-###	# * Effective Dat	* Effective Date (mm/dd/yyyy)			
00530105		(562) 657-8527	01/30/2016	01/30/2016			
4. REQUEST PAID TIM	E-OFF - (Contin	ued)					
Did employee request to u	se Flexible Persor	nal Days?	Number of days	OR	Number of hours		
☐Yes ☐No				On			
Note: Flexible Personal Da applied.	ys can only be us	ed in full day or two hour increments. On	y available Flexible	Personal	Days will be		
Did employee request Milit	ary Make-up Pay	?					
☐Yes ☐ No							
5. SUBMITTED BY							
* Name (First, MI, Last)		-					
Adriana Martinez		· · · ·					
* Employee ID	Employee ID * Title						
00289603							
* E-mail Address							
Adriana.D.Martine:	z@kp.org	(562) 461-6808					
6. MANAGER INFORM	ATION DETAIL						
* Name (First, MI, Last)							
Michelle Lenabı	ırg						
Supervisor ID * Title							
* E-mail Address		* Work Phone Number (###) ###-###					
Michelle.L.Lenaburg@kp.org (562) 657-8527					7-8527		
7. ALTERNATE CONT. communication (i.e. time		FION - Someone, in addition to the Matus, etc)	anager, who shou	ıld receiv	e leave		
* Name (First, MI, Last)							
Barbara X Lespron							
* E-mail Address		* Work Phone Number (###) ###-###					
Barbara.X.Lespron	®kp.org		(5	62) 65	7-9624		
	· · · · · · · · · · · · · · · · · · ·						

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* First Name

Darlene

LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

* Last Name Walls

Middle Name

Page 5 of 5

* Employee ID		* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105		(562) 657-8527	01/30/2016
8. MANAGER	ATTESTATION		
		you have read and understand each item.	
agree to dire	ect the employee requesting	g Leave to submit any and all supporting dod	cumentation to me or the National HR Service
I agree to sub to extend his terminated.	omit form 1500 - Extend Lea or her leave beyond their e	ave and any supporting documentation at the xpected return date or fails to return on their	e time I learn that the employee intends r expected date, fails to respond, and is not
☑ I agree to sub	omit form 1510 - Return from	n Leave when the employee returns to work	
☑ TIME must be	e coded for all paid and unp	paid leave taken by the employee.	
9. MANAGER	SIGNATURE - (Required	d 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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March 16, 2016

Darlene Walls 16323 cortuna ave # 8 Beliflower, CA 90706 Employee ID: 00530105 Case Number: 39193694

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="" domestic="" family="" member="" parent="" partner=""> due to his/her serious health condition.</spouse>
An exigency arising out of the fact that your <spouse daughter="" or="" parent="" son=""> is on active duty or call to active duty status.</spouse>
Your need to care for your <spouse daughter="" kin="" next="" of="" or="" parent="" son=""> due to his/her serious injury or illness incurred in the line of duty as a covered servicemember.</spouse>
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.

National HR Service Center

Fax to: (877) 477-2329 Telephone: (877) 457-4772

Executives: Contact your Executive Benefits Specialist

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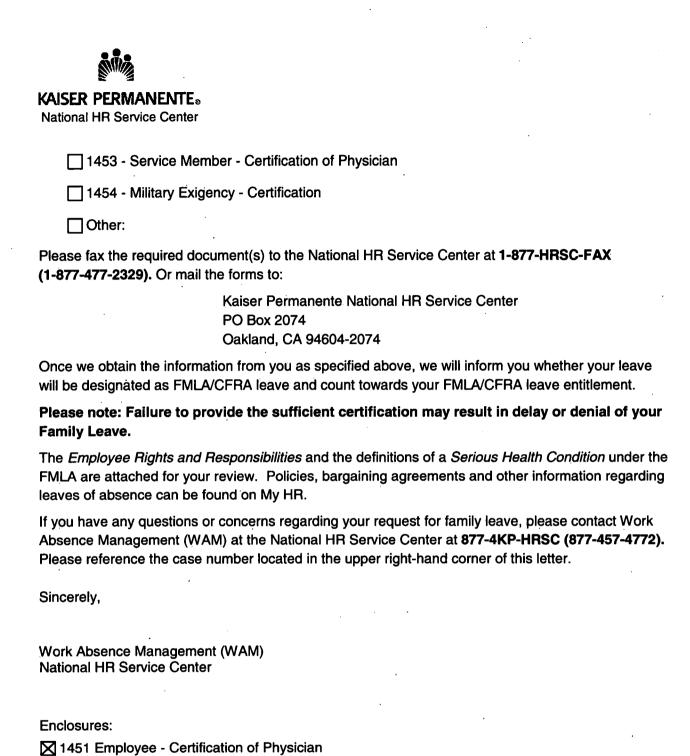


☐ 1451 Employee - Certification of Physician ☐ The control of th	
1451 Employee - Certification of Physician	
1452 Family Member - Certification of Physician	
1453 Service Member - Certification of Physician	
Sufficient certification to indicate your adult child is incapable of self-care because of a 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 kin>. Military Orders	
1454 - Military Exigency - Certification	
Other:	
The certification you provided is not complete and sufficient to determine whether the FMLA/CF applies to your leave request. You must provide the following information no later than	:R/
<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</mm>	€.
circumstances despite your diligent good faith efforts. The information provided on the Certification of Physician/Provider does not meet the	€.
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	€.
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	
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 Specific care domestic partner relationship between your adult child is incapable of self-care because of a physical or mental disability.	

National HR Service Center
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Executives: Contact your Executive Benefits Specialist

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2520 - Personal Data Change

Fax to: (877) 477-2329 Telephone: (877) 457-4772

1452 Family Member - Certification of Physician 1453 Service Member - Certification of Physician

Executives: Contact your Executive Benefits Specialist

1454 - Military Exigency - Certification

2090 - Supplement to Sick Leave Request

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

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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

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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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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Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided
- 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.

National HR Service Center

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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, attended 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.

National HR Service Center

Fax to: (877) 477-2329 Telephone: (877) 457-4772

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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="" domestic="" family="" member="" parent="" partner=""> due to his/her serious health condition.</spouse>
An exigency arising out of the fact that your <spouse daughter="" or="" parent="" son=""> is on active duty or call to active duty status.</spouse>
Your need to care for your <spouse daughter="" kin="" next="" of="" or="" parent="" son=""> due to his/her serious injury or illness incurred in the line of duty as a covered servicemember.</spouse>
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 mos="" num=""> 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</enter>
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.</enter></mm>

National HR Service Center

Fax to: (877) 477-2329 Telephone: (877) 457-4772

Executives: Contact your Executive Benefits Specialist

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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.



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 PERMANENTES

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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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)

ار	ear Dariene,
C	n 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="" domestic="" family="" member="" parent="" partner=""> due to his/her serious health condition.</spouse>
	An exigency arising out of the fact that your <spouse daughter="" or="" parent="" son=""> is on active duty or call to active duty status.</spouse>
	Your need to care for your <spouse daughter="" kin="" next="" of="" or="" parent="" son=""> due to his/her serious injury or illness incurred in the line of duty as a covered service member.</spouse>

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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Our records indicate you have used 0 hours during the immediately preceding 12 mo <enter date=""> your remaining <hours workweeks=""> are:</hours></enter>	nths. As of
Your continuous Family Leave begins on <enter date=""> and ends on <enter date="">.</enter></enter>	
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 <u>31 days</u> 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 t					
	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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DAY 3 Confirm Benefit change: To confirm that your enrollment was successfully completed, log				
		and print a confirmation statement for your records.		
	DAVA	Cubmit comporting decomposts: Be cure to submit any required comporting decompostation to		

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.

National HR Service Center

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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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National HR Service Center

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

Basic Leave Entitlement

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- To care for the employee's child after birth, or placement for adoption or foster care;
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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 the qualified family member from participating in school or other daily activities.

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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.

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LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

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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.
- 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 -00530105		(213) 401-8827		08/17/2016	
		Middle Name			
Pirst Name Middle Dar Lene		ivame		* Last Name Walls	
				V40113	
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	e 	Bond	ing
Last Day Worked (mm/dd/yyyy)	* First	* First Day of Leave (mm/dd/yyyy)		Expected Return Date (mm/dd/yyyy)	
	08/17	7/2016			
Is this an intermittent or reduced work sched	ule Leav	ve? 🛛 Interi	mittent Reduced V	Nork Schedule	Not Applicable
Is this a Donor Leave? Yes No	, <u> </u>	Unknown			
Estimated frequency and duration of absence	es				· ·
as prescribed by physician					
			`		
If absence is for Care of Eligible Family M	lember	or Bonding:	· · · · · · · · · · · · · · · · · · ·		
Name of Eligible Family Member			Relationship to Employee		
·					
Is Family Member age 18 or under? If Yes	, enter a	ge	Delivery/Adoption/Foster Care Placement Date (mm/dd/yyyy)		
Yes No			Actual Date		
Is the child's other parent employed by Kaiser Permanent			If Yes, full name of ot	her parent	
Yes No					
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 Seeing off leaving or returning Service Me	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	incurre	ed injury or ill	ness in the line of dut	ty	
		181 11811 818			

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Telephone: (877) 457-4772 Executives: Contact your Executive Benefits Specialist



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LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

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* First Name	Middle Name	* Last f	Name	
Darlene		Walls		
* Employee ID	* Contact Phone Number (###) ###-### * Effect	tive Date (mm/dd/yyyy)	
00530105	(213) 401-8827	08/17	7/2016	
1. LEAVE INFORMATION - (Continu	ed)	· · · · · · · · · · · · · · · · · · ·		
If absence is for Employee's own health		y or Workers' Comp/Indus	strial)	
Date of illness or injury (mm/dd/yyyy) Was hospitalization required? Date Hospitalized (mm/dd/y				
07/12/2016	Yes ⊠No Unknow	'n		
Estimated/Actual hours worked on last day	y If Leave is due to ma	ernity	Delivery Date (mm/dd/yyyy)	
8	Actual Delivery Da	te Expected Delivery	Date	
If absence is pregnancy related, does the complete?	employee plan to take Bonding	g time immediately after th	ne pregnancy related absence is	
Yes No				
If absence is for Union Leave				
Type of Union Leave:	-	,		
Short Term (30 days or less)	Long Term (greater that	n 30 days) Lelec	cted Official	
Name of Union	•		-	
	·			
If absence is for Military Leave				
Is this absence for Military Training or A		·	_	
Military Training	Active Duty			
* If for Personal Leave, indicate reason				
,				
Tamanana Amanay at Milliana Comilar (anked for EASI A all all all all all all all all all a			
Temporary Agency or Military Service (
Has the Employee worked for Kaiser Perm	nancine iess 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)	
' <i>'</i>	buty in the past 12 months?	June Date (minute) j j j j	Lita Data (minaarjiji)	
Yes No			una birado	
Did the Employee work for Kaiser Perman	ente with a Temporary Agenc	y in the year before they w	vere nired?	
Yes No			· · · <u>-</u>	

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LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

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* First Name		Middle f	Name		* Last Name	9	-	
Darlene	. <u> </u>				Walls			
* Employee ID		l l	* Contact Phone Number (###) ###-###			Date (mm/dd	/yyyy)	
00530105		(213)	401-8827	08/17/20)16 			
1. LEAVE INFORM	ATION - (Con	tinued)						
Name of Agency								
Start Date (mm/dd/yy	уу)	End Dat	te (mm/dd/yyyy)		Agency Pho	one Number	(###) ###-###	
2. COMMENTS								
3. EMPLOYEE SC	HEDULE							
This information is employees absent f	or their own dis	ability. Please	use a 24 hr clo			mis is requ	airea tor	
Week 1								
	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	
Start Time: (hh:mm)								
Hours:								
Hours: Week 2 (Only n								
Week 2 (Only n	eeded if schedu Sunday	le changes wee	k to week) Tuesday	Wednesday	Thursday	Friday	Saturday	
Week 2 (Only n				Wednesday	Thursday	Friday	Saturday	
Week 2 (Only n				Wednesday	Thursday	Friday	Saturday	
Week 2 (Only n	Sunday			Wednesday	Thursday	Friday	Saturday	
Week 2 (Only n Start Time: (hh:mm) Hours:	Sunday TIME-OFF tive Bargaining re will not supe	Monday Agreement and risede condition	Tuesday d/or Summary I ns set in Collec	Plan Description	Booklet before	o completing	g this section.	
Week 2 (Only n Start Time: (hh:mm) Hours: 4. REQUEST PAID Review your Collect Selections made he	Sunday TIME-OFF tive Bargaining re will not supe , or applicable \$	Monday Agreement and redections and Federal Agreement Agreement	Tuesday d/or Summary I ns set in Collect ral Laws.	Plan Description	Booklet before	e completing	g this section.	
Week 2 (Only n Start Time: (hh:mm) Hours: 4. REQUEST PAID Review your Collect Selections made he KP and HR Policies	Sunday TIME-OFF tive Bargaining re will not supe , or applicable \$	Monday Agreement and redections and Federal Agreement Agreement	Tuesday d/or Summary I ns set in Collect ral Laws.	Plan Description	Booklet before Agreements, S	e completing ummary Pla	g this section. an Descriptions,	
Week 2 (Only n Start Time: (hh:mm) Hours: 4. REQUEST PAID Review your Collect Selections made he KP and HR Policies Did employee reques	Sunday TIME-OFF tive Bargaining re will not supe , or applicable set EarnedTime O	Agreement and resede condition State and Feder	d/or Summary I ns set in Collect ral Laws.	Plan Description tive Bargaining acation?	Booklet before Agreements, S	e completing ummary Pla able hours hours	g this section. an Descriptions,	
Week 2 (Only n Start Time: (hh:mm) Hours: 4. REQUEST PAID Review your Collect Selections made he KP and HR Policies. Did employee request Yes No	Sunday TIME-OFF tive Bargaining re will not supe , or applicable set EarnedTime O	Agreement and resede condition State and Feder	d/or Summary I ns set in Collect ral Laws.	Plan Description tive Bargaining acation?	Booklet before Agreements, S Use all availa Use selected	e completing summary Plantible hours hours	g this section. an Descriptions,	
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LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

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* 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	E-OFF - (Continu	ued)	<u>, l </u>				
Did employee request to us	<u></u>		Number of days		Number of hours		
☐Yes ☑No			•	OR			
	s can only be use	ا ed in full day or two hour increments. Only	y available Flexible	Personal	L Days will be		
Did employee request Milita	ry 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			(5	62) 65	7-8593		
6. MANAGER INFORMA	ATION DETAIL	1	•				
* 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 CONTA communication (i.e. time		TION - Someone, in addition to the Ma atus, etc)	anager, who shou	uld receiv	e leave		
* Name (First, MI, Last)	-						
Barbara Lespron				1			
* E-mail Address			* Work Phone	Number	###) ###-###		
		(562) 657-9624					

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* First Name

Darlene

LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

* Last Name Walls

Middle Name

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* 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 y		
I agree to direct the employee requesting Center.	Leave to submit any and all supporting docu	mentation to me or the National HR Service
	ve and any supporting documentation at the spected return date or fails to return on their e	
☑ I agree to submit form 1510 - Return from	Leave when the employee returns to work.	
TIME must be coded for all paid and unp	aid leave taken by the employee.	
9. MANAGER SIGNATURE - (Required	if not submitted online.)	
* Manager Signature	· D	ate (mm/dd/yyyy)

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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="">.</enter></enter>
	Your intermittent Family Leave begins on 08/17/16 and ends on 02/16/17. You are approved fo 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 <u>31 days</u> 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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DAY 3 Confirm Benefit change: To confirm	m that your enrollment was successfully completed, log on
and print a confirmation statement	t 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:



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 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 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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LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

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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.
- 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	mber (###) ###-###					
00530105	(562) 657-8	527	03/18/2017			
* First Name	Middle Name		* Last Name			
Darlene			Walls			
1. LEAVE INFORMATION						
Employee E-mail Address	Alternate Er	nployee Phone Number	(###) ###-####	New or Revised Request		
			,	New ☐ Revised		
* Leave Type:						
Medical ·	Union		☐ Care	for Eligible Family Member		
Maternity	Personal		Famil	ly Military Leave		
☐ Workers' Comp/Industrial	☐ Military Servi	се	Bond	ing		
Last Day Worked (mm/dd/yyyy)	* First Day of Leave	(mm/dd/yyyy)	Expected Return	n Date (mm/dd/yyyy)		
	03/18/2017		·			
Is this an intermittent or reduced work sched	lule Leave? 🔀 Inte	rmittent Reduced \	Work Schedule	Not Applicable		
Is this a Donor Leave? Yes No	Unknown					
Estimated frequency and duration of absence						
to be determined by physician						
	•	•	• •			
If absence is for Care of Eligible Family N	lember or Bonding:					
Name of Eligible Family Member		Relationship to Emplo	oyee			
	·			·		
Is Family Member age 18 or under? If Yes	, enter age	Delivery/Adoption/Foster Care Placement Date (mm/dd/yyyy)				
Yes No		Actual Date Expected Date				
Is the child's other parent employed by Kaise	er Permanente?	If Yes, full name of ot	her parent			
☐Yes ☐No						
If absence is due to Family Member's Military Service please select the reason(s) that apply:						
Name of Eligible Family Member		Relationship to Emplo	oyee			
Qualifying Exigency, (matters related to Seeing off leaving or returning Service Mo	deployment such as embers.)	_JChild Care issues, Finar	ncial Planning, and	d Family Support Sessions,		
Care for qualified Service Member who		liness in the line of du	ty ·			
		,				

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LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

