THE NAVAJO NATION

Joe Shirley, Jr.
PRESIDENT

Frank J. Dayish, Jr.
VICE PRESIDENT

April 29, 2003

MEMORANDUM

TO : All Division, Department, and Program Directors
Executive and Legislative Branches

FROM : Bernadette Bernally
Bernadette Bernally, Director
Department of Personnel Management

SUBJECT : Revised Family and Medical Leave Procedures

The Family and Medical Leave procedures have been revised to support and define the Family and Medical Leave policies of the Executive and Legislative Branches as contained in Section X.D of the Navajo Nation Personnel Policies Manual.

All relevant documents are attached hereto for your information. Please distribute to all staff. Contact your assigned Personnel Analyst at the Department of Personnel Management if there are any questions.

Attachments

Distribution

DEPARTMENT OF PERSONNEL MANAGEMENT
P.O. BOX 7080, WINDOW ROCK, AZ 86515
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PROCEDURES
EXECUTIVE AND LEGISLATIVE BRANCHES
DEPARTMENT OF PERSONNEL MANAGEMENT

SECTION:	LEAVE ADMINISTRATION	NO: 03 -X.D-003
SUBJECT:	FAMILY AND MEDICAL LEAVE	RELEASE DATE: 10/01/96
CROSS REFERENCE	PPM SECTION X.D Family and Medical Leave; X.C.1 Approved leave without pay	REVISION DATE: 05/05/03

PURPOSE:

To outline the conditions under which an eligible employee may request time off without pay for a limited period with job protection and no loss of accumulated service, provided the employee returns to work. These procedures support and define the Family and Medical Leave policies of the Navajo Nation Executive Branch as contained in Section X.D of the Navajo Nation Personnel Policies Manual approved January 13, 2003 and effective March 10, 2003.

APPLICABILITY:

These procedures apply to all regular status employees who have been employed with the Navajo Nation for at least one year.

DEFINITIONS:

Family/Medical Leave: approved unpaid leave available to eligible employees for up to six months per year under particular circumstances that are critical to the life of a family. Leave may be taken in the following situations: the birth of the employee's child and in order to care for the child; the placement of a child with the employee for adoption or foster care; when the employee is needed to care for a child, spouse, or parent who has a serious health condition; or when the employee is unable to perform the functions of his/her position because of a serious health condition.

Health Care Provider: a doctor of medicine or osteopathy who is authorized to practice medicine or surgery, (as appropriate) by the State in which the doctor practices. In addition podiatrists, dentists, clinical psychologists, optometrists, and chiropractors (limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray to exist) authorized to practice in the applicable state or the Navajo Nation.

In loco parentis: persons with day-to-day responsibilities to care for and financially support a child.

Intermittent Leave: Leave taken in intervals; recurrent periodical leave due to a single qualifying reason;

Parent: the biological parent of an employee or an individual who stood in loco parentis to an employee when the employee was a child. This includes an individual who assumed day-to-day responsibility for a child.

Reduced leave schedule: a leave schedule that reduces the usual number of hours per workweek, or hours per workday, of an employee.

Serious health condition: an illness, injury, impairment, or physical or mental condition that involves:

a. inpatient care (e.g. an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity, or any subsequent treatment in connection with such inpatient care; or

b. continuing treatment by a health care provider.

Son or daughter: a biological, adopted, or foster child, a step child, a legal ward, or a child of a person standing in loco parentis (in place of a parent), who is

a. under 18 years of age; or

b. 18 years of age or older and incapable of self-care because of a mental or physical disability.

Spouse: a husband or wife as defined or recognized by Navajo Nation law.

PROCEDURE:

I. Family and Medical Leave

Family and medical leave is without pay and may be available to employees for up to six months. The first three months are nondiscretionary; If an employee requests leave consistent with the Family/Medical leave policies and procedures, the supervisor must approve the leave. The second three months are discretionary. The supervisor has the authority to approve or disapprove the leave.