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* First Name	Middle Name * Last Name						
Darlene		Walls					
* Employee ID	* Co	* Contact Phone Number (###) ###-###			* Effective Date (mm/dd/yyyy)		
00530105	(56	(562) 657-8527			/201	7	
1. LEAVE INFORMATION - (Contin	ued)						
If absence is for Employee's own hea	lth condi	tion (Medical, Materni	ty or Workers' Cor	mp/Indus	trial)		
Date of illness or injury (mm/dd/yyyy)	Was ho	spitalization required?			Date	Hospitalized (mm/dd/yyyy)	
03/18/2017	Yes	No Unknow	vn				
Estimated/Actual hours worked on last of	lay	If Leave is due to ma	ternity			Delivery Date (mm/dd/yyyy)	
12		Actual Delivery D	ate Expected	Delivery	Date		
If absence is pregnancy related, does th complete?	e employ	ee plan to take Bondir	ng time immediatel	y after th	ne preç	nancy related absence is	
☐ Yes ☐ No		·				·	
If absence is for Union Leave						,	
Type of Union Leave:		. -					
Short Term (30 days or less)		ong Term (greater that	ın 30 days)	Elec	ted Of	ficial	
Name of Union							
If absence is for Military Leave						,	
Is this absence for Military Training o	r Active	Duty?					
☐ Military Training		Active Duty					
* If for Personal Leave, indicate reaso	n						
		•					
		•					
Temporary Agency or Military Service	(asked f	or FMLA eligibility)					
Has the Employee worked for Kaiser Pe	rmanente	e less than one year?					
☐ Yes 🔀 No							
Has the Employee been on active Milita	ry Duty in	the past 12 months?	Start Date (mm/c	dd/yyyy)		End Date (mm/dd/yyyy)	
☐ Yes ☑ No						·	
Did the Employee work for Kaiser Perma	anente wi	ith a Temporary Agend	cy in the year before	re they w	ere hi	red?	
☐Yes ☐No							
							

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Start Time: (hh:mm) Hours: Week 2 (Only needed if schedule changes week to week) Sunday Monday Tuesday Wednesday Thursday Friday Satur 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 Description KP and HR Policies, or applicable State and Federal Laws. Did employee request EamedTime Off (ETO)/Paid Time Off (PTO)/Vacation? Use all available hours Number of head of the property of the pr	* First Name		Middle N	Name		* Last Nam	e	•		
Name of Agency Start Date (mm/dd/yyyyy) End Date (mm/dd/yyyyy) Agency Phone Number (###) ###-### Agency Phone Number (###) ### Age	Darlene					Walls				
Name of Agency Start Date (mm/dd/yyyyy) End Date (mm/dd/yyyyy) Agency Phone Number (###) ###-### Agency Phone Number (###) ### Age	* Employee ID		* Contac	* Contact Phone Number (###) ###-###			## * Effective Date (mm/dd/www)			
Start Date (mm/dd/yyyy) 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 Satur Start Time: (hh:mm) Hours: Week 2 (Only needed if schedule changes week to week) Sunday Monday Tuesday Wednesday Thursday Friday Satur 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 is not applicable State and Federal Laws. Did employee request EamedTime Off (ETO)/Paid Time Off (PTO)/Vacation? Use all available hours Number of hours of the proper in the Number of the proper in the	, ,		- 1		()	I	-	-77777		
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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 Satur Start Time: (hh:mm) Hours: Week 2 (Only needed if schedule changes week to week) Sunday Monday Tuesday Wednesday Thursday Friday Satur 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 Descriptic KP and HR Policies, or applicable State and Federal Laws. Did employee request EamedTime Off (ETO)/Paid Time Off (PTO)/Vacation? Use all available hours Number of hyper and the property of the property of the plant of the property of the plant of		IATION - (COIII			<u> </u>	•	· · · ·	· · · · · · · · · · · · · · · · · · ·		
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	☐Yes ☐No					Use selected	l hours	ļ		
Only available Float	Did employee reques	t to use Float Ho	olidays?					Number of days		
☐ Yes ☐ No Holidays will be applied.	Yes No					Holidays will be	applied.			

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Executives: Contact your Executive Benefits Specialist



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LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

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* First Name							
Darlene			Walls				
* Employee ID	 -	* Contact Phone Number (###) ###-###	## * Effective Date (mm/dd/yyyy)				
00530105		(562) 657-8527	03/18/2017	7			
4. REQUEST PAID TIM	IE-OFF - (Contin	ued)	•				
Did employee request to u	se Flexible Persor	Number of days	OR	Number of hours			
☐Yes ☐No				On			
Note: Flexible Personal Da applied.	ays can only be us	ed in full day or two hour increments. On	ly available Flexible	Personal	Days will be		
Did employee request Milit	tary Make-up Pay	?		٦			
☐Yes ☐No							
5. SUBMITTED BY				-			
* Name (First, MI, Last)					•		
Erik A Humbert							
* Employee ID	* Title	-					
00677786	J				,		
* E-mail Address	!		* Work Phone	Number	(###) ###-###		
erik.a.humbert@kp	.org		(5	62) 62	2-4029		
6. MANAGER INFORM	ATION DETAIL						
* Name (First, MI, Last)							
danny jimenez							
Supervisor ID	* Title						
		-					
* E-mail Address	* E-mail Address						
danny.p.jimenez@kp.org (562) 657-8527							
7. ALTERNATE CONT. communication (i.e. time		FION - Someone, in addition to the Matus, etc)	lanager, who shou	ıld receiv	e leave		
* Name (First, MI, Last)							
	_						
* E-mail Address			* Work Phone	Number	(###) ###-###		

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* First Name

Darlene

LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

* Last Name Walls

Middle Name

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* 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 y		·		
I agree to direct the employee requesting Center.	Leave to submit any and all supporting docu	mentation to me or the National HR Service		
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.)			
		A STATE OF THE STA		
* Manager Signature	-0	ate (mm/dd/yyyy)		

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Telephone: (877) 457-4772

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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="" domestic="" family="" member="" parent="" partner=""> due to his/her serious health condition.</spouse>
An exigency arising out of the fact that your <spouse daughter="" or="" parent="" son=""> is on active duty or call to active duty status.</spouse>
Your need to care for your <spouse daughter="" kin="" next="" of="" or="" parent="" son=""> due to his/her serious injury or illness incurred in the line of duty as a covered servicemember.</spouse>
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 <i>Employee Rights and Responsibilities</i> regarding eligibility criteria or

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.

requirements. Should your employment status change prior to the start of your leave, you may not

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qualify for FMLA/CFRA.

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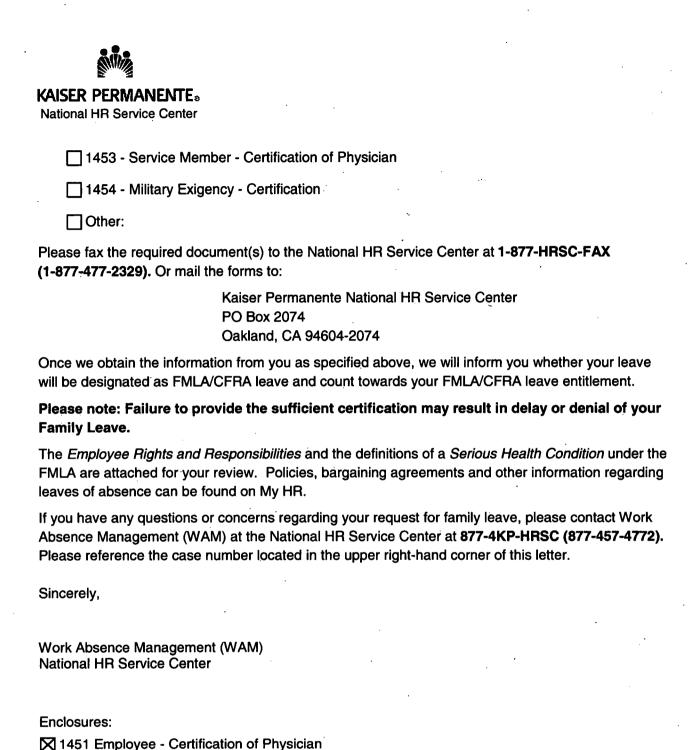


Sufficient certification to support your request for FMLA/CFRA leave.	
☑ 1451 Employee - Certification of Physician	
1452 Family Member - Certification of Physician	
1453 Service Member - Certification of Physician	
☐ Sufficient certification to indicate your adult child is incapable of self-care because 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 <bir> </bir>	
Military Orders	
1454 - Military Exigency - Certification	
Other:	
The certification you provided is not complete and sufficient to determine whether the FMLA/CF 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.	
con care because of a projection of memory.	
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>.	•
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	•

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2520 - Personal Data Change

Fax to: (877) 477-2329 Telephone: (877) 457-4772

1454 - Military Exigency - Certification

2090 - Supplement to Sick Leave Request

1452 Family Member - Certification of Physician 1453 Service Member - Certification of Physician

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KAISER PERMANENTES

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 FMI A:
- 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.

National HR Service Center

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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 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).
Any period of incapacity related to pregnancy or for prenatal care.
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.
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.
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="" domestic="" family="" member="" parent="" partner=""> due to his/her serious health condition.</spouse>
An exigency arising out of the fact that your <spouse daughter="" or="" parent="" son=""> is on active duty or call to active duty status.</spouse>
Your need to care for your <spouse daughter="" kin="" next="" of="" or="" parent="" son=""> due to his/her serious injury or illness incurred in the line of duty as a covered servicemember.</spouse>
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 mos="" num=""> 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</enter>
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</enter></mm>
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=""></fmla>
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="" care="" domestic="" foster="" marriage="" partner="" relationship="">.</birth>
Military Orders
<certification an="" certification="" exigency="" ill="" injured="" of="" servicemember=""></certification>
□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.



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 PERMANENTES

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 the qualified family member from participating in school or other dally 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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Executives: Contact your Executive Benefits Specialist

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LEAVE OF ABSENCE - CARE FOR FAMILY MEMBER

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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 Num	ber (###) ###-###	* 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 Emp	loyee Phone Number	(###) ###-####	New or Revised Request	
				☐ New ☐ Revised	
* Leave Type:	<u> </u>	-			
Medical Medical	Union		Care	for Eligible Family Member	
Maternity	Personal		∏ Famil	y Military Leave	
☐ Workers' Comp/Industrial	Military Service	9	Bond	ing	
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 sched	ule Leave?	mittent Reduced	Work Schedule	Not Applicable	
Is this a Donor Leave? Yes No	Unknown		_		
Estimated frequency and duration of absence	es				
If absence is for Care of Eligible Family M	lember or Bonding:				
Name of Eligible Family Member		Relationship to Empl	oyee	•	
Delores Williams		Mother			
Is Family Member age 18 or under? If Yes,	, enter age	Delivery/Adoption/Fo	ster Care Placeme	ent Date (mm/dd/yyyy)	
☐ Yes ☑ No	Actual Date E		Expected Date		
Is the child's other parent employed by Kaiser Permanente?		If Yes, full name of o	ther parent		
☐Yes ☐No					
If absence is due to Family Member's Military Service please select the reason(s) that apply:					
Name of Eligible Family Member		Relationship to Empl	oyee		
Qualifying Exigency, (matters related to Seeing off leaving or returning Service Me		child Care issues, Fina	ncial Planning, and	d Family Support Sessions,	
Care for qualified Service Member who incurred injury or illness in the line of duty					

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LEAVE OF ABSENCE - CARE FOR FAMILY MEMBER

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* First Name	Mid	dle Name		* Last Name		
Darlene				Walls		
* Employee ID	* Co	ontact Phone Number	(###) ###-###	* Effective Date (mm/dd/yyyy)		
00530105	(21	13) 401-8827		09/16/2	2017	
1. LEAVE INFORMATION - (Contin	ued)					
If absence is for Employee's own hea	lth condi	tion (Medical, Materni	ty or Workers' Con	np/Industri	al)	
Date of illness or injury (mm/dd/yyyy)	Was ho	spitalization required?		D	ate Hospitalized (mm/dd/yyyy)	
	Yes	☐ No ☐ Unknow	vn			
Estimated/Actual hours worked on last	lay	If Leave is due to ma	ternity		Delivery Date (mm/dd/yyyy)	
		Actual Delivery D	ate Expected [Delivery Da	ate .	
If absence is pregnancy related, does the complete?	e employ	ee plan to take Bondir	g time immediately	y after the	pregnancy related absence is	
☐Yes ☐No			· 			
If absence is for Union Leave						
Type of Union Leave:						
Short Term (30 days or less)		ong Term (greater tha	n 30 days)	☐ Elected	d Official	
Name of Union		٠.				
If absence is for Military Leave						
Is this absence for Military Training o	r Active	Duty?				
Military Training Active Duty						
* If for Personal Leave, indicate reason	n	-				
			`			
					•	
Temporary Agency or Military Service	(asked f	or FMLA eligibility)				
Has the Employee worked for Kaiser Pe	rmanente	e less than one year?				
☐ Yes ☑ No		·	_			
Has the Employee been on active Milita	ry Duty in	the past 12 months?	Start Date (mm/d	ld/yyyy)	End Date (mm/dd/yyyy)	
☐ Yes ☑ No						
Did the Employee work for Kaiser Perm	anente wi	th a Temporary Agend	y in the year befor	e they wer	re hired?	
Yes No		·				

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LEAVE OF ABSENCE - CARE FOR FAMILY MEMBER

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					·r-				
* First Name		Middle I	Name ·		* Last Name	Ð			
Darlene						Walls			
* Employee ID		* Contac	* Contact Phone Number (###) ###-###			## * Effective Date (mm/dd/yyyy)			
00530105		(213)	401-8827		09/16/2017				
1. LEAVE INFORM	MATION - (Con	tinued)							
Name of Agency	•			-					
Start Date (mm/dd/y	ууу)	End Da	te (mm/dd/yyyy)		Agency Pho	one Number	(###) ###-####		
2. COMMENTS									
							,		
				,					
3. EMPLOYEE SC	HEDULE				·				
This information is employees absent t						This is requ	uired for		
NOTE: This section	is not applicab	le for the KRO	NOS regions.						
Week 1									
	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday		
Start Time: (hh:mm)									
Hours:									
Week 2 (Only r	needed if schedu		,	L Mandana da	Thursday	Total	Cotumber		
Start Time: (hh:mm)	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday		
Hours:									
4. REQUEST PAIL	TIME_OEE		<u> </u>	<u></u>	<u> </u>	<u>l</u> .			
		A		Non Dogodniko	- Dealdet hefer				
Review your Collec Selections made he KP and HR Policies	re will not supe	ersede conditio	ns set in Collec						
Did employee request EarnedTime Off (ETO)/Paid Time Off (PTO)/Vacation? Use all available hours Number of hours									
Yes ☐ No ☐ Use selected hours									
						Number of hours			
⊠Yes □No									
Did employee reques	st to use Float Ho	olidays?			Only available F	loat	Number of days		
☐Yes ☐No					Holidays will be				
National HR Servi	ce Center	1 188			■1				

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LEAVE OF ABSENCE - CARE FOR FAMILY MEMBER

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* First Name		Middle Name	* Last Name	7		
Darlene			Walls	Walls		
* Employee ID		* Contact Phone Number (###) ###-###	# * Effective Date	* Effective Date (mm/dd/yyyy)		
00530105		(213) 401-8827	09/16/201	7		
4. REQUEST PAID TIM	IE-OFF - (Contin	ued)	<u> </u>			
Did employee request to u	se Flexible Persor	nal Days?	Number of days	0.0	Number of hours	
☐Yes ☐No				OR		
Note: Flexible Personal Da applied.	ays can only be us	ed in full day or two hour increments. On	y available Flexible	Personal	Days will be	
Did employee request Milit	ary Make-up Pay?	?	•	. <u>-</u>		
☐Yes ☐No						
5. SUBMITTED BY		· · · · · · · · · · · · · · · · · · ·				
* Name (First, MI, Last)			• •			
Danny P Jimenez		•				
* Employee ID	* Title					
00685629		_		•		
* E-mail Address						
danny.p.jimenez@kp.org (562) 657-8527						
6. MANAGER INFORM	ATION DETAIL		•			
* Name (First, MI, Last)						
Danny Jimenez						
Supervisor ID	* Title					
* E-mail Address			* Work Phone	Number (###) ###-###	
danny.p.jimenez@kp.org (562) 657-8527					7-8527	
7. ALTERNATE CONT. communication (i.e. time		FION - Someone, in addition to the Matus, etc)	anager, who shou	ıld receiv	e leave	
* Name (First, MI, Last)			-		<u>-</u>	
* E-mail Address * Work Phone Number (###) ###-##					###) ###-###	

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* First Name

LEAVE OF ABSENCE - CARE FOR FAMILY MEMBER

Middle Name

* Last Name

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Darlene			Walls .
* Employee ID		* Contact Phone Number (###) ###-###	* Effective Date (mm/dd/yyyy)
00530105		(213) 401-8827	09/16/2017
8. MANAGER	ATTESTATION		
* Checking thes	se items acknowledges that y	you have read and understand each item.	,
I agree to dir Center.	ect the employee requesting	Leave to submit any and all supporting docu	mentation to me or the National HR Service
I agree to su to extend his terminated.	bmit form 1500 - Extend Lea or her leave beyond their ex	eve and any supporting documentation at the expected return date or fails to return on their expected return on the expected return on the	time I learn that the employee intends expected date, fails to respond, and is not
☑ I agree to su	bmit form 1510 - Return fron	n Leave when the employee returns to work.	
TIME must b	e coded for all paid and unp	aid leave taken by the employee.	·
9. MANAGER	SIGNATURE - (Required	if not submitted online.)	
			the state of the s
	,		
	* Manager Signature	*D	Pate (mm/dd/yyyy)

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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 Dariene 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 daughter="" or="" parent="" son=""> is on active duty or call to active duty status.</spouse>
Your need to care for your <spouse daughter="" kin="" next="" of="" or="" parent="" son=""> due to his/her serious injury or illness incurred in the line of duty as a covered servicemember.</spouse>
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 <i>Employee Rights and Responsibilities</i> regarding eligibility criteria or

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.

requirements. Should your employment status change prior to the start of your leave, you may not

National HR Service Center

qualify for FMLA/CFRA.

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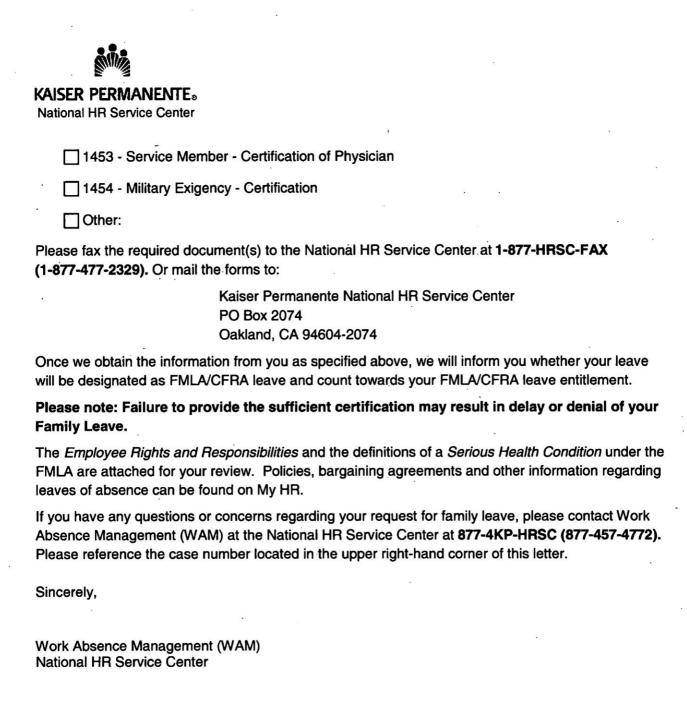
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Sufficient certification to support your request for FMLA/CFRA leave. 1451 Employee - Certification of Physician □ 1452 Family Member - Certification of Physician ☐ 1453 Service Member - Certification of Physician Sufficient certification to indicate 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. 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

2520 - Personal Data Change

Enclosures:

1451 Employee - Certification of Physician

1454 - Military Exigency - Certification 2090 - Supplement to Sick Leave Request

1453 Service Member - Certification of Physician

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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.

Eliqibility 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

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

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
- 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)		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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LEAVE OF ABSENCE - CARE FOR FAMILY MEMBER

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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.
- 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 Nun	nber (###) ###-####	* Effective Date (mm/dd/yyyy)				
00530105	(213) 401-8827		09/13/2017				
* First Name	Middle Name		* Last Name				
Darlene	,	s	Walls				
1. LEAVE INFORMATION			<u> </u>				
Employee-E-mail Address	Alternate Emp	oloyee Phone Number	(###) ###-####	New or Revised Request			
,		÷		New ⊠ Revised			
* Leave Type:				 .			
Medical	Union	ŧ	Care	for Eligible Family Member			
Maternity	Personal	٠	☐ Fami	ly Military Leave			
Workers' Comp/Industrial	Military Servic	e • • •	` Bond	ing ,			
Last Day Worked (mm/dd/yyyy)	* First Day of Leave_0	(mm/dd/yyyy)	Expected Return	n Date (mm/dd/yyyy)			
09/12/2017	09/13/2017		09/25/2017				
Is this an intermittent or reduced work sched	tule Leave? Inter	mittent Reduced	Work Schedule	Not Applicable			
Is this a Donor Leave? Yes No	o Unknown						
Estimated frequency and duration of absence	ces	*		,			
			•	۰ د			
If absence is for Care of Eligible Family N	lember or Bonding:						
Name of Eligible Family Member	0	Relationship to Empli	òyee -				
Delores Williams	•	Mother		ý			
Is Family Member age 18 or under? If Yes	, enter age	Delivery/Adoption/Fo	ster Care Placeme	ent,Date (mm/dd/yyyy)			
Yes No		Actual Date E	Expected Date				
Is the child's other parent employed by Kaise	er Permanente?	If Yes, full name of ot	ther parent				
Yes No			L				
If absence is due to Family Member's Military Service please select the reason(s) that apply:							
Name of Eligible Family Member		Relationship to Empl	oyee				
		2					
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	o incurred injury or ill	ness in the line of du	ty				
			* *				

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LEAVE OF ABSENCE - CARE FOR FAMILY MEMBER

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* First Name	Middle Name	* Las	t Name		
Darlene		Wa I	Walls		
* Employee ID	* Contact Phone Number	(###) ###-### * Effe	ctive Date (mm/dd/yyyy)		
00530105	(213) 401-8827	09/1	3/2017		
1. LEAVE INFORMATION - (Contin	ued)				
If absence is for Employee's own hea	th condition (Medical, Matem	ity or Workers' Comp/Ind	ustrial)		
Date of illness or injury (mm/dd/yyyy)	Was hospitalization required?	,	Date Hospitalized (mm/dd/yyyy)		
•	Yes No Unknow	wn-	<u>.</u>		
Estimated/Actual hours worked on last of	ay If Leave is due to ma	aternity	Delivery Date (mm/dd/yyyy)		
*	Actual Delivery D	ate Expected Deliver	y Date .		
If absence is pregnancy related, does th complete?	e employee plan to take Bondii	ng time immediately after	the pregnancy related absence is		
☐ Yes ☐ No					
If absence is for Union Leave					
Type of Union Leave:					
Short Term (30 days or less)	Long Term (greater that	an 30 days)	ected Official		
Name of Union	·		· .		
If absence is for Military Leave					
Is this absence for Military Training o	Active Duty?	•	·		
Military Training	Active Duty				
* If for Personal Leave, indicate reaso	n				
Temporary Agency or Military Service	(asked for FMLA eligibility)				
Has the Employee worked for Kaiser Pe	rmanente less than one year?	•			
☐ Yes ☑ No	·				
Has the Employee been on active Militar	y Duty in the past 12 months?	Start Date (mm/dd/yyy)) End Date (mm/dd/yyyy)		
☐ Yes ☑ No					
Did the Employee work for Kaiser Perma	anente with a Temporary Agend	cy in the year before they	were hired?		
Yes No	-·-				

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LEAVE OF ABSENCE - CARE FOR FAMILY MEMBER

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• Eliza Naci		8:81:3:41 · 8	la-sa-a		*1 1 1		
* First Name	. Middle f	Middle Name		* Last Name			
Darlene			•	Walls			
* Employee ID	ı		ər (###) ###-###	1	Date (mm/dd/	уууу)	
00530105		(213)	401 - 8827		09/13/20)17	
1. LEAVE INFORM	IATION - (Cont	tinued)					
Name of Agency	,		,				
Start Date (mm/dd/yy	yy) .	End Dat	End Date (mm/dd/yyyy) Agency Phone Number (###) ###-#			(###) ###-###	
2. COMMENTS							
Revision of pr	eviously la	unched 1480	on 9/11/2	017			
							•
3. EMPLOYEE SC	HEDULE		<u>`</u>				
This information is employees absent for						This is requ	ired for
NOTE: This section	is not applicab	le for the KRON	NOS regions.				
Week 1			_				
	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start Time: (hh:mm)							
Hours:		•				•.	
Week 2 (Only n	eeded if schedu	le changes weel	k to week)	•	•		
	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start Time: (hh:mm)							
Hours:					<u> </u>		
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? Use all available hours Number of hours							
⊠Yes □No	☑Yes ☐No ☐Use selected hours						
Did employee request to use Extended Sick Leave (ESL)/Sick Leave? Use all available hours Number of hour				Number of hours			
⊠Yes □No	Yes ☐ No ☐ Use selected hours						
Did employee reques	Did employee request to use Float Holidays? Only available Float Number of days					Number of days	
Yes No				Holidays will be		,	
	-						•

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LEAVE OF ABSENCE - CARE FOR FAMILY MEMBER

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* First Name		Middle Name * Last Name			
Darlene			Walls		
* Employee ID		* Contact Phone Number (###) ###-####		/ y yyy)	
00530105		(213) 401-8827	09/13/201	7	
4. REQUEST PAID TIM	IE-OFF - (Contin	ued)			
Did employee request to u	se Flexible Persor	nal Days?	Number of days	00	Number of hours
☐Yes ☐No				OR	
Note: Flexible Personal Da applied.	ays can only be us	ed in full day or two hour increments. Onl	y available Flexible	Personal	Days will be
Did employee request Milit	ary Make-up Pay	?			
☐Yes ☐No	·	•	-		
5. SUBMITTED BY					
* Name (First, MI, Last) Danny P Jimenez					
* Employee ID	* Title		· · ·	-	
00685629			_		
* E-mail Address					
danny.p.jimenez@kp.org (562) 6				62) 65	7 - 8527
6. MANAGER INFORM	ATION DETAIL		1		
* Name (First, MI, Last)				-	
Danny Jimenez					
Supervisor ID	* Title			-	-
* E-mail Address	* E-mail Address				
danny.p.jimenez@kp.org (562) 657-8527				7-8527	
7. ALTERNATE CONT. communication (i.e. time		FION - Someone, in addition to the Matus, etc.)	anager, who shou	ıld receiv	re leave
* Name (First, MI, Last)					
* E-mail Address			* Work Phone	Number	(###) ###-###

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* First Name

LEAVE OF ABSENCE - CARE FOR FAMILY MEMBER

* Last Name

Middle Name

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Darlene			Walls		
* Employee ID		* Contact Phone Number (###) ###-###	* Effective Date (mm/dd/yyyy)		
00530105	•	(213) 401-8827	09/13/2017		
8. MANAGER	ATTESTATION				
ı		you have read and understand each item.			
I agree to di Center.	rect the employee requesting	Leave to submit any and all supporting doc	umentation to me or the National HR Service		
I agree to su to extend his terminated.	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				
☑ I agree to su	ubmit form 1510 - Return fron	n Leave when the employee retums to work.			
		· ·	•		
TIME must b	oe coded for all paid and unp	aid leave taken by the employee.			
9. MANAGER	SIGNATURE - (Required	if not submitted online.)			
1 - ,- 1					
	* Manager Signature	-1	Date (mm/dd/yyyy)		

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October 9, 2017

Dear Darlene.

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)

	•
On 09/11/2017, we were informed that you need	ed 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 he	er serious health condition.
An exigency arising out of the fact that you or call to active duty status.	r <spouse daughter="" or="" parent="" son=""> is on active duty</spouse>
Your need to care for your <spouse duty<="" illness="" in="" incurred="" injury="" line="" of="" or="" son="" td="" the=""><td>daughter parent next of kin> due to his/her serious as a covered service member.</td></spouse>	daughter parent next of kin> due to his/her serious 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 a approved for the following frequency and duration of leave: Frequency: <enter frequency=""> Duration:</enter></enter></enter>	ıre

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:



KAISER PERMANENTE₃

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 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 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.

National HR Service Center

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Executives: Contact your Executive Benefits Specialist

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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)

)€	ear Darlene,
O	n 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 need to care for your <spouse child="" domestic="" family="" member="" parent="" partner=""> due to his/her serious health condition.</spouse>
	An exigency arising out of the fact that your <spouse daughter="" or="" parent="" son=""> is on active duty or call to active duty status.</spouse>
	Your need to care for your <spouse daughter="" kin="" next="" of="" or="" parent="" son=""> due to his/her serious injury or illness incurred in the line of duty as a covered service member.</spouse>

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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X	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="">.</enter></enter>
	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:</enter>

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 <u>31 days</u> 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
ļ.,	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
l		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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KAISER PERMANENTES

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 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 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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LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

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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 Num	ber (###) ###-###	* Effective Date	* Effective Date (mm/dd/yyyy)		
00530105	(562) 657-85	27	10/15/2017			
* First Name	Middle Name		* Last Name			
Darlene			Walls			
1. LEAVE INFORMATION		-				
Employee E-mail Address	Alternate Em	ployee Phone Numb	er (###) ###-###	New or Revised Request		
	,			New ☐ Revised		
* Leave Type:		÷				
Medical	Union		Care	for Eligible Family Member		
Maternity	Personal		Fam	Family Military Leave		
Workers' Comp/Industrial	Military Service	e	Bond	Bonding		
Last Day Worked (mm/dd/yyyy)	* First Day of Leave (mm/dd/yyyy)	Expected Retur	n Date (mm/dd/yyyy)		
	10/15/2017					
is this an intermittent or reduced work sched	ule Leave? X Inter	mittent Reduced	Work Schedule	Not Applicable		
Is this a Donor Leave? Yes No	Unknown					
Estimated frequency and duration of absence	es					
tbd by physician						
, ,						
If absence is for Care of Eligible Family M	lember or Bonding:					
Name of Eligible Family Member		Relationship to Employee				
Is Family Member age 18 or under? If Yes, enter age		Delivery/Adoption/Foster Care Placement Date (mm/dd/yyyy)				
☐ Yes ☐ No		Actual Date Expected Date				
Is the child's other parent employed by Kaiser Permanente?		If Yes, full name of	other parent	,		
Yes No						
If absence is due to Family Member's Military Service please select the reason(s) that apply:						
Name of Eligible Family Member		Relationship to Em	oloyee			
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						

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LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

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* First Name	Middle Name	* Las	* Last Name		
Darlene		Wal	Walls		
* Employee ID	* Contact Phone Number	(###) ###-### * Eff	* Effective Date (mm/dd/yyyy)		
00530105	(562) 657-8527	10/	15/201	7	
1. LEAVE INFORMATION - (Contin	<u> </u>				
If absence is for Employee's own hea	th condition (Medical, Matem	ity or Workers' Comp/Inc	lustrial)	· · · · · · · · · · · · · · · · · · ·	
Date of illness or injury (mm/dd/yyyy)	Was hospitalization required?	·	Date	Hospitalized (mm/dd/yyyy)	
10/15/2017	Yes No Unkno	☐Yes ☑No ☐ Unknown			
Estimated/Actual hours worked on last of	lay If Leave is due to ma	If Leave is due to maternity Delivery Date (mm/dd/y			
8	Actual Delivery D	ate Expected Delive	ry Date		
If absence is pregnancy related, does th complete?	e employee plan to take Bondi	ng time immediately afte	the pre	gnancy related absence is	
Yes No					
If absence is for Union Leave					
Type of Union Leave:	•	•			
Short Term (30 days or less)	Long Term (greater that	an 30 days) 🔲 E	ected O	fficial	
Name of Union				-	
If absence is for Military Leave					
Is this absence for Military Training o	r Active Duty?				
Military Training	Active Duty				
* If for Personal Leave, indicate reason	n	•			
				·	
Temporary Agency or Military Service (asked for FMLA eligibility)					
Has the Employee worked for Kaiser Permanente less than one year?					
☐Yes ☑No		<u>. </u>			
Has the Employee been on active Militar	y Duty in the past 12 months?	Start Date (mm/dd/yyy	y)	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	· 				

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LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

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				·				
* First Name		Middle I	Middle Name			* Last Name		
Darlene						Walls		
* Employee ID		* Contac	* Contact Phone Number (###) ###-###			*# * Effective Date (mm/dd/yyyy)		
00530105.		(562)	(562) 657-8527			17		
1. LEAVE INFORM	MATION - (Con	tinued)				.		
Name of Agency	<u>.</u>							
Start Date (mm/dd/yy	/yy)	End Da	End Date (mm/dd/yyyy)			Agency Phone Number (###) ###-###		
2. COMMENTS			_	·				
	· _							
							ı	
<u></u>								
3. EMPLOYEE SC	HEDULE							
This information is employees absent t						This is requ	aired for	
NOTE: This section	is not applicab	le for the KROI	NOS regions.		••••	•		
Week 1				•				
	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	
Start Time: (hh:mm)					_			
Hours:								
Week 2 (Only r	needed if schedu	, 		1	T =			
	Sunday.	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	
Start Time: (hh:mm)								
Hours:								
4. REQUEST PAIL								
Review your Collec Selections made he KP and HR Policies	ere will not supe	ersede conditio	ns set in Collec	Plan Description ctive Bargaining	n Booklet before g Agreements, S	e completing cummary Pla	g this section. an Descriptions,	
					Number of hours			
□Yes □No				Use selected hours				
Did employee request to use Extended Sick Leave (ESL)/Sick Leave?				Use all available hours Number of hours				
□Yes □No				Use selected hours				
					Number of days			
☐Yes ☐No					Holidays will be			
Notional UD Conti	Conton	1 1881						

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LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

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* First Name		Middle Name	* Last Name	* Last Name		
Darlene			Walls	Walls		
* Employee ID		* Contact Phone Number (###) ###-###	# * Effective Dat	* Effective Date (mm/dd/yyyy)		
00530105		(562) 657-8527	10/15/2017	7		
4. REQUEST PAID TIM	E-OFF - (Contin	ued)	<u> </u>			
Did employee request to use Flexible Personal Days?			Number of days Number of ho			
∏Yes ∏No				OR		
Note: Flexible Personal Da applied.	lys can only be us	ed in full day or two hour increments. Onl	y available Flexible	Personal	Days will be	
Did employee request Milit	ary 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 jimenez						
Supervisor ID * Title						
* E-mail Address			* Work Phone	Number (###) ###-####	
danny.p.jimenez@kp.org			(5	(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

Darlene

LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

* Last Name Walls

Middle Name

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			<u> </u>
* Employee ID		* Contact Phone Number (###) ###-###	* Effective Date (mm/dd/yyyy)
00530105		(562) 657-8527	10/15/2017
8. MANAGER AT	TESTATION		
* Checking these it	ems acknowledges that	you have read and understand each item.	
I agree to direct Center.	the employee requesting	Leave to submit any and all supporting do	cumentation to me or the National HR Service
I agree to submit to extend his or terminated.	t form 1500 - Extend Lea her leave beyond their ex	ve and any supporting documentation at the control of the control	ne time I learn that the employee intends ir expected date, fails to respond, and is not
☑ I agree to submi	t form 1510 - Return fron	n Leave when the employee returns to work	k.
☑ TIME must be c	oded for all paid and unp	aid leave taken by the employee.	
9. MANAGER SIG	GNATURE - (Required	if not submitted online.)	
-	Manager Signature		Date (mm/dd/yyyy)
		: <u> </u>	

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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 condition.<="" constitutions="" health="" serious="" td=""><td>hild parent domestic partner family member> due to his/her</td></spouse>	hild parent domestic partner family member> due to his/her
An exigency arising out of the fact that call to active duty status.	it your <spouse daughter="" or="" parent="" son=""> is on active duty o</spouse>
Your need to care for your <spouse illness="" in="" incurred="" injury="" line="" of<="" or="" s="" td="" the=""><td>on or daughter parent next of kin> due to his/her serious duty as a covered servicemember.</td></spouse>	on or daughter parent next of kin> due to his/her serious duty as a covered servicemember.
This notice is to inform you that you have	e 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.