A. Leave Requests

1. An Application for Family and Medical Leave and a PAF must be

completed and signed by the employee and submitted as far in advance as practicable to the appropriate supervisor(s) for proper approval.

2. When the need for leave is foreseeable, such as the birth or adoption of a child, or planned medical treatment, the employee must submit an application for leave at least 30 days before the leave is to begin.

3. Requests for family and medical leave of absence must have sufficient medical certification as required in B.1-3 below.

4. Upon receipt of the request for family/medical leave, a supervisor must provide a response (decision) within two working days. If appropriate medical certification is not provided by the employee, the supervisor must request this information, preferably in writing. An employee has 15 calendar days to provide the requested medical certification.

5. If medically necessary for a serious health condition, leave may be requested on an "intermittent" or "reduced leave schedule." However, if leave is requested on this basis, the Navajo Nation may require the employee to be assigned to another position which better accommodates a recurring period of absence or a part-time work schedule, provided the position has equivalent pay.

B. Medical Certification

1. For purposes of leave due to a serious health condition of the employee's child, spouse, or parent, the certificate should include:

   a. the date on which the serious health condition commenced;
   b. the probable duration of the condition;
   c. the appropriate medical facts within the knowledge of the health care provider regarding the condition; and
   d. an estimate of the amount of time that the employee is needed to provide such care.

2. If leave is being requested for an employee's own serious health condition, in addition to B.1.a-c above, the certification must also include a statement that the employee is unable to perform the functions of his/her position.

3. In the case of certification for recurrent or periodical leave (intermittent), or leave on a reduced leave schedule for planned and/or unanticipated medical treatment of a related serious health

condition or for the recovery from treatment or recovery from a serious health condition or to provide care or psychological comfort to an immediate family member with a serious health condition, the dates on which such treatment is expected to be given and the duration of such treatment must be stated.

C. When the leave is for the birth or placement of a child, an employee must submit an application for leave at least 30 days before leave is to begin.

1. Entitlement to leave for a birth or placement expires at the end of 12 months after the date of birth or placement.

   For example: If a child is born November 4, leave must be taken by November 4 of the following year.

2. Spouses who are both employed by the Navajo Nation are entitled to a total of six months of leave (rather than six months each) for the birth or adoption of a child or for the care of a sick parent.

D. If leave is unforeseeable, the employee must provide notice to the supervisor as soon as practicable. If medical certification has not been provided, it must be submitted within 15 days of notice from the supervisor. Failure to provide appropriate medical certification within the required period may result in the denial of or delay in the use or approval of family/medical leave.

E. Reporting Requirements

1. In cases of illness, the employee will be required to report periodically on his or her leave status and intention to return to work.

2. If an employee fails to return to work after leave expires or gives notice of intent not to return to work it shall be deemed a resignation unless an extension is granted.

F. Extension of Family and Medical Leave

1. An employee who requests an extension of family and medical leave due to the continuation, recurrence, or onset of his/her own serious health condition or the serious health condition of the employee's spouse, child or parent must submit a written request for extension to the employee's supervisor.

2. This request should be made as soon as the employee realizes that he/she will not be able to return at the expiration of the leave period.

G. Return from Leave

1. An employee must complete a Notice of Intent to Return from Family and Medical leave before he/she can be returned to active status.

2. If an employee wishes to return to work prior to the expiration of leave, notification must be given to the employee's supervisor at least five working days prior to an employee's planned return.

ATTACHMENTS:

FORMS -

1. Personnel Action Form
2. Application for Family/Medical Leave
3. Response to Request for Family/Medical Leave (Form FMLV-002)
4. Certification of Physician or Practitioner (Form FMLV-001)
5. Notice of Intention to Return from Leave

Optional forms

1. Medical Certification Statement (Illness of employee's family member)
2. Medical Certification Statement (Employee's own serious illness)

DISTRIBUTION

THE NAVAJO NATION
PERSONNEL ACTION FORM

Employee Position I.D. No.
DPM USE ONLY

Jane Doe X1234

☐ Employment Notice	☑ Change Notice	Termination Notice	Effective Date
			May 5, 2003

Last Name	First	Middle	Address	City/State/Zip Code	Social Security Number
DOE,	John	Yazzie			123-45-6789

Census Number	Marital Status	Sex	Date of Birth	Ethnic Code	Tax Exemption

Division/Department	Department No.	Account Number	Worksite
DHR/Department of Personnel Management	022	3-18290-1001	

Position Title	Class Code	Grade Step	Hourly Rate	Per Annum
Administrative Assistant	1260			

REMARKS: FAMILY AND MEDICAL LEAVE: Not to exceed May 19, 2003.

Employee Signature	Date
Department Acceptance	Date
Department Release	Date
Department of Personnel Management	Date

Type of Termination: ☐ Resignation ☐ Discharge ☐ Layoff

Employee is responsible and accountable for the following:

All Tribal monies/property during employment has been accounted for the Financial Services Department:

Cashiers	Accts. Rec. (Vets./Pers.)
Travel Advances	Account Receivable
Tribal Housing	Credit Services
Fleet Management	Property
Group Insurance	Travel Office

Clearance by initial from each section/departments.

DPM (White) Insurance Dept. (Green) Payroll Department (Canary) Department (Pink) Employee Copy (Goldenrod)

FAMILY AND MEDICAL LEAVE

REQUIREMENTS:

1. A copy of health care provider's statement is required.
2. Employee's signature is preferred. If employee is unavailable, PAF can state UNAVAILABLE FOR SIGNATURE.
3. Department's approval signature is required. Check with supervisor for other required approvals.
4. Refer to the Family and Medical Leave Procedures for further information.

THE NAVAJO NATION
PERSONNEL ACTION FORM

Employee Position I.D. No.
DPM USE ONLY

Jane Doe X1234

☐ Employment Notice	☑ Change Notice	Termination Notice	Effective Date
			May 19, 2003

Last Name	First	Middle	Address	City/State/Zip Code	Social Security Number
DOE,	John	Yazzie			123-45-6789

Census Number	Marital Status	Sex	Date of Birth	Ethnic Code	Tax Exemption

Division/Department	Department No.	Account Number	Worksite
DHR/Department of Personnel Management	022	3-18290-1001	

Position Title	Class Code	Grade Step	Hourly Rate	Per Annum
Administrative Assistant	1260			

REMARKS: END FAMILY AND MEDICAL LEAVE

Employee Signature	Date
Department Acceptance	Date
Department Release	Date
Department of Personnel Management	Date

Type of Termination: ☐ Resignation ☐ Discharge ☐ Layoff

Employee is responsible and accountable for the following:

All Tribal monies/property during employment has been accounted for the Financial Services Department:

Cashiers	Accts. Rec. (Vets./Pers.)
Travel Advances	Account Receivable
Tribal Housing	Credit Services
Fleet Management	Property
Group Insurance	Travel Office

Clearance by initial from each section/departments.

DPM (White) Insurance Dept. (Green) Payroll Department (Canary) Department (Pink) Employee Copy (Goldenrod)

END FAMILY AND MEDICAL LEAVE

REQUIREMENTS:

1. A copy of health care provider's statement is required.
2. Employee's signature is preferred. If employee is unavailable, PAF can state UNAVAILABLE FOR SIGNATURE.
3. Department's approval signature is required. Check with supervisor for other required approvals.

Application for Family or Medical Leave

Application for Family or Medical Leave

Name:_____ Department:_____

Current Address:_____

State Date of Anticipated Leave:_____

Expected Date of Return to Work:_____

Reason for Leave (Explain):_____

_____

_____

_____

_____

NOTE: A leave request based on an employee's serious health condition or the serious health condition of an employee's spouse, child or parent must be accompanied by a verifying medical certification from a physician.

I hereby authorize a health care provider representing the Navajo Nation to contact my physician to verify the reason for my requested family and medical leave.