National HR Service Center

Fax to: (877) 477-2329 Telephone: (877) 457-4772

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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 <bir> birth marriage adoption/foster care domestic partner relationship next of kin>.</bir>
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</mm>
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 <bir>birth marriage adoption/foster care domestic partner relationship next of kin>.</bir>
Military Orders

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☐ 1453 - Service	é Member - Certification of Physician
1454 - Military	/ Exigency - Certification
Other:	
Please fax the require (1-877-477-2329). Or	ed document(s) to the National HR Service Center at 1-877-HRSC-FAX mail the forms to:
	Kaiser Permanente National HR Service Center PO Box 2074 Oakland, CA 94604-2074
	nformation from you as specified above, we will inform you whether your leave FMLA/CFRA leave and count towards your FMLA/CFRA leave entitlement.
Please note: Failure Family Leave.	to provide the sufficient certification may result in delay or denial of your
FMLA are attached for	s and Responsibilities and the definitions of a Serious Health Condition under the or your review. Policies, bargaining agreements and other information regarding n be found on My HR.
Absence Managemer	tions or concerns regarding your request for family leave, please contact Work nt (WAM) at the National HR Service Center at 877-4KP-HRSC (877-457-4772). case number located in the upper right-hand corner of this letter.
Sincerely,	
Work Absence Mana National HR Service	
Enclosures:	
	Certification of Physician
	ber - Certification of Physician
_	nber - Certification of Physician
	gency - Certification
_	nt to Sick Leave Request
2520 - Personal D	ata Change

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

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.

Eliaibility 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

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
- 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.

National HR Service Center

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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.

National HR Service Center

Fax to: (877) 477-2329 Telephone: (877) 457-4772

Executives: Contact your Executive Benefits Specialist

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January 29, 2018

Employee ID: 00530105 Case Number: 41467995

Darlene Walls 16323 cortuna ave # 8 Bellflower, CA 90706

Dear Darlene Walls,

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

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="" domestic="" family="" member="" parent="" partner=""> due to serious health condition.</spouse>	his/her
An exigency arising out of the fact that your <spouse daughter="" or="" parent="" son=""> is on active call to active duty status.</spouse>	duty or
Your need to care for your <spouse daughter="" kin="" next="" of="" or="" parent="" son=""> due to his/her ser injury or illness incurred in the line of duty as a covered servicemember.</spouse>	ious
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 requered leave, you will have worked approximately <enter mos="" num=""> months towards this required you are still on leave at the completion of 12 months of service please contact the NHRSC request your eligibility for FMLA/CFRA. For more information please see the attached not the Employee Rights and Responsibilities.</enter>	ement. If C to
You have not met the 1,250 hours worked requirement within the 12 months preceding the your leave. As of <mm dd="" yyyy=""> you have worked <enter hours=""> hours towards the eligible requirement. You can check the number of hours worked by contacting the NHRSC.</enter></mm>	

National HR Service Center

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You exhausted your <12 26>-week entitlement to leave under the <fmla cfra=""></fmla>
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="" care="" domestic="" foster="" marriage="" partner="" relationship="">.</birth>
☐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.



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



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National HR Service Center

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

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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

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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.

National HR Service Center

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LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

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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.
- 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 Num	nber (###) ###-###	* Effective Date (mm/dd/yyyy)		
00530105	(213) 401-88	27	01/03/2018		
* First Name	Middle Name		* Last Name		
Darlene			Walls		
1. LEAVE INFORMATION					
Employee E-mail Address	Alternate Em	ployee Phone Number	(###) ###-###	New or Revised Request	
			. ·	New Revised	
* Leave Type:	-				
Medical .	Union	•	☐ Care fo	or Eligible Family Member	
Maternity	Personal		Family	Military Leave	
☐ Workers' Comp/Industrial	Military Service	9	Bondin	ng , ,	
Last Day Worked (mm/dd/yyyy)	* First Day of Leave (mm/dd/yyyy)	Expected Return I	Date (mm/dd/yyyy)	
<u>-</u>	01/03/2018				
Is this an intermittent or reduced work sched	lule Leave? 🔀 Inter	mittent Reduced V	Vork 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 M	lember or Bonding:				
Name of Eligible Family Member		Relationship to Emplo	yee		
·					
Is Family Member age 18 or under? If Yes	, enter age	Delivery/Adoption/Foster Care Placement Date (mm/dd/yyyy)			
Yes No		Actual Date Expected Date			
Is the child's other parent employed by Kaise	er Permanente?	if Yes, full name of otl	ner parent		
Yes No					
If absence is due to Family Member's Military Service please select the reason(s) that apply:					
Name of Eligible Family Member		Relationship to Emplo	yee		
Qualifying Exigency, (matters related to Seeing off leaving or returning Service Mo	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					
					

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LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

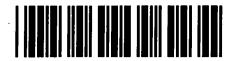
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* First Name	Middle Name	* Last Name			
Darlene		Walls			
* Employee ID	* Contact Phone Number (###) ###-###	* Effective	Date (mm/dd/yyyy)		
00530105	(213) 401-8827	01/03/2	018		
1. LEAVE INFORMATION - (Continu	ed)	· · · · · · · · · · · · · · · · · · ·			
If absence is for Employee's own health	condition (Medical, Maternity or Workers' Co	mp/Industria)		
Date of illness or injury (mm/dd/yyyy)	Vas hospitalization required?	Da	te Hospitalized (mm/dd/yyyy)		
01/03/2018	Yes No Unknown		<i>y</i>		
Estimated/Actual hours worked on last day	If Leave is due to maternity		Delivery Date (mm/dd/yyyy)		
8	Actual Delivery Date Expected	Delivery Dat	e		
If absence is pregnancy related, does the complete?	employee plan to take Bonding time immediate	ly after the p	regnancy related absence is		
☐Yes ☐No			<u> </u>		
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 Perm	nanente less than one year?				
☐Yes ☑No			·		
Has the Employee been on active Military	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					

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Executives: Contact your Executive Benefits Specialist



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LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

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* First Name		Middle I	Name		* Last Name			
Darlene						Walls		
* Employee ID		* Conta	* Contact Phone Number (###) ###-###			## * Effective Date (mm/dd/yyyy)		
00530105		(213)	4Ò1-8827		01/03/20	18		
1. LEAVE INFORM	MATION - (Con	tinued)			,	-		
Name of Agency	,							
Start Date (mm/dd/yy	₍ /yy)	End Date	End Date (mm/dd/yyyy)			Agency Phone Number (###) ###-####		
2. COMMENTS		<u>l</u>			•		· ·	
			,		·		· .	
3. EMPLOYEE SC	HEDULE						•	
This information is employees absent f	or their own dis	sability. Please	use a 24 hr clo			i nis is requ	Jirea for	
Week 1								
	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	
Start Time: (hh:mm)	,							
Week 2 (Only needed if schedule changes week to week)								
Week 2 (Only r	sunday	le changes weel	k to week) Tuesday	Wednesday	Thursday	Friday	Saturday	
Start Time: (hh:mm)	Sunday	Wioriday	luesuay	Wednesday	illuisuay	Filday	Saturday	
Hours:						l		
4. REQUEST PAIL	TIME-OFF		<u> </u>			<u> </u>		
Review your Collec Selections made he KP and HR Policies	tive Bargaining ere will not supe	rsede conditio	ns set in Collec	Plan Description tive Bargaining	n Booklet before Agreements, S	e completing	g this section. an Descriptions,	
Did employee reques	st EarnedTime O	ff (ETO)/Paid Ti	me Off (PTO)/Va	acation?	Use all availa	able hours	Number of hours	
☐Yes ☐No ☐Use se				Use selected	hours			
Did employee reques	st to use Extende	ed Sick Leave (E	SL)/Sick Leave	? .	Use all availa	able hours	Number of hours	
☐Yes ☐No				Use selected hours		ľ		
Did employee request to use Float Holidays? Only available Float Number of control of the cont					Number of days			
☐ Yes ☐ No Holidays will be applied.								
Notional UD Comi	04				- ·			

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LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

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* First Name Da r I ene	·		* Last Name Walls				
* Employee ID 00530105				## * Effective Date (mm/dd/yyyy) 01/03/2018			
4. REQUEST PAID TIME-OFF -	Continued)						
Did employee request to use Flexible	Personal Days?	Nur	mber of days	OB	Number of hours		
☐Yes ☐No				OR			
Note: Flexible Personal Days can on applied.	y be used in full day or two hour increments	s. Only av	available Flexible Personal Days will be				
Did employee request Military Make-	up Pay?	_					
Yes No							
5. SUBMITTED BY							
* Name (First, MI, Last) Danny P Jimenez							
* Employee ID							
00685629							
* E-mail Address					###) ###-####		
danny.p.jimenez@kp.org			(5	62) 657	7-8527		
6. MANAGER INFORMATION D	ETAIL				. *		
* Name (First, MI, Last)							
Danny Jimenez					·		
Supervisor ID * Title							
* E-mail Address					###) ###-###		
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

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* First Name

LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

* Last Name

Middle Name

Page 5 of 5

Darlene			Walls
* Employee ID		* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105		(213) .401-8827	01/03/2018
8. MANAGER	ATTESTATION		
* Checking thes	e items acknowledges that	you have read and understand each item.	
I agree to dir	ect the employee requesting	Leave to submit any and all supporting doc	umentation to me or the National HR Service
		ave and any supporting documentation at the expected return date or fails to return on their	
☑ I agree to sul	bmit form 1510 - Return fron	n Leave when the employee returns to work.	
☑ TIME must b	e coded for all paid and unp	aid 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

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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)

De	ear Darlene Walls,
	n 02/13/18, we were informed that you requested an extension of your leave that began on 0/02/17 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="" domestic="" family="" member="" parent="" partner=""> due to his/her serious health condition.</spouse>
	An exigency arising out of the fact that your <spouse daughter="" or="" parent="" son=""> is on active dut or call to active duty status.</spouse>
	Your need to care for your <spouse daughter="" kin="" next="" of="" or="" parent="" son=""> due to his/her serious injury or illness incurred in the line of duty as a covered servicemember.</spouse>
×	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

National HR Service Center

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app FM	s Notice is to inform you that, while you remain eligible for leave under the FMLA/CFRA, proval of your request is pending receipt of sufficient certification to support your request for LA/CFRA leave, as indicated below. The documentation must be provided to the NHRSC by nter Date>, or your request for an extension may be denied.
	1451 Employee - Certification of Physician
	1452 Family Member - Certification of Physician
	Other:
_	is 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=""></fmla>
	effective <enter date="">.</enter>
	A Health Care Provider Certification form was not received.
	the state of the s
	The certification document you submitted was not sufficient to support your request.

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.



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:



IAJIDEL I MAINIMADALE

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 FMI A
- 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.

National HR Service Center

Fax to: (877) 477-2329 Telephone: (877) 457-4772

Executives: Contact your Executive Benefits Specialist

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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.

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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

Tyour 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.

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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 <u>31 days</u> of the birth or adoption to ensure coverage for your new dependent.

Enroll on-line at: http://kp.org/myhr:

D	AY 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.							
D	AY 2	Make benefit changes on-line: Log on and follow the online process to enroll your dependent.							

National HR Service Center

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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.

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

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

Basic Leave Entitlement

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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 the qualified family member from participating in school or other daily activities.

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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.

National HR Service Center

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LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

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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.
- 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.

00530105	(323) 401-88		08/13/2018		
* First Name	Middle Name	,	* Last Name		
Darlene			Walls	•	
1. LEAVE INFORMATION					
Employee E-mail Address	Alternate Em	ployee Phone Number	(###) ###-####	New or Revised Request	
				☐ New ☐ Revised	
* Leave Type:			 		
Medical	Union		☐ Care	for Eligible Family Member	
Maternity	Personal		Famil	ly Military Leave	
☐ Workers' Comp/Industrial	Military Servic	е	Bond	ing _.	
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 sched	ule Leave? 🔀 Inter	mittent Reduced V	Vork Schedule	Not Applicable	
Is this a Donor Leave? Yes No	Unknown			•	
Estimated frequency and duration of absence					
Frequency 1 episode 2 times a Duration whole scheduled shif	month t				
If absence is for Care of Eligible Family N	lember or Bonding:				
Name of Eligible Family Member		Relationship to Emplo	pyee		
Is Family Member age 18 or under? If Yes	, enter age	Delivery/Adoption/Foster Care Placement Date (mm/dd/yyyy)			
Yes No.		Actual Date Expected Date			
Is the child's other parent employed by Kaise	er Permanente?	If Yes, full name of other parent			
☐Yes ☐No					
If absence is due to Family Member's Mili	tary Service please s	elect the reason(s) the	at apply:		
Name of Eligible Family Member		Relationship to Emplo	oyee		
Qualifying Exigency, (matters related to Seeing off leaving or returning Service Me		Child Care issues, Finar	ncial Planning, and	d Family Support Sessions,	
☐ Care for qualified Service Member who	incurred injury or ill	ness in the line of dut	у		
	·				

National HR Service Center

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LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

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* First Name	Mid	dle Name		* Last N	ame	. •
Darlene				Walls		
* Employee ID	* Co	ontact Phone Number	(###) ###-###	* Effective Date (mm/dd/yyyy)		
00530105	(32	23) 401-8827		08/13/	/2018	8
1. LEAVE INFORMATION - (Continu	red)	· · · · · · · · · · · · · · · · · · ·				· · · · · · · · · · · · · · · · · · ·
If absence is for Employee's own healt	h condi	tion (Medical, Materni	ty or Workers' Con	np/Indust	rial)	
Date of illness or injury (mm/dd/yyyy)	Was ho	spitalization required?		T	Date I	Hospitalized (mm/dd/yyyy)
08/13/2018	Yes	No ☐ Unknov	vn ·			
Estimated/Actual hours worked on last da	ay	If Leave is due to ma	ternity			Delivery Date (mm/dd/yyyy)
8		Actual Delivery Da	ate Expected I	Delivery [Date	
If absence is pregnancy related, does the complete?	employ	ee plan to take Bondin	g time immediatel	y after the	e preg	nancy related absence is
☐Yes ☐No						
If absence is for Union Leave	· 					
Type of Union Leave:						
Short Term (30 days or less)		ong Term (greater tha	n 30 days)	Elect	ed Off	ficial
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	1					
		-				
Temporary Agency or Military Service	(asked f	or 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/d	ld/yyyy)		End Date (mm/dd/yyyy)
☐ Yes ☑ No						
Yes No			· · · · · · · · · · · · · · · · · · ·			
☐ Yes ☑ No Did the Employee work for Kaiser Perma	nente wi	ith a Temporary Agenc	y in the year befor	e they we	ere hir	ed?