I understand that a failure to return to work at the end of my leave period may be treated as a resignation unless an extension has been agreed upon and approved in writing by my supervisor.

Signature:_____ Date:_____

APPROVED BY:

_____

Supervisor Date

Sample Forms and Documents

Employer Response to Employee Request for Family and Medical Leave

(Date)

TO: _____
(Employee's name)

FROM: _____
(Name of appropriate employer representative)

SUBJECT: Request for Family/Medical Leave

On _____, you notified us of your needs to take family/medical leave due to:
(date)

□ the birth of your child, or the placement of a child with you for adoption or foster care; or

□ a serious health condition that makes you unable to perform the essential functions of your job; or

□ a serious health condition affecting your □ spouse, □ child,□parent, for which you are needed to provide care.

You notified us that you need this leave beginning on _____ and that you expect leave to continue until on or about _____. (date)
(date)

Except as explained below, you have right under the FMLA for up to 6 months of unpaid leave in a 12-month period for the reasons listed (that the first 3 months are nondiscretionary, the second 3 months are discretionary). Also, your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work, and you must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from leave.

This is to inform you that: (*check appropriate boxes, explain where indicated*)

1. You are □ eligible □ not eligible for leave under the Family and Medical Leave Policies.

2. The requested leave □ will □ will not be counted against your annual Family and Medical leave entitlement.

3. You will □ will □ not be required to furnish medical certification of a serious health condition. If required, you must furnish certification by _____ (*insert date*) (must be at least 15 days after you are notified of this requirement) or we may delay the commencement of your leave until the certification is submitted.

c. If a **regimen of continuing treatment** by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment):

3. a. If medical leave is required for the employee's **absence from work** because of the **employee's own condition** (including absences due to pregnancy or a chronic condition), is the employee **unable to perform** work of any kind: _____

b. If able to perform some work, is the employee **unable to perform any one or more of the essential functions of the employee's job** (the employee or the employer should supply you with information about the essential job functions)? _____
If yes, please list the essential functions the employee is unable to perform:

c. If neither a. nor b. applies, is it necessary for the employee to be **absent from work for treatment?** _____

8. a. If leave is required to **care for a family member** of the employee with a serious health condition, **does the patient require assistance** for basic medical or personal needs or safety, or for transportation? _____

b. If no, would the employee's presence to provide **psychological comfort** be beneficial to the patient or assist in the patient's recovery? _____

c. If the patient will need care only **intermittently** or on a part-time basis, please indicate the probable duration of this need:

_____ _____
(Signature of Health Care Provider) (Type of Practice)

_____ _____
(Address) (Telephone number)

To be completed by the employee needing family leave to care for a family member:

State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule:

_____ _____
(Employee signature) (Date)

Sample Forms and Documents

Certification of Physician or Practitioner

1. Employee's Name:

2. Patient's Name (if different from employee):

3. The attached sheet describes what is meant by a **"serious health condition"** under the Family and Medical Leave policies of the Navajo Nation. Does the patient's condition[1] qualify under any of the categories described: If so, please check the applicable category.

   (1)___(2)___(3)___(4)___(5)___(6)___, or None of the above ____

4. Describe the **medical facts** which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories.

5. a. State the approximate **date** the condition commenced, and the probable **duration** of the condition (and also the probable duration of the patient's present incapacity[2] if different):

   b. Will it be necessary for the employee to take work only **intermittently or to work on a less than full schedule** as a result of the condition (including for treatment described in Item 6 below)? _____

   If yes, give the probable duration:

   c. If the condition is a **chronic condition** (condition #4) or **pregnancy**, state whether the patient is presently incapacitated[2] and the like duration and frequency of **episodes of incapacity[2]:**

6. a. If additional **treatments** will be required for the condition, provide an estimate of the probable number of such treatments.