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LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

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* First Name		Middle I	Name		* Last Nam	e .	
Darlene					Walls		
* Employee ID		* Conta	ct Phone Numbe	er (###) ###-###	# * Effective I	Date (mm/dd	/vvv)
00530105			401-8827	` '	08/13/20		
1. LEAVE INFORM	MATION - (Con	<u> </u>					
Name of Agency	<u></u>	<u> </u>				<u> </u>	
Start Date (mm/dd/yy	/yy)	End Da	te (mm/dd/yyyy)	···	Agency Pho	one Number	(###) ###-###
2. COMMENTS	•				<u> </u>		`
							•
3. EMPLOYEE SC							· · · · · · · · · · · · · · · · · · ·
This information is employees absent f	essential for the or their own dis	e NHRSC to pre sability. Please	epare a worksh use a 24 hr clo	eet to assist wi ck: 00:00 thru 2	th TIME coding. 24:00.	This is requ	uired for
NOTE: This section	is not applicab	le for the KROI	NOS regions.				
Week 1							
	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start Time: (hh:mm)					-		
Hours:						,	
Week 2 (Only n	eeded if schedu	,					
	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start Time: (hh:mm)							
Hours:							
4. REQUEST PAID							
Review your Collect Selections made he	re will not supe	ersede conditio	ns set in Collec				
KP and HR Policies							T.,
Did employee reques	t EarnedTime O	ff (ETO)/Paid Ti	me Off (PTO)/Va	acation?	Use all availa	able hours	Number of hours
Yes No	Yes ☐ No ☐ Use selected hours						
Did employee reques	Did employee request to use Extended Sick Leave (ESL)/Sick Leave?					able hours	Number of hours
∑Yes			<u> </u>		Use selected	hours	
Did employee reques	st to use Float H	olidays?		•	Only available F		Number of days
☐ Yes No		·- <u></u>			Holidays will be	applied.	
National HR Service	ce Center	1 188	الحالة الحال الحا				

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

Page 4 of 5

* First Name		Middle Name	* Last Name				
Darlene			Walls				
* Employee ID		* Contact Phone Number (###) ###-###	# * Effective Dat	e (mm/dd	/yyyy)		
00530105		(323) 401-8827	08/13/2018	3			
4. REQUEST PAID TIM	E-OFF - (Contin	ued)					
Did employee request to u	se Flexible Persoi	nal Days?	Number of days	OR	Number of hours		
☐Yes ☐No				Uņ.			
Note: Flexible Personal Da applied.	ays can only be us	ed in full day or two hour increments. On	ly available Flexible	Personal	Days will be		
Did employee request Milit	ary Make-up Pay	?					
☐ Yes ☐ No							
5. SUBMITTED BY		· · · · · · · · · · · · · · · · · · ·					
* Name (First, MI, Last)							
Danny P Jimenez	•						
* Employee ID	* Title						
00685629							
* E-mail Address	L.		* Work Phone	Number (###) ###-###		
danny.p.jimenez@k	p.org		(5	62) 65	7-8527		
6. MANAGER INFORM	ATION DETAIL						
* Name (First, MI, Last)	<u> </u>						
Danny Jimenez							
Supervisor ID	* Title						
,							
* E-mail Address	-		* Work Phone	Number	(###) ###-###		
danny.p.jimenez@k	p.org		(5	62) 65	7-8527		
7. ALTERNATE CONTACOMMUNICATION (i.e. time		FION - Someone, in addition to the Matus, etc.)	lanager, who shou	ıld receiv	e leave		
* Name (First, MI, Last)							
* E-mail Address		· · · · · · · · · · · · · · · · · · ·	* Work Phone	Number	(###) ###-###		
	•						
	<u>-</u> _		<u>_</u>				

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* First Name

Darlene .

LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

*Last Name Walls

Middle Name

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* Employee ID	* Contact Phone Number (###) ###-###	* Effective Date (mm/dd/yyyy)							
00530105	(323) 401-8827	08/13/2018							
8. MANAGER ATTESTATION									
_	that you have read and understand each item.								
I agree to direct the employee reque Center.	esting Leave to submit any and all supporting doc	umentation to me or the National HR Service							
I agree to submit form 1500 - Extend to extend his or her leave beyond the terminated.	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	n from Leave when the employee returns to work.								
☑ TIME must be coded for all paid and	I unpaid leave taken by the employee.								
9. MANAGER SIGNATURE - (Requ	uired 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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LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

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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.
- 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 00530105	* Contact Phone Nun (562) 657-85		* Effective Date (mm/dd/yyyy) 08/02/2018			
* First Name Darlene	Middle Namė		* Last Name Walls	· · · · · · · · · · · · · · · · · · ·		
			Waiis			
1. LEAVE INFORMATION						
Employee E-mail Address	Alternate Em	ployee Phone Numbe	r (###) ###-###	New or Revised Request		
				New Revised		
* Leave Type:						
Medical Medical	Union		☐ Care	for Eligible Family Member		
Maternity	Personal		☐ Fami	ly Military Leave		
☐ Workers' Comp/Industrial	Military Servic	e	Bond	ling		
Last Day Worked (mm/dd/yyyy)	* First Day of Leave (mm/dd/yyyy)	Expected Return	n Date (mm/dd/yyyy)		
	08/02/2018		• .			
Is this an intermittent or reduced work scheo	lule Leave? X Inter	mittent Reduced	Work Schedule	Not Applicable		
Is this a Donor Leave? Yes	Unknown			2		
Estimated frequency and duration of absence	es					
tbd by physician						
If absence is for Care of Eligible Family N	lember or Bonding:					
Name of Eligible Family Member	•	Relationship to Emp	loyee	•		
				•		
Is Family Member age 18 or under? If Yes	, enter age	Delivery/Adoption/Fo	oster Care Placeme	ent Date (mm/dd/yyyy)		
☐Yes ☐No		Actual Date	Expected Date			
Is the child's other parent employed by Kaise	er Permanente?	If Yes, full name of o	other parent			
Yes No				,		
If absence is due to Family Member's Military Service please select the reason(s) that apply:						
Name of Eligible Family Member		Relationship to Emp	loyee			
			. •			
Qualifying Exigency, (matters related to Seeing off leaving or returning Service Mo		Child Care issues, Fina	ancial Planning, an	d Family Support Sessions,		
Care for qualified Service Member who	incurred injury or ill	ness in the line of du	ıty			

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LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

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* First Name .	Middle Name	[*]	* Last Name		
Darlene	·	Wa	Walls		
* Employee ID	* Contact Phone Number	(###) ###-#### * 8	* Effective Date (mm/dd/yyyy)		
00530105	(562) 657-8527	08	3/02/201	.8	
1. LEAVE INFORMATION - (Contin					
If absence is for Employee's own hea	Ith condition (Medical, Matern	ity or Workers' Comp/	ndustrial)		
Date of illness or injury (mm/dd/yyyy)	Was hospitalization required?	•	Date	Hospitalized (mm/dd/yyyy)	
08/02/2018	☐ Yes ☑ No ☐ Unknow	wn ·			
Estimated/Actual hours worked on last of	day If Leave is due to ma	aternity		Delivery Date (mm/dd/yyyy)	
8	Actual Delivery D	ate Expected Del	very Date		
If absence is pregnancy related, does th complete?	e employee plan to take Bondii	ng time immediately at	ter the pre	gnancy related absence is	
☐Yes ☐No	· · · · · · · · · · · · · · · · · · ·				
If absence is for Union Leave					
Type of Union Leave:					
Short Term (30 days or less)	Long Term (greater that	an 30 days)	Elected O	fficial	
Name of Union					
			٠.		
If absence is for Military Leave					
Is this absence for Military Training o	r Active Duty?				
Military Training	Active Duty				
* If for Personal Leave, indicate reaso	on				
Temporary Agency or Military Service	e (asked for FMLA eligibility)				
Has the Employee worked for Kaiser Pe	rmanente less than one year?				
☐Yes ⊠No					
Has the Employee been on active Milita	ry Duty in the past 12 months?	Start Date (mm/dd/y	ууу)	End Date (mm/dd/yyyy)	
☐ Yes ☑ No					
Did the Employee work for Kaiser Perma	anente with a Temporary Agend	cy in the year before th	ney were hi	red?	
☐Yes ☐No					

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Executives: Contact your Executive Benefits Specialist



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LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

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* First Name		Middle I	Name		* Last Nam	<u> </u>		
Darlene					Walls			
* Employee ID	ID		er (###) ###-###	## * Effective Date (mm/dd/yyyy)				
00530105		(562)	(562) 657-8527			08/02/2018		
1. LEAVE INFORM	IATION - (Con	tinued)	·			-		
Name of Agency	`	•	-			· · · · · · · · · · · · · · · · · · ·		
Start Date (mm/dd/yyyy)		End Dat	End Date (mm/dd/yyyy)			Agency Phone Number (###) ###-###		
2. COMMENTS	·				<u> </u>			
AR 09/05/18-14	80 submitte	d on behalf	f of manage	er. Eĥ			-	
					-			
				· 				
3. EMPLOYEE SCI	<u> </u>							
This information is employees absent for	essential for the or their own dis	e NHRSC to pre ability. Please	epare a worksh use a 24 hr clo	eet to assist wi ock: 00:00 thru 2	th TIME coding. 24:00.	This is requ	uired for	
NOTE: This section		•	•					
Week 1	is not applicab	ie iui tile Khoi	103 regions.					
	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	
Start Time: (hh:mm)								
Hours:								
Week 2 (Only n	eeded if schedu	le changes wee	k to week)					
	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday Saturda		
Start Time: (hh:mm)	•		,	<u> </u>				
Hours:						<u></u>		
4. REQUEST PAID						•	 	
Review your Collect Selections made he								
KP and HR Policies,								
Did employee request EarnedTime Off (ETO)/Paid Time Off (PTO)/Vacation?			acation?	Use all available hours Number of ho		Number of hours		
Yes No Use selected hours								
Did employee request to use Extended Sick Leave (ESL)/Sick Leave?			?	Use all available hours Number of		Number of hours		
☐Yes ☐No			,	Use selected hours				
Did employee request to use Float Holidays?				Only available Float		Number of days		
☐Yes ☐No				Holidays will be				
						•	•	

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LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

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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	08/02/2018			
4. REQUEST PAID TIM	E-OFF - (Contin	ued)				
Did employee request to use Flexible Personal Days?			Number of days	0.0	Number of hours	
☐ Yes ☐ No				OR		
Note: Flexible Personal Da applied.	lys can only be us	ed in full day or two hour increments. On	y available Flexible	Personal	Days will be	
Did employee request Milit	ary 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.d	org		(562) 622-4029		2-4029	
6. MANAGER INFORM	ATION DETAIL		-			
* Name (First, MI, Last)						
erik humbert						
Supervisor ID	* Title					
		4				
* E-mail Address			* Work Phone	Number (###) ###-###	
erik.a.humbert@kp	.org	•	(5	62) 657	7-8527	
7. ALTERNATE CONTA		TION - Someone, in addition to the Matus, etc)	anager, who shou	ld receiv	e leave	
* Name (First, MI, Last)						
		(·,				
* E-mail Address			* Work Phone	Number (###) ###-###	
	•		·			

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* First Name

Darlene

LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

* Last Name Walls

Middle Name

Page 5 of 5

* Employee ID		* Contact Phone Number (###) ###-###	* Effective Date (mm/dd/yyyy)
00530105	•	(562) 657-8527	08/02/2018
8. MANAGER	ATTESTATION		
ļ	_	you have read and understand each item.	
agree to die Center.	rect the employee requesting	g Leave to submit any and all supporting doc	umentation to me or the National HR Service
I agree to su to extend his terminated.	bmit form 1500 - Extend Lea s or her leave beyond their e	ave and any supporting documentation at the xpected return date or fails to return on their	time I learn that the employee intends expected date, fails to respond, and is not
⊠ I agree to su	bmit form 1510 - Return fror	n Leave when the employee returns to work.	
☑ TIME must b	pe coded for all paid and unp	aid leave taken by the employee.	
9. MANAGER	SIGNATURE - (Required	I if not submitted online.)	·
		· · · · · · · · · · · · · · · · · · ·	
	* Manager Signature		Date (mm/dd/yyyy)

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Executives: Contact your Executive Benefits Specialist



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October 5, 2018

Dariene Walls 16323 cortuna ave # 8 Beliflower, CA 90706 Employee ID: 00530105 Case Number: 3039373

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="" domestic="" family="" member="" parent="" partner=""> due to his/her serious health condition.</spouse>
An exigency arising out of the fact that your <spouse daughter="" or="" parent="" son=""> is on active duty or call to active duty status.</spouse>
Your need to care for your <spouse daughter="" kin="" next="" of="" or="" parent="" son=""> due to his/her serious injury or illness incurred in the line of duty as a covered servicemember.</spouse>
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.

National HR Service Center

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

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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

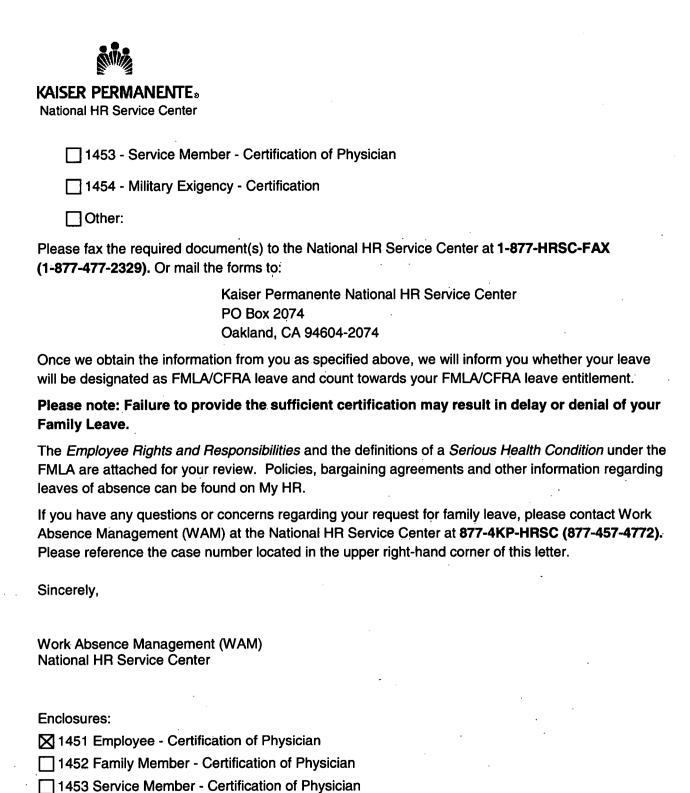
National HR Service Center

Fax to: (877) 477-2329 Telephone: (877) 457-4772

Executives: Contact your Executive Benefits Specialist

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National HR Service Center

Executives: Contact your Executive Benefits Specialist

1454 - Military Exigency - Certification

2520 - Personal Data Change

2090 - Supplement to Sick Leave Request

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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.

National HR Service Center

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

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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.

National HR Service Center

Fax to: (877) 477-2329 Telephone: (877) 457-4772

Executives: Contact your Executive Benefits Specialist

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October 8, 2018

Darlene Walls 16323 cortuna ave # 8 Beliflower, CA 90706 Employee ID: 00530105 Case Number: 2863571

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="" domestic="" family="" member="" parent="" partner=""> due to his serious health condition.</spouse>	s/her
An exigency arising out of the fact that your <spouse daughter="" or="" parent="" son=""> is on active ducall to active duty status.</spouse>	ıty or
Your need to care for your <spouse daughter="" kin="" next="" of="" or="" parent="" son=""> due to his/her seriou injury or illness incurred in the line of duty as a covered servicemember.</spouse>	JS
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 qual FMLA/CFRA you must meet the eligibility requirements at the beginning of your leave. Please refer to the attached <i>Employee Rights and Responsibilities</i> regarding eligibility criteria or requirements. Should your employment status change prior to the start of your leave, you may 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

National HR Service Center

may be denied.

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

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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 <bir>birth marriage adoption/foster care domestic partner relationship next of kin>.</bir>
Military Orders
1454 - Military Exigency - Certification
Other:
The certification you provided is not complete and sufficient to determine whether the FMLA/CFR/applies to your leave request. You must provide the following information no later than kmm/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 <bir>birth marriage adoption/foster care domestic partner relationship next of kin>.</bir>
☐ Military Orders

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

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\cdot	
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 you will be designated as FMLA/CFRA leave and count towards your FMLA/CFRA leave entitlem	
Please note: Failure to provide the sufficient certification may result in delay or denial Family Leave.	of your
The Employee Rights and Responsibilities and the definitions of a Serious Health Condition of FMLA are attached for your review. Policies, bargaining agreements and other information releaves of absence can be found on My HR.	
If you have any questions or concerns regarding your request for family leave, please contact Absence Management (WAM) at the National HR Service Center at 877-4KP-HRSC (877-45). 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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Executives: Contact your Executive Benefits Specialist

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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

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- 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

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
- 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.

National HR Service Center

Fax to: (877) 477-2329 Telephone: (877) 457-4772

Executives: Contact your Executive Benefits Specialist

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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="" domestic="" family="" member="" parent="" partner=""> due to his/her serious health condition.</spouse>
An exigency arising out of the fact that your <spouse daughter="" or="" parent="" son=""> is on active du or call to active duty status.</spouse>
Your need to care for your <spouse daughter="" kin="" next="" of="" or="" parent="" son=""> due to his/her seriou injury or illness incurred in the line of duty as a covered service member.</spouse>

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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Duration: 1 day per episode

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

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 <u>31 days</u> 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 of	n
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:



KAISER PERMANENTES

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 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 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 Regulrements

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

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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.

00530105	(213) 401–8827		01/17/2019		
* First Name Darlene	Middle Name	·	* Last Name Walls		
1. LEAVE INFORMATION	! -				
Employee E-mail Address	Alternate Em	ployee Phone Number	(###) ###-###	New or Revised Request	
* Leave Type:		· · · · · · · · · · · · · · · · · · ·		<u> </u>	
⊠ Medical	Union		Care	for Eligible Family Member	
Maternity	Personal		☐ Famil	ly Military Leave	
☐ Workers' Comp/Industrial	Military Service	e	Bond	ing	
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 sched	lule Leave? 🔀 Inter	mittent Reduced V	Nork Schedule	Not Applicable	
Is this a Donor Leave? Yes No	o 🔀 Unknown				
Estimated frequency and duration of absence	ces				
Frequency 2 times per month 8 hours per episode		· .		· .	
If absence is for Care of Eligible Family N					
Name of Eligible Family Member		Relationship to Emplo	oyee		
Is Family Member age 18 or under? If Yes	, enter age	Delivery/Adoption/Fos	ster Care Placeme	ent Date (mm/dd/yyyy)	
Yes No		Actual Date Expected Date			
Is the child's other parent employed by Kaise	If Yes, full name of other parent				
Yes No	·				
If absence is due to Family Member's Mil	itary Service please s	T			
Name of Eligible Family Member		Relationship to Emplo	oyee		
Qualifying Exigency, (matters related to Seeing off leaving or returning Service M	embers.)	•	, -	d Family Support Sessions,	

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LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

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- 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 - (Contin	nued)				
If absence is for Employee's own hea	Ith condition (Medical, Maternity or Workers' Co	mp/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 o	day If Leave is due to maternity	Delivery Date (mm/dd/yyyy)			
8	Actual Delivery Date Expected	Delivery Date			
complete?	e employee plan to take Bonding time immediate	ly after the pregnancy related absence is			
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 o	r Active Duty?				
Military Training	Active Duty				
* If for Personal Leave, indicate reason	on	· · · · · · · · · · · · · · · · · · ·			
•	,				
· 	·				
		,			
		·			
Temporary Agency or Military Service	e (asked for FMLA eligibility)				
Has the Employee worked for Kaiser Pe	rmanente less than one year?				
☐ Yes X No	* * * * * * * * * * * * * * * * * * * *				
Has the Employee been on active Milita	ry Duty in the past 12 months? Start Date (mm/	/dd/yyyy) End Date (mm/dd/yyyy)			
Yes No	*				
Did the Employee work for Kaiser Perm	anente with a Temporary Agency in the year before	ore they were hired?			
Yes No					
	•	* * * * * * * * * * * * * * * * * * * *			

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LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

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* First Name		Middle I	Name		* Last Name	 9	
Darlene	clene			Walls			
* Employee ID	* Contact Phone Number (###) ###-##			er (###) ###-###	# * Effective D	Date (mm/dd	/уууу)
00530105		(213)	401-8827		01/17/20	19	
1. LEAVE INFORM	IATION - (Con	tinued)			<u> </u>		
Name of Agency							
Start Date (mm/dd/yyyy)		End Dat	te (mm/dd/yyyy)	Agency Phone Number (###) ###-####			
2. COMMENTS							
							····
3. EMPLOYEE SC	UEDIU E					· <u>-</u>	
	· · · · · ·						
This information is employees absent for						This is requ	uired for
		-		OK. 00.00 WHG 2	.4.00.		
NOTE: This section	is not applicab	le for the KRO	NOS regions.	•			
Week 1							
	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start Time: (hh:mm)		<u></u>		-		· .	· · · · · · · · · · · · · · · · · · ·
Hours:							
Week 2 (Only n				T	T		
· .	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start Time: (hh:mm)	,		<u> </u>				
Hours:					<u> </u>	<u>!</u>	
4. REQUEST PAID							
Review your Collect	ive Bargaining	Agreement and	d/or Summary	Plan Descriptio	n Booklet before	e completin	g this section.
Selections made he KP and HR Policies	re will not supe , or applicable (ersede conditio State and Fedei	ns set in Collec ral Laws.	tive Bargaining	g Agreements, S	ummary Pi	an Descriptions,
Did employee reques	t EamedTime O	ff (ETO)/Paid Ti	me Off (PTO)/Va	acation?	Use all availa	ble hours	Number of hours
☐Yes ☐No					Use selected hours		
Did employee reques	Did employee request to use Extended Sick Leave (ESL)/Sick Leave?			?	Use all available hours Number of h		
☐Yes ☐No							I
		•			Use selected	hours	
Did employee reques	t to use Float Ho	olidays?					Number of days
	t to use Float Ho	olidays?		<u>.</u> .	Only available F Holidays will be	loat	Number of days

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LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

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* First Name Darlene		Middle Name	* Last Name Walls		
* Employee ID		* Contact Phone Number (###) ###-###	# * Effective Date	e (mm/dd	/ yyyy)
00530105		(213) 401-8827	01/17/2019	1/17/2019	
4. REQUEST PAID TIM	E-OFF - (Contin	ued)	•.		
Did employee request to u	se Flexible Persor	nal Days?	Number of days	OR	Number of hours
☐Yes ☐No) On	
Note: Flexible Personal Da applied.	ys can only be us	ed in full day or two hour increments. On	ly available Flexible	Personal	Days will be
Did employee request Milit	ary 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@kr	o.org		(562) 657-8527		
6. MANAGER INFORM	ATION DETAIL		•		
* Name (First, MI, Last)					
Danny Jimenez					
Supervisor ID	* Title				
		•			
* E-mail Address			* Work Phone	Number ((###) ###-###
danny.p.jimenez@kp.org		(5	62) 65	7-8527	
7. ALTERNATE CONTACOMMUNICATION (i.e. time		TION - Someone, in addition to the Matus, etc)	anager, who shou	ıld receiv	e leave
* Name (First, MI, Last)					
* E-mail Address		-	* Work Phone	Number ((###) ###-###
·				•	·

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* First Name

Darlene

LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

Middle Name

* Last Name

Walls

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* Employee ID	* Contact P	hone Numbėr (###) ###-###	* Effective Date (mm/dd/yyyy)	
00530105	. (213) 40	1-8827	01/17/2019	
8. MANAGER ATTESTATIO	N	 		
* Checking these items acknow	•			
agree to direct the employe Center.	e requesting Leave to sub	omit any and all supporting doc	cumentation to me or the National HR Service	
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 subm	itted online.)		
* Manager Signa	ture		Date (mm/dd/yyyy)	

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LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

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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.
- 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 00530105	* Contact Phone Num (213) 401-88		* Effective Date 01/16/201	
* First Name	Middle Name		* Last Name	
Darlene			Walls.	
1. LEAVE INFORMATION				
Employee E-mail Address	Alternate Em	ployee Phone Number	(###) ###-###	New or Revised Request
	·			☐ New ☐ Revised
* Leave Type:				
Medical	Union		☐ Care	for Eligible Family Member
Maternity	Personal		Fami	ly Military Leave
Workers' Comp/Industrial	Military Servic	е	Bond	ing
Last Day Worked (mm/dd/yyyy)	* First Day of Leave (mm/dd/yyyy)	Expected Return	n Date (mm/dd/yyyy)
	01/16/2019			
Is this an intermittent or reduced work sched	dule Leave? 🔀 Inter	mittent Reduced V	Vork Schedule	Not Applicable
Is this a Donor Leave? Yes N	o 🔀 Unknown			,
Estimated frequency and duration of absence				
Frequency 2 times per 1 month 1 day per episode				
If absence is for Care of Eligible Family N	lember or Bonding:			
Name of Eligible Family Member		Relationship to Emplo	byee	
	·			· · · · · · · · · · · · · · · · · · ·
Is Family Member age 18 or under? If Yes	, enter age	Delivery/Adoption/Fos	ter Care Placeme	ent Date (mm/dd/yyyy)
Yes No		Actual Date	xpected Date	
Is the child's other parent employed by Kais	er Permanente?	If Yes, full name of ot	her parent	
∐Ýes ∐No				
If absence is due to Family Member's Mil	itary Service please s	elect the reason(s) th	at apply:	
Name of Eligible Family Member		Relationship to Emplo	oyee	·
		<u> </u>		
Qualifying Exigency, (matters related to Seeing off leaving or returning Service M	child Care issues, Finar	ncial Planning, and	d Family Support Sessions,	
☐ Care for qualified Service Member who	incurred injury or ill	ness in the line of du	У	
				-

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

Page 2 of 5

* First Name	Middle Name	* Last Name)	
Darlene		Walls		
* Employee ID	* Contact Phone Number (###) ###-###	## * Effective Date (mm/dd/yyyy)		
00530105	(213) 401-8827	01/16/20	19	
1. LEAVE INFORMATION - (Continu	ed)			
If absence is for Employee's own healti	n condition (Medical, Maternity or Workers' Co	mp/Industrial)	•	
Date of illness or injury (mm/dd/yyyy)	Was hospitalization required?	Dat	e Hospitalized (mm/dd/yyyy)	
01/16/2019	Yes No Unknown			
Estimated/Actual hours worked on last da	y 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 complete?	employee plan to take Bonding time immediate	ly after the pro	egnancy related absence is	
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				
		•		
			<u>. </u>	
Temporary Agency or Military Service (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/c	dd/yyyy)	End Date (mm/dd/yyyy)	
☐ Yes No				
Did the Employee work for Kaiser Perman	ente with a Temporary Agency in the year befo	re they were	nired?	
Yes No			·	

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LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

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		Middle I	Name		* Last Nam	е	•
Darlene					Walls		
* Employee ID		* Contac	ct Phone Number	er (###) ###-###	* Effective I	Date (mm/dd	/уууу)
00530105		(213)	401-8827		01/16/20	019	
1. LEAVE INFORM	ATION - (Con	tinued)	· · ·				
Name of Agency	<u> </u>				•		
Start Date (mm/dd/yy	уу)	End Dat	te (mm/dd/yyyy)		Agency Pho	one Number	(###) ###-###
	···						
2. COMMENTS							
3. EMPLOYEE SC	HEDULE				<u> </u>		
This information is	essential for the	e NHRSC to pre	epare a worksh	eet to assist wit	h TIME coding.	This is requ	uired for
empleyees shoom f	or their own dis	sability. Please	use a 24 hr clo	ck: 00:00 thru 2	4:00.		
employees absent i	o • a	•	400 4,21 0.0				
• •		•					
• •		•					
NOTE: This section		•		Wednesday	Thursday	Friday	Saturday
NOTE: This section Week 1	is not applicab	le for the KRO	NOS regions. Tuesday			Friday	Saturday
NOTE: This section Week 1 Start Time: (hh:mm) Hours:	is not applicab	Monday	NOS regions. Tuesday			Friday	Saturday
NOTE: This section Week 1 Start Time: (hh:mm)	Sunday eeded if schedu	Monday le changes weel	Tuesday k to week)	Wednesday	Thursday		
NOTE: This section Week 1 Start Time: (hh:mm) Hours: Week 2 (Only n	is not applicab	Monday	NOS regions. Tuesday	Wednesday		Friday	
NOTE: This section Week 1 Start Time: (hh:mm) Hours: Week 2 (Only n	Sunday eeded if schedu	Monday le changes weel	Tuesday k to week)	Wednesday	Thursday		
NOTE: This section Week 1 Start Time: (hh:mm) Hours: Week 2 (Only n Start Time: (hh:mm) Hours:	Sunday eeded if schedu Sunday	Monday le changes weel	Tuesday k to week)	Wednesday	Thursday		
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Executives: Contact your Executive Benefits Specialist



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LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

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* First Name		Middle Name	* Last Name			
Darlene			Walls	•		
* Employee ID		* Contact Phone Number (###) ###-###	# * Effective Da	te (mm/dd	/yyyy)	
00530105		(213) 401-8827	01/16/201	01/16/2019		
4. REQUEST PAID TIM	E-OFF - (Contin	ued)		•		
Did employee request to us	se Flexible Persor	nal Days?	Number of days	00	Number of hours	
☐Yes ☐No				OR		
Note: Flexible Personal Da	ys can only be us	ed in full day or two hour increments. On	ly available Flexible	Personal	Days will be	
Did employee request Milita	ary Make-up Pay?	,				
∐Yes						
5. SUBMITTED BY						
* Name (First, MI, Last)						
Danny P Jimenez		•				
* Employee ID	* Title		-			
00685629						
* E-mail Address			* Work Phone	Number ((###) ###-###	
danny.p.jimenez@kr	o.org		(5	62) 65	7-8527	
6. MANAGER INFORM	ATION DETAIL					
* Name (First, MI, Last)		· · · · · · · · · · · · · · · · · · ·		-		
Danny Jimenez			•			
Supervisor ID	* Title				<u> </u>	
* E-mail Address			* Work Phone	Number ((###) ###-###	
danny.p.jimenez@kr	o.org		(5	62) 65	7-8527	
7. ALTERNATE CONTA		TION - Someone, in addition to the Matus, etc)	anager, who sho	uld receiv	e leave	
* Name (First, MI, Last)						
* E-mail Address			* Work Phone	Number ((###) ###-####	
					<u> </u>	

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* First Name

LEAVE OF ABSENCE - MEDICAL LEAVE

* Last Name

Middle Name

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Darlene		Walls
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
00530105	(213) 401-8827	01/16/2019
8. MANAGER ATTESTATION		
l .	ges that you have read and understand each item.	:
I agree to direct the employee re Center.	equesting Leave to submit any and all supporting do	cumentation to me or the National HR Service
I agree to submit form 1500 - Extend his or her leave beyon terminated.	ctend Leave and any supporting documentation at the distribution of their expected return date or fails to return on their	e time I learn that the employee intends r expected date, fails to respond, and is not
☑ I agree to submit form 1510 - Re	eturn 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 - (F	Required if not submitted online.)	
* Manager Signature	*	Date (mm/dd/yyyy)
	<u> </u>	

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Executives: Contact your Executive Benefits Specialist



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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)

)	ear Darlene,
C	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="" domestic="" family="" member="" parent="" partner=""> due to his/her serious health condition.</spouse>
	An exigency arising out of the fact that your <spouse daughter="" or="" parent="" son=""> is on active duty or call to active duty status.</spouse>
	Your need to care for your <spouse daughter="" kin="" next="" of="" or="" parent="" son=""> due to his/her serious injury or illness incurred in the line of duty as a covered service member.</spouse>

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.

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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 <u>31 days</u> 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.
٠	DAY 2	Make benefit changes on-line: Log on and follow the online process to enroll your dependent.

National HR Service Center

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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.

National HR Service Center

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

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Please reference the case number located in the upper right corner of this letter.
Sincerely,
Work Absence Management
Enclosures:
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 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 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.

National HR Service Center

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

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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)

De	ear Darlene Walls,
	n 02/04/2019, we were informed that you requested an extension of your leave that began on 3/13/2018 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="" domestic="" family="" member="" parent="" partner=""> due to his/her serious health condition.</spouse>
	An exigency arising out of the fact that your <spouse daughter="" or="" parent="" son=""> is on active duty or call to active duty status.</spouse>
	Your need to care for your <spouse daughter="" kin="" next="" of="" or="" parent="" son=""> due to his/her serious injury or illness incurred in the line of duty as a covered servicemember.</spouse>
×	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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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.</enter>
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=""> effective <enter date="">.</enter></fmla> ☐ 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.



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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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 hirth:
- 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.

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

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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.

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	Unio	n		Care	for Eligible Family Member	
Maternity	Personal			Family Military Leave		
☐ Workers' Comp/Industrial	al Military Service			Bond	ing .	
Last Day Worked (mm/dd/yyyy)	* First Day of Leave (mm/dd/yyyy		nm/dd/yyyy)	Expected Return	Date (mm/dd/yyyy)	
	04/11/2019					
Is this an intermittent or reduced work sched	ule Leave?	Intern	nittent Reduced V	Work Schedule	Not Applicable	
Is this a Donor Leave? Yes No	Unki	nown				
Estimated frequency and duration of absence	es		•			
tbd by physician				-		
If absence is for Care of Eligible Family M	lember or Bo	onding:				
Name of Eligible Family Member			Relationship to Employee			
					· 	
Is Family Member age 18 or under? If Yes, enter age			Delivery/Adoption/Foster Care Placement Date (mm/dd/yyyy)			
☐Yes ☐No			Actual Date Expected Date			
Is the child's other parent employed by Kaiser Permanente?		te?·	If Yes, full name of other parent			
☐Yes ☐No						
If absence is due to Family Member's Mili	tary Service	please se	elect the reason(s) th	at apply:		
Name of Eligible Family Member			Relationship to Emplo	oyee		
Qualifying Exigency, (matters related to Seeing off leaving or returning Service Me	deployment : embers.)	such as C	hild Care issues, Finar	ncial Planning, and	d Family Support Sessions,	
☐ Care for qualified Service Member who	incurred in	jury or illr	ness in the line of dut			

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Telephone: (877) 457-4772

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LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

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* First Name	Middle Name * Last Name					
Darlene		Wal	Walls			
* Employee ID	* Contact Phone Number (##	#) ###-### * Effe	* Effective Date (mm/dd/yyyy)			
00530105 -	(562) 657-8527	04/	04/11/2019			
1. LEAVE INFORMATION - (Continue	ed)			· · · · · · · · · · · · · · · · · · ·		
If absence is for Employee's own health	condition (Medical, Maternity	or Workers' Comp/Ind	ustrial)			
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/yyy						
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 3	30 days)	ected Of	ficial		
Name of Union						
	•			,		
If absence is for Military Leave				<u></u>		
Is this absence for Military Training or A	ctive 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 D	Outy in the past 12 months? S	tart Date (mm/dd/yyy	/)	End Date (mm/dd/yyyy)		
☐Yes ☑No		•				
Did the Employee work for Kaiser Permane	nte with a Temporary Agency i	n the year before they	were hi	red?		
Yes No						

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LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