If the patient will be absent from work or other daily **activities** because of **treatment** of an **intermittent** or **part-time** basis, also provide an estimate of the probable number and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any:

   b. If any of these treatments will be provided by **another provider of health services** (e.g., physical therapist), please state the nature of the treatments:

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[1]Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking Family and Medical Leave.

[2]**"Incapacity,"** for purpose of Family and Medical Leave, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom.

A **"Serious Health Condition"** means an illness, injury, impairment, or physical or medical condition that involves one of the following:

1. Hospital Care

Inpatient care (*i.e.*, an overnight stay) in a hospital, hospice or residential medical care facility, including any period of incapacity[2] or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

(1) A period of incapacity[2] of **more than three consecutive calendar days** including any subsequent treatment or period of incapacity[2] relating to the same condition), that also involves:

(1) **Treatment**[3] **two or more times** by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (*e.g.*, physical therapist) under orders of, or on referral by, a health care provider; *or*

(2) **Treatment** by a health care provider on **at least one occasion** which results in **regimen of continuing treatment**[4] under the supervision of the health care provider.

3. Pregnancy

Any period of incapacity due to **pregnancy**, or for **prenatal care.**

4. Chronic Conditions Requiring Treatments

A chronic condition which:

(1) Requires **periodic visits** for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;

(2) Continues over an **extended period of time** (including recurring episodes of a single underlying condition); and

(3) May cause **episodic** rather than a continuing period of incapacity 2 (e.g., asthma, diabetes, epilepsy, etc.).

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[3]Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

[4]A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

5. Permanent/Long-term Conditions Requiring Supervision

A period of **incapacity**[2] which is **permanent or long-term** due to a condition for which treatment may not be effective. The employee or family member must be **under the continuing supervision or, but need not be receiving active treatment by, a health care provider.** Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

6. Multiple Treatments (Non-Chronic Conditions)

Any period of absence to receive **multiple treatments** (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for **restorative surgery** after an accident or other injury, **or** for a condition that **would likely result in a period of incapacity**[2] **of more than three consecutive calendar days in the absence of medical intervention or treatment,** such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).

Sample Forms and Documents

Notice of Intention to Return From Leave

Notice of Intention to Return From Leave

Name:_____

Supervisor:_____

Date Leave Commenced:_____

Date of Planned Return:_____

I understand that my restoration to employment is subject to the following conditions:

1. As a condition of restoration, each employee must provide a written certification from his or her health provider that the employee is able to resume working.

2. Every attempt will be made to restore an employee returning from leave to his or his original position. If the employee's original position is unavailable, the employee will placed in an equivalent position with equivalent pay and benefits.

3. An employee returning from family and medical leave shall not be entitled to the accrual of any seniority or employment benefits during the period of leave.

_____ _____

Employee's Signature Date

I have examined [employee] and can certify that she/he is fully able to resume working.

_____ _____

Health Care Provider's Signature Date

OPTIONAL FORMS

Optional Medical Certification Statement for the Employee's Own Illness

Medical Certification Statement
(Employee's Own Serious Illness)

Name of Employee:_____

Date Condition Began:_____

Date Condition Ended (or is expected to end):_____

Medical facts regarding the condition:_____

_____

_____

_____

Explanation of extent to which employee is unable to perform the functions of his or her job:

_____

_____

_____

Health Care Provider Signature:_____

Date: _____ Office Phone:_____

Medical Release:

I authorize the release of any medical information necessary to process the above request.

Patient's Signature:_____ Date:_____

Sample Forms and Documents

Medical Certification Statement
(Illness of Employee's Family Member)

Name of Employee:_____

Name of Ill Family Member:_____

Date Condition Began:_____

Date Condition Ended (or is expected to end):_____

Medical facts regarding the condition:_____

_____

_____

_____

Explanation of extent to which employee is needed to care for the ill spouse, child or parent:

_____

_____

_____

_____

Health Care Provider Signature:_____

Date:_____ Office Phone:_____

Medical Release:

I authorize the release of any medical information necessary to process the above request.

Patient's Signature:_____ Date:_____