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* First Name		Middle I	Nomo	· · · · · · · · · · · · · · · · · · ·	* Last Nam				
Darlene		Ivildule I	Name		Walls	e	•		
* Employee ID			* Contact Phone Number (###) ###-####			Date (mm/dd.	/уууу)		
00530105		(562)	657-8527		04/11/2019				
1. LEAVE INFORM	ATION - (Cont	tinued)							
Name of Agency									
	•								
Start Date (mm/dd/yy		End Dat	End Date (mm/dd/yyyy)			Agency Phone Number (###) ###-###			
		,							
2. COMMENTS		<u> </u>			· I		<u> </u>		
AR 06/04/19-14	80 submitte	d on behali	f of manage	er. EH					
		•							
						•			
3. EMPLOYEE SC	HEDULE	<u> </u>		 			·		
This information is		NHRSC to pre	pare a worksh	eet to assist wi	th TIME coding.	This is requ	uired for		
employees absent f									
NOTE: This section	is not applicabl	le for the KRON	NOS regions.						
Week 1	••		J						
	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday		
Start Time: (hh:mm)									
Hours:						<u> </u>			
Week 2 (Only n	eeded if schedul	le changes weel	k to week)	. ,					
	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday Saturda			
Start Time: (hh:mm)									
Hours:	-		-						
4. REQUEST PAID	TIME-OFF			· -					
Review your Collect									
Selections made he	re will not supe	rsede condition	ns set in Collec	ctive Bargaining	g Agreements, S	Summary Pla	an Descriptions,		
KP and HR Policies,	, or applicable S	State and Feder	ral Laws.	anation?	Llac all avails	abla baura	Number of hours		
KP and HR Policies, Did employee reques	, or applicable S	State and Feder	ral Laws.	acation?	Use all availa		Number of hours		
KP and HR Policies, Did employee reques ☐ Yes ☐ No	, or applicable S	State and Feder	ral Laws. me Off (PTO)/V		Use selected	hours			
KP and HR Policies, Did employee reques	, or applicable S	State and Feder	ral Laws. me Off (PTO)/V		_	hours	Number of hours Number of hours		
KP and HR Policies, Did employee reques ☐ Yes ☐ No	, or applicable S	State and Feder	ral Laws. me Off (PTO)/V		Use selected	hours able hours			
MP and HR Policies, Did employee reques ☐ Yes ☐ No Did employee reques	or applicable S t EarnedTime Of	State and Feder of (ETO)/Paid Tile d Sick Leave (E	ral Laws. me Off (PTO)/V		Use selected	hours able hours			
KP and HR Policies, Did employee reques Yes No Did employee reques Yes No	or applicable S t EarnedTime Of	State and Feder of (ETO)/Paid Tile d Sick Leave (E	ral Laws. me Off (PTO)/V		Use selected Use all availa	hours able hours hours	Number of hours		

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LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

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* First Name		Middle Name	* Last Name			
Darlene '			Walls	Walls		
* Employee ID		* Contact Phone Number (###) ###-###	# * Effective Dat	e (mm/dd	/уууу)	
00530105 .		(562) 657-8527	04/11/2019	€	·	
4. REQUEST PAID TIM	E-OFF - (Contin	ued)		•		
Did employee request to u	se Flexible Persor	nal Days?	Number of days	OR	Number of hours	
☐Yes ☐No				OH		
Note: Flexible Personal Da applied.	ays can only be us	ed in full day or two hour increments. On	ly available Flexible	Personal	Days will be	
Did employee request Milit	ary 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	(5	62) 62:	2-4029		
6. MANAGER INFORM	ATION 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 CONTA		TION - Someone, in addition to the Matus, etc.)	anager, who shou	ıld receiv	e leave	
* Name (First, MI, Last)				-	-^··	
* E-mail Address		· · · · · · · · · · · · · · · · · · ·	* Work Phone	Number	(###) ###-###	
		· · · · · · · · · · · · · · · · · · ·				

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* First Name Darlene

LEAVE OF ABSENCE - MEDICAL LEAVE - INTERMITTENT

* Last Name

Walls

Middle Name

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* Employee ID	,	* Contact Phone Number (###) ###-###	* Effective Date (mm/dd/yyyy)
00530105		(562) 657-8527	04/11/2019
8. MANAGER A	TTESTATION		
_	, ,	ou have read and understand each item.	
I agree to direct Center.	the employee requesting	Leave to submit any and all supporting do	cumentation to me or the National HR Service
I agree to subm to extend his or terminated.	it form 1500 - Extend Lea her leave beyond their ex	ve and any supporting documentation at the opected return date or fails to return on their	ne time I learn that the employee intends ir expected date, fails to respond, and is not
☑ I agree to subm	it form 1510 - Return fron	n Leave when the employee returns to work	k.
TIME must be o	coded for all paid and unp	aid leave taken by the employee.	
9. MANAGER SI	GNATURE - (Required	if not submitted online.)	
	• • • • • • • • • • • • • • • • • • • •		
	•		
-	Manager Signature		Date (mm/dd/yyyy)

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July 2, 2019

Darlene Walls 16323 cortuna ave # 8 Bellflower, CA 90706 Employee ID: 00530105 Case Number: 4550201

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="" domestic="" family="" member="" parent="" partner=""> due to his/he serious health condition.</spouse>
An exigency arising out of the fact that your <spouse daughter="" or="" parent="" son=""> is on active duty call to active duty status.</spouse>
Your need to care for your <spouse daughter="" kin="" next="" of="" or="" parent="" son=""> due to his/her serious injury or illness incurred in the line of duty as a covered servicemember.</spouse>
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.

National HR Service Center

Fax to: (877) 477-2329 Telephone: (877) 457-4772 Executives: Contact your Executive Benefits Specialist 7084 06/10/2019 12

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National HR Service Center

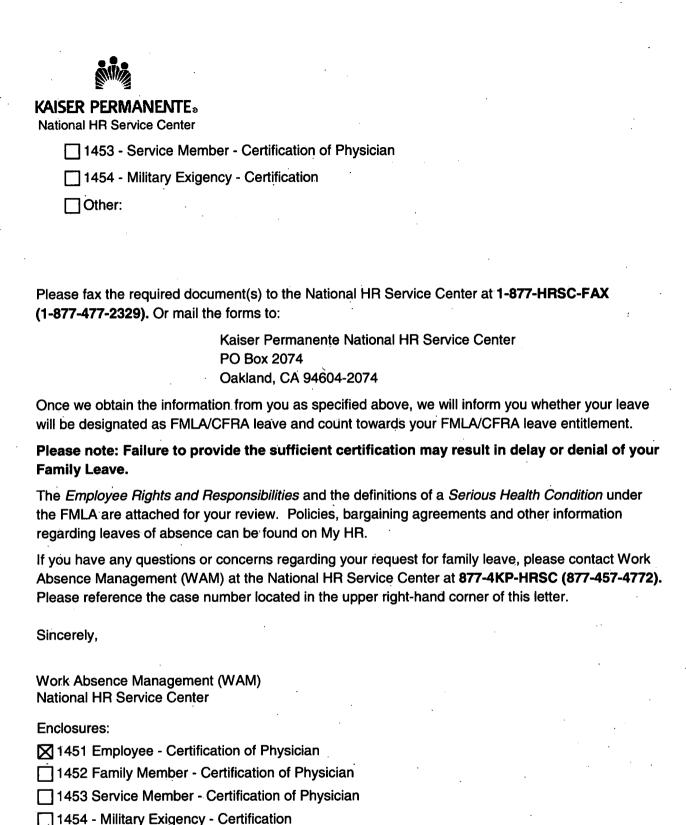
Sufficient certification to support your request for FMLA/CFRA leave.
☐ 1451 Employee - Certification of Physician
1452 Family Member - Certification of Physician
1453 Service Member - Certification of Physician
Sufficient certification to indicate your adult child is incapable of self-care because of 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 <bir>birth marriage adoption/foster care domestic partner relationship next of kin>.</bir>
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.</mm>
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 adoption="" care="" domestic="" foster="" marriage="" partner="" relationship<="" td=""></birth>
next of kin>.
Military Orders

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National HR Service Center

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

National HR Service Center

Fax to: (877) 477-2329 Telephone: (877) 457-4772

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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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Executives: Contact your Executive Benefits Specialist

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July 23, 2019

Darlene Walls 16323 Cortuna Ave # 8 Beliflower, CA 90706 Employee ID: 00530105 Case Number: 4550201

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

Dear Dariene 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="" domestic="" family="" member="" parent="" partner=""> due to his/her serious health condition.</spouse>
An exigency arising out of the fact that your <spouse daughter="" or="" parent="" son=""> is on active duty or call to active duty status.</spouse>
Your need to care for your <spouse daughter="" kin="" next="" of="" or="" parent="" son=""> due to his/her serious injury or illness incurred in the line of duty as a covered servicemember.</spouse>
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 mos="" num=""> 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.</enter>
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.</enter></mm>

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National HR Service Center

You exhausted your <12 26>-week entitlement to leave under the <fmla cfra=""></fmla>
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 shirth 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.

National HR Service Center

Fax to: (877) 477-2329 Telephone: (877) 457-4772

Executives: Contact your Executive Benefits Specialist

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Page 2 of 4



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 PERMANENTES

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

National HR Service Center

Fax to: (877) 477-2329 Telephone: (877) 457-4772

Executives: Contact your Executive Benefits Specialist

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Page 4 of 4



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PERFORMANCE EVALUATION COVER SHEET

Page 1 of 1

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.

1555/155;		v. De sure to retein the	original and the fax receipt for your	
*Employee ID	*Contact Phone Number (###) ###-####		* Effective Date (mm/dd/yyy)	
530105	323-674-5660			
* First Name	Middle Name		6/18/2013 *Last Name	
Darlene			Walls	
1. EMPLOYEE INFORMATION			114113	
Job Title		G/L Location		
CNA			01 90107 0100	
2. PERFORMANCE EVALUATION	-		01-80101-0100	
1. Annual Introductory/Probattor	18nv			
	•	From (mm/dd/yyy)	To (mm/dd/yyy	
Date range covered by this performance	evaluation:	07/01/12	6/30/13	
3. Date evaluation was given (mm/dd/yyy)		30,42,	0/30/13	
 Rating of Performance Evaluation (pleat 				
Expert Preceptor, teac	hes others, deemed inde	pendent (Exemplary: 8.6-	10-PMP; exceeds requirements).	
raindependent Performed all c	mical core elements with	out supervision (Fully effe	ctive [+/-]; 4.6-8.5-PMP; meets	
	7-j) Pave of Absence			
<u> </u>		25) /Doublesmont manifes	d; 1-4.5-PMP; Improvement required)	
	INIZATION. New to service	new area markle to south	m all critical core elements without	
	HOLITICAL PROPERTY OF THE PROPERTY OF	Birrulee, Stucent, Intems).		
3. REQUIREMENTS COVERED BY T	HE PERFORMANCE	EVALUATION		
Note: Check boxes below if applicable and items selected.	attach all documentation	verifying completion of t	the evaluation / observation of the	
Initial / First Time Requirements				
The report is done from the actual document	received. All initial first-ti	me 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	_			
M Infection Control			□ Corporate Compliance	
Hazardous Materials/ Waste Management		e (interacts with members)	☐ Health Screen -	
☑ Fire Safety	☐ Other:			
Clinical Position Annual Requirements	_			
☑ Department-Specific Competencies	Procedural Sedation		Patient Safety Training	
Pain Management	☐ Clinical Competency		Team Dynamics Training	
Restraint Education	☐ Other:		Waived Testing Competency	
Vational HR Service Center				
ax to: (877) 477-2329 elephone: (877) 457-4772				



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Page 1 of 1



DOWNEY MEDICAL CENTER 2012 - 2013 Performance Evaluation

Name ~ Job Title: Walls, Darlene ~ CNA			Unit ~	Unit ~ Shift: 6EAST ~ DAY			
Employee Number: 530105				License Number ~ Expiration: 688083 ~ 3/23/2015			
ACLS Expiration:				BLS Expiration: 8/31/2014			
		METHODS (OF EVALUA	TION			
WA: Writing A	ssessment			e Supervision			
				S: Patient Care Scenarios			
-	-	S	KILLS		1100		
N=Novice	E≂Expert	l≃independ	ent N	, IM=Not Met	NA=Not Applicable		
Service	Clinical	Quality	Financial	Attendance	Interpersonal Skills		
r	ı	I	I	·I	I		

Manager's Comments:

GENERAL OPPORTUNITIES FOR IMPROVEMENT:

- Eliminate Incremental Overtime
 - o You are expected to clock in and clock out on time every day you are scheduled to be at work
- Customer Service
 - o Hourly Rounds
 - o Nurse Knowledge Exchange (NKE)
 - o Call Bells

KP — Downey Medical Center 6th Fi./Telemetry 2012-2013— Old Performance Evaluation Darlene Walls/530105

C	SUSTOMER SERVICE:
	IOURLY ROUNDS
•	Hourly Rounds are to be performed and documented in KP Health Connect. Rounds are performed each hour
	The state of the second to the second to the second
•	politik Larboseiai Juonity Konude' Aofi Mili:
1	1. Assess the 4 Ps (pain, potty, position, and plan)
	2. Perform an environmental "Be Safe" check (hed alarm plugged in coll light in touch does unall the safe.
	or the particular districts is their subtiling I can do for you hetere I forces I have the a
1	To inform the patient, ramily members), and/or visitoris) that you or someone on the team will be book to about an
	dichi again ili i riqui (2 riquis perwaen 10:00pm and 6:00am)
N	URSE KNOWLEDGE EXCHANGE (NKE)
[NKE + is to be performed at the change of shift without exception.
1.	
1	Similar of the pension follows: The ortgoing CNA Mil.
	o Introduce the incoming CNA Provide full report to the incoming CNA while involving the periods in the provide to the incoming CNA while involving the periods in the provider.
ĺ	
	 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 teath?"
	"Do you need help with your meete?"
2.	Update the Care Board; The Care Board should be undated with the following:
	O Day, Date, Name of the incoming CNA, and any other pertinent information (bearing impointed visually
_	
	ALL 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:
W	o "Hello (patient's preferred name). This is Darlene. How can I help you?"
•	Observe and adhere to all "Safety Always" rules.
TE	Aliwork:
•	
	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:
	o Avoiding the 3Bs (bickering, back-biting and blame).
	o Practicing the 3Cs (Caring, Committing and collaborating)
DE	LEGATION
•	The RN has primary responsibility for the patient's overall care. As a result, the RN has the ability to delegate work
	10) 42. I I I I I I I I I I I I I I I I I I I
	o Take direction and delegation from the RN
	o Provide routine updates to the RN throughout your shift so that she/he can update the patient's plan of care.
PRI	10/01/2A110/4.
•	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 promotive being present and available for
_	report acture beginning or your assigned shift
	TIENT PROBLEMS:
AŞ.	A STAFF MEMBER AT DOWNEY MEDICAL CENTER, YOU ARE COMMITTED TO:
•	The Falls prevention program • The prevention of Hospital acquired pressure ulcers
_	
•	Dedicated to the safety of all members and staff. • Ensuring hand hygiene
·	Dedicated to the safety of all members and staff. • Ensuring hand hygiene
E	Evaluator's Signature: Magnague Date: 6/18/13
E	Ensuring hand hygiene VALUATOR'S SIGNATURE: Michelle Lenaburg, RN, BS — Assistant Clinical Director DATE: 4/18/13
E	Evaluator's Signature: Magnague Date: 6/18/13

KP – DOWNEY MEDICAL CENTER 6TH FLOOR/TELEMETRY 2013-2014 - FUTURE OBJECTIVES AND EVALUATION

EMPLOYEE NAME/NUMBER:	Walls, D	<u>Darlene</u>	CNA/530105	DAY	
OVERALL PERFORMANCE RATING:	Independ	ient			·

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.

Skill, Experience, or Knowledge Needed	Action To Be Yaken	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 Menitor Technician job classification.	Ongoing June 30, 201:
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, 201
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, 201
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 Checkpoin		
D. EMPLOYEE'S DESIR	D FUTURE OBJECTIVES/IMPROVEMENT ACTIVITIES.	
<u> </u>	Objective (Optional)	Target Date
Trytogotos	chool for H.D. tech	2014
- •		

RP — Downey Hedical Center 6th Floor/Telemetry 2013-2014 - Future Objectives and Evaluation Darlene Walls/S30105

MM. COMMENTS:	
Darlene is independent in her duties as a Certified Nursing Attendant. She gets along well with her co-worker. The staff appreciates the fact that you are helpful and a team player.	rs.
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 the operation of the Unit and the organization.	: s on
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 well.	as
NN.EMPLOYEE'S SUGGESTIONS REGARDING DEPARTMENTAL EDUCATION / QUALITY IMPROVEMENT ACTIVITIES: (LEADERSHIP, PARTMERSHIP, QUALITY OF SERVICE, DEPT. IN-SERVICES, ETC.)	
49.	<u></u>
50.	_
	-
51	_
52.	-
	-
Evaluator's Signature: Date: Employee's Signature:	-
Managure: Date: Employee's Signature: Date: Date:	<u></u>
	<u>5.</u>



be# 00530105

4000

PERFORMANCE EVALUATION COVER SHEET

Page 1 of 1

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 - fay to the number below. So sure to retain the original and the fay special for the number below.

	to the number below. Be sure		the fax receipt for your records.
* Employee ID	* Contact Phone Num	ber (###) ###-#### *	Effective Date (mm/dd/yyyy)
530 105	(219)57	0-9242	82/25/2008
* First Name	Middle Name	•	Last Name
* First Name Day feve			Walls
1. EMPLOYEE INFORMATION			
Job Title CNA		G/L Location	
CNA		Uni-	f 3000
2. PERFORMANCE EVALUATIO	N		
1. Annual Introductory / Prob	ationary	ı (m g ı/dd/yyyy)	To (moddless)
2. Date range covered by this perform	OR.	7-101 12010	To (mm/dd/yyyy) 86 30 201
3. Date evaluation was given (mm/dd/	$t = \overline{T}$	211	
4. Rating of Performance Evaluation (- 11	
	,	endent (Exemplary: 8.6-	10-PMP; exceeds requirements).
	all critical core elements witho		ctive [+/-]; 4.6-8.5-PMP; meets
☐LOA Employee (on Leave of Absence.		
☐ Not Met Not met (m	ust attach corrective action ple	an) (Development require	ed; 1-4.5-PMP; improvement required).
☐ Novice New to the		new grad, unable to perf	om all critical core elements without
3. REQUIREMENTS COVERED E			
_ 			f the evaluation / observation of the items
selected.		, • •	
Initial / First Time Requirements The report is done from the actual doc the appropriate tab individually. (Orien	cument received. All initial first	-time documents have th	eir own document type and are listed in
Medical Center - General Orientation	on X Sexual Abuse		☑ Initial Assessment
Department-Specific Orientation		Child	Abuse Reporting: Dependent/Elder
Confidentiality Agreement	Other:		Abuse Reporting: Domestic Abuse
Annual Requirements			
M Infection Control	Emergency/Disas	_	Corporate Compliance
Hazardous Materials/ Waste Manag	gement XAge Specific Care	(interacts with member	s) Health Screen
Ñ Fire Safety	Other:		
Clinical Position Annual Requireme			
Department-Specific Competencies	-	•	Patient Safety Training
Pain Management	Clinical Competer	тсу	Team Dynamics Training
Restraint Education	Other:		☐ Waived Testing Competency
HR Service Center Fax to: (877) 477-2329 Telephone: (877) 457-4772			4000 09/08/2008 a Page 1 of 1



VCH 00530105 PERFORMANCE EVALUATION

Nar		μ	VI E	WE WALLS	epan	ment: 0103		cutecar			<u> </u>
EE	#:	·		-] Initial Asse Date	ssmen	t/Dept. (Orientat	ion.	
ľПı	Ünrei	orese	ented	Represented Union		Probationa	rv Fval	uation	Da	te	
				tment Administrator and/or	VX	Annual Eva	luation	<u>uu</u>		20 09	<u>ن</u> `
				nent Administrator						, ,	
Med	dical	Cent	er: S	South Bay F	inal C	Competency	Rating	(t			
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RA	TING	KEY]	•							•
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pen	cil tesi	i Met	recor	C = case study response, O = observation in the d review, E = exercises (written), V = verbal response.	real și onse/d	etung, m = moc discussion (for a	x event. custome	, demonsi :r service :	ration, P skills onl	= pap: v).	er and
											·
Con	npete	ncy R	ating	: Not met - unable to perform the criteria even w	ith coa	aching. Novice	- able 1	o perform	the crite	ria]
with the	coacl cotens	hing. s inde	indej nendi	pendent - able to perform the criteria independent ently and able to teach or mentor others in this ar	tiy wit	hout any coach	ing. Ex	pert - abi	e to perfe	orm	1
	elf Ass			Note: Initial and date each	ÇQ.	Assessme	nt/ Comp	etency	Evalu	ation	ŀ
				assessment/evaluation column		Validation	on if requ	ired	1		
				Accountabilities	Ī						
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ert	8	8	¥ Set			ert - Foend Met	ds A	rod Jatic	de d	scter scter	12 E
Expert	<u>ag</u>	Novice	Not Met			Expert – E Independent Novice – N* Not Met*	Needs Action Plan*	Method of Validation	Improvement Needed*	Meets Expectations	Exceeds Expectation
	X	\Box		Consistently demonstrates support of the I	(P	.1		0		X	
_	7"	—	–	mission, promise, strategic goals and the			1			7	
	ĺ	[Labor Management Partnership that positi	vely						
	}	1		impacts affordable, quality health care, performance, access and service, communications.	nihe				.		
	۱.,]	İ	benefit and health outcomes.	шу						
	以			Consistently responsive to the needs of				0		X	
				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 posit	ive						1
				image for the organization by willingly taking		l					
				the initiative to resolve member/co-worker issues dealing with complaints in a positive							
			İ	manner.	•		1 .	_			} }
	A			Consistently supports the precepts of		1		D		X	
	7			Corporate Compliance and Principles of			7		7 -	7	
		i	İ	Responsibility by maintaining confidentiality	y,						
			ŀ	protecting the assets of the organization, acting with integrity, reporting observed fra	ued						
				and abuse and complying with applicable							
				state, federal and local laws and program				•			
- T	-		 	policies and procedures.					- Period		
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Goal Accomplishment in the Past Year: (not applicable for probationary evaluation)

	Goal	Threshold**	Target**	Stretch**	Actual Outcome
Hour	y Rounding				
		14	.፟፟፟፟፟፟፟፟፟፟፟፟		
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l _		<u> </u>		 	J
Final	Rating				
	Not met - On corrective action plan.				
	Novice - New to the organization, new to service	, new grad, unai	bie to perfo	rm all critical	core elements
A	without supervision or mentoring. Needs develop	oment.		L.C	
X	Independent - Consistently meets and occasional core elements without supervision.	ally exceeds pos	mon expec	ations. Pen	orms all critical
	Expert - Performs core elements independently.	Precepts and/o	r teaches o	thers. Consis	stently exceeds
	position expectations.	•		-	,
0	- for Domine Value				
Goal	s for Coming Year:				
	Goal				
Work	place Safety				
	dance				
HCAI	IPS (Service)				
	~~ · · · · · · · · · · · · · · · · · ·				
** If a	pplicable				
	pphotolo				
Verifi	cation signature				
Empl	oyee Signature: Wollmell Ol	Date	7/2	7//)	
		Date.		· /	
CNS/	Preceptor Signature:	Date:		····	
(Requi	red only for Orientation Sompetency)	10	_ /	1.	
DA/A	DA Signature South To Square	Date:	04/27	1/2011	
				/	
Form	based on the State of California DWW Form RU-91 (1/95) Description of J	ob Duties		

Kaiser Permanente Medical Center - South Bay VL#005301X Educational Assessment and Needs Evaluation for Year 2007

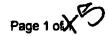
	1 -	Educational As	sessment and Needs Evaluation for Year	2007	- 01		
Employce		•	WALLS				
Name:	LJH	RIENE					
Employee ID #:	53	0105	Date of Hire: 92/25/2008	· 			
Job Title:	0	NA	Facility: South Bay Department: Acutecare-Med	/Surg-	D		•
			ate work related education that you ha	ve taker	in t	he k	ıst y
 			ified for yourself.				
enhan	ce your	role as a he	ed both in and outside of the orga althcare worker. (do not include E the first time you have been certif	LS / A			
The name of t class / semina	he	Class was giver			De	ate	
2.							
3 .							
1, 							
5. 	-						
Employe	ee's sugg	estions regardin	ctives / improvement activities. g departmental education / quality improv y of service, dept. In-services, etc.)	rement o	ctivi	ties:	
Baria	tric	Service	TRAING	1	2	3	4
survu				1	2	3	4
3.	<u> </u>			1	2	3	4
1.				1	2	3	4
5.				1	2		4
Manager Comm	ents:			Plea	se cir each estio	'cle d	
	er if enou e		essed e department (75% plus)				

sonnel Representative Signature: _______ Date: _____

Date:



4000 PERFORMANCE EVALUATION COVER SHEET



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.				· · · · · · · · · · · · · · · · · · ·
*Employee ID	•	Contact Phone Numb	er (###) ### ####	* Effective Date (mm/dd/yyy)
530105		323-67	4-5660	6/13/12
* First Name		Middle Name		* Last Name
Darlene				Walls
1. EMPLOYEE INFORMATION	ON			
Job Title	· · 		G/L Location	
CN	IA		(0801-80101-0100
2. PERFORMANCE EVALUA	ATION	<u>·</u>		
1. Annual Introductory	Probationary	,	" "	
	•		From (mm/dd/yyy)	To (mm/dd/yyy
2. Date range covered by this pe	erformance ev	, , ,	06/30/2011	6/30/2012
3. Date evaluation was given (m	m/dd/yyy) _	6/13/1	2	-
4. Rating of Performance Evalua	_	•		
	• •	•		8.6-10-PMP; exceeds requirements).
	rmed all critic rements [+/-])		nout supervision (Fully	effective [+/-]; 4.6-8.5-PMP; meets
LOA Empl	oyee on Leav	e of Absence		
	-			uired; 1-4.5-PMP; Improvement required)
			new grad, unable to po ermitee, student, intern	erform all critical core elements without
3. REQUIREMENTS COVER				10).
				of the evaluation / observation of the
items selected.	Cable aliu at	IACH All GOCCHRENIALIC	ar vernying completion	of the evaluation? Observation of the
Initial / First Time Requirements		•		
The report is done from the actual appropriate tab individually. (Orien		ceived. All initial first-	time documents have t	heir own document type and are listed in the
☐ Medical Center - General Orien	•	☐ Sexual Abuse		☐ Initial Assessment
☐ Department-Specific Orientation		☐ Abuse Reporting	a: Child	☐ Abuse Reporting: Dependent/Elder
☐ Confidentiality Agreement	•	☐ Other:	G . •	Abuse Reporting: Domestic Abuse
Annual Requirements				
☑ Infection Control		☑ Emergency/Disa	aster Management	
	anagement	☐ Age Specific Ca	re (interacts with memi	bers) Health Screen -
□ Fire Safety		☐ Other:		
Clinical Position Annual Require	ments			
□ Department-Specific Competer	des	☑ Procedural Sedation	on Education	☐ Patient Safety Training
□ Pain Management	(Clinical Competent	cy .	☐ Team Dynamics Training
□ Restraint Education		Other:		☐ Waived Testing Competency
National HR Service Center	1		Elli erin issi	
Fax to: (877) 477-2329	f.]]			

Telephone: (877) 457-4772



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DOWNEY MEDICAL CENTER Telemetry/6East CNA 2011 – 2012 Performance Evaluation

Name ~ Job T	itle: Is, Darlene	~ CNA	Unit ~	,	6East ~ DAY
Employee Nu	mber: 530105		Licens	e Number ~ E 688083 ~	ixpiration: 3/23/2013
ACLS Expirat	ion:	•	BLS E	xpiration: 8/31	/2012
		METHODS	OF EVALUA	TION	
WA: Writing As	ssessment		RS: Routing	e Supervision	
OBS: Observa			PCS: Patie	nt Care Scenar	rios
			SKILLS		
N=Novice	E=Expert	l=Indepen	dent N	IM=Not Met	NA=Not Applicable
Service	Clinical	Quality	Financial	Attendance	Interpersonal Skills
I	I	I	I	I ·	1

Manager's Comments:

GENERAL OPPORTUNITIES FOR IMPROVEMENT:

- Eliminate Incremental Overtime
 - o You are expected to clock in and clock out on time every day you are scheduled to be at work
- Customer Service
 - o Hourly Rounds
 - o Nurse Knowledge Exchange (NKE)
 - o Call Bells

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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)

 - Perform an environmental and safety check (call light, bedside table, etc)
 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:
 - o 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

PRIORITIZATION:

Direct patient care is the #1 priority. Entering data into the computer is a lower priority

EVALUATOR'S SIGNATURE: EMPLOYEE SIGNATURE:

KP - Downey Medical Center Telemetry/6East CNA 2011-2012 - Future Objectives and Evaluation

EMPLOYEE NAME/NUMBER:	Walls,	Darlene	CNA/530105	DAY	
OVERALL PERFORMANCE RATING:	Indepe	ndent			

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.

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 Checkpoin		
B. EMPLOYEE'S DESIRE	ED FUTURE OBJECTIVES/IMPROVEMENT ACTIVITIES.	Target Date
B. EMPLOYEE'S DESIRE	Objective (Optional)	Target

C. COMMENTS:

KP - Downey Medical Center Telemetry/6East CNA 2011-2012- Future Objectives and Evaluation Darlene Walls/530105

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
2
3.
4.
Evaluator's Signature: Date: Date: Employee's Signature: Date: 13/12 Documents 13/12





PERFORMANCE EVALUATION COVER SHEET

Page 1 of 1

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 records.	to the number below	. Be sure to retain t	he original and the fax receipt for your	
*Employee ID	*Contact Phone Number (###) ###-#####		* Effective Date (mm/dd/yyy)	
530105	213-401-8827		6/2/2014	
* First Name	213-401-8827 Middle Name		* Last Name	
			Walls	
Darlene	l		Walls	
34. EMPLOYEE INFORMATION		r		
Job Title	G/L Location			
CNA			0801-80101-0100	
35. PERFORMANCE EVALUATION			4.5	
45. Annual introductory/Probations	ary	From (mm/dd/yyy)	To (mm/dd/yyy	
46. Date range covered by this performance	evaluation:	6/30/13	7/1/14	
47. Date evaluation was given (mm/dd/yyy)	6/2/14			
48. Rating of Performance Evaluation (pleas	e select one.)			
☐ Expert Preceptor, teach	nes others, deemed ind	ependent (Exemplary;	8.6-10-PMP; exceeds requirements).	
☑ Independent Performed all cr requirements [+		nout supervision (Fully	effective [+/-]; 4.6-8.5-PMP; meets	
	Employee on Leave of Absence			
	t attach corrective action plan) (Development required; 1-4.5-PMP; Improvement required)			
Novice New to the orga supervision or n	nization, new to service nentorship (e.g. interim)	, new grad, unable to p permitee, student, inter	perform all critical core elements without ms).	
36. REQUIREMENTS COVERED BY T	HE PERFORMANCE	EVALUATION		
Note: Check boxes below if applicable and items selected.	attach all documentation	on verifying completion	n of the evaluation / observation of the	
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	7	☐ Initial Assessment	
☐ Department-Specific Orientation	☐ Abuse Reportir	ng: Child	☐ Abuse Reporting: Dependent/Elder	
Confidentiality Agreement	☐ Other.		☐ Abuse Reporting: Domestic Abuse	
Annual Requirements				
☑ Infection Control		aster Management		
☐ Hazardous Materials/ Waste Management	t Age Specific C	Age Specific Care (Interacts with members)		
	Other:			
Clinical Position Annual Requirements				
☑ Department-Specific Competencies	☐ Procedural Sedati	on Education	☑ Patient Safety Training	
☐ Pain Management		icy	☐ Team Dynamics Training	
☑ Restraint Education	☐ Other:		☐ Waived Testing Competency	
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Telephone: (877) 457-4772





DOWNEY MEDICAL CENTER 2013 – 2014 Performance Evaluation

Name ~ Job Title: Walls, Darlene ~ CNA			Unit ~	Unit~Shift: 6East Telemetry ~ DAY		
Employee Number: 530105			Licens	License Number ~ Expiration: 688083 ~ 3/23/2015		
ACLS Expirat	ion:		BLS E	BLS Expiration: 8/31/2014		
		METHODS	OF EVALUA	TION	·	
WA: Writing As	ssessment	•	RS: Routine	Supervision		
OBS: Observa	DBS: Observation PCS: Patient Care Scenarios			rios		
			SKILLS		· · · · · · · · · · · · · · · · · · ·	
N=Novice	E=Expert	I=indepen	dent N	IM=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
 - o You are expected to clock in and clock out on time every day you are scheduled to be at work
- Customer Service
 - o Hourly Rounds
 - o Nurse Knowledge Exchange (NKE)
 - o Call Lights

	MINIMUM PERFORMANCE EXPECTATIONS
CUS	STOMER SERVICE:
	POSEFUL 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)
A2	RSE KNOWLEDGE EXCHANGE (NKE)
	KE + is to be performed at the change of shift without exception.
- N	Bedside Rounds include; the outgoing and incoming CNA's will meet at the patient's bedside to perform change of shift report.
23.	Begside Rounds include; the outgoing and incoming Crin's will meet at the patient's bedside to perform draings of smith operation.
	During the bedside rounds, the <u>outgoing</u> CNA will:
	o 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: ### 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?"
<u>.</u> .	"Do you need help with your meals?"
24.	Update the Care Board: The Care Board should be updated with the following:
	O Day, Date, Name of the incoming CNA, and any other pertinent information (hearing impaired, visually impaired, fall risk,
	etc.)
CAI	LL 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:
<u></u>	o "Helio (patient's preferred name). This is Darlene. How can I help you?"
Wo	DRIK 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.
TE	ARRWORK
•	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:
1	o Avoiding the 3Bs (bickering, back-biting and blame).
l	o Practicing the 3Cs (Caring, Committing and collaborating).
DE	LEGATION
	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:
	o Take direction and delegation from the RN
١.	o Provide routine updates to the RN throughout your shift so that she/he can update the patient's plan of care.
Pe	IORITIZATION
	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
BA:	TIENT PROBLEMS:
	A STAFF MEMBER AT DOWNEY MEDICAL CENTER, YOU ARE COMMITTED TO:
~~	
•	
•	Dedicated to the safety of all members and staff. • Ensuring hand hygiene is performed
•	Dedicated to the safety of all members and staff. • Ensuring hand hygiene is performed
۰	Dedicated to the safety of all members and staff. • Ensuring hand hygiene is performed EVALUATOR'S SIGNATURE: DATE: 4/2/14
١	Dedicated to the safety of all members and staff. • Ensuring hand hygiene is performed
•	Dedicated to the safety of all members and staff. • Ensuring hand hygiene is performed EVALUATOR'S SIGNATURE: Assistant Clinical Director Assistant Clinical Director
•	Dedicated to the safety of all members and staff. • Ensuring hand hygiene is performed EVALUATOR'S SIGNATURE: DATE: 4/2/14

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.

address Skill, Experience or Knowledge Needs	
Action To Be Taken	Target Date
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
Maintain job description requirements, including BLS certification. Successfully complete competencies for Monitor Technician job classification.	Ongoing June 30, 2015
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
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
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
	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. Maintain job description requirements, including BLS certification. Successfully complete competencies for Monitor Technician job classification. Demonstrate compliance with Kaiser policies and procedures. Participate in all Performance Improvement activities. Ensure regulatory guidelines are adhered to (crash cart, refrigerator, etc). Prioritize work to ensure all tasks are performed within established timeframes. Follow the Automated Timekeeping System policy and procedure. Eliminate incidental overtime. 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:

 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

Ų,	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.	· 	
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