CITY OF APPLETON POLICY	TITLE: **Bone Marrow and Organ Donation Leave**	
ISSUE DATE: (Day after Council)	LAST UPDATE: November 2016	SECTION: HR
POLICY SOURCE: Human Resources Department	AUDIENCE: All City Employees	TOTAL PAGES: 5
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I. PURPOSE

To outline the policies, procedures and obligations of the City of Appleton and the rights and obligations of employees under the Wisconsin Bone Marrow and Organ Donation Leave law.

II. POLICY

It is the policy of the City of Appleton to comply with the Bone Marrow and Organ Donation Leave law (Section 103.11 Wis. Stats.)

Employees are entitled to bone marrow and organ donation leave benefits if they have been employed by the City for at least 52 consecutive weeks and for at least 1000 hours during that 52-week period.

An employee may take bone marrow or organ donation leave for up to 6 weeks in a 12-month period.

III. DISCUSSION

This policy provides an introduction to the rights and provisions of the Bone Marrow and Organ Donation Leave law. Specific questions an employee may have about this law should be directed to the City Human Resources Department.

IV. PROCEDURE

If an employee intends to take leave for the purpose of serving as a bone marrow or organ donor, the employee shall do the all of the following:

A. **Employee's Request**: Employees requesting leave must submit a completed health care provider certification (Exhibit 1) and submit to the employee's supervisor or Human Resources at least 30 days before the need. If the 30-day notice is not possible, the employee will notify his/her supervisor as soon as reasonable and practical. This should be interpreted to mean within one to two working days of the employee learning of the need for leave.

Employees who take medical leave should make reasonable efforts to schedule planned medical treatments so as not to unduly disrupt business operations.

B. **Status while on Leave**: During the leave the employee must update their supervisor at least

every 30 days of his/her status with health care provider certification and the intention to return to work.

C. **Return to Work**: The employee will be required to provide a "return to work" certification (Exhibit II) before they return to work indicating that the essential functions of the job can be performed. This must be obtained from the health care provider.

D. **Approval**: Human Resources must approve or deny all requests.

E. **Group Health Coverage**: Group health care coverage will continue for employees on leave as if they were still working. If applicable, employees who are granted a leave under this policy are advised to arrange to pay their share of premiums during the absence. If the leave is paid, premiums will continue to be paid through payroll deductions. If the leave is unpaid, employees are responsible for making sure the City receives premium payments by the normal payroll dates. If payments are not received within 30 days of the due date, coverage may be discontinued. This includes other benefits such as life, dental, flexible spending accounts, etc.

F. **No Return to Work from Leave**: If an employee chooses not to return to work (i.e. return to work for 30 calendar days) after an approved leave, the City may recover from the employee the cost of any premiums made to maintain the employee's health insurance, unless the failure to return is because of a serious health condition or reasons beyond the employee's control. Benefit entitlements based on length of service will be calculated as of the last paid workday before the start of the unpaid absence. If the employee substitutes leave, the length of service will be calculated as of the last paid workday substituted.

V. FALSIFICATION OF FORMS

An employee will be subject to disciplinary action up to and including discharge for falsifying any information required or requested as part of the application process, or receiving leave or benefits under this policy.

Exhibit I Note to provider: Job descriptions are available at www.appleton.org (City Employment, job descriptions)

MEDICAL LEAVE (for Bone Marrow & Organ Donation Leave)

HEALTH CARE PROVIDER CERTIFICATION

Employee requesting leave:_____ Date:_____

I, _____, confirm that _____
(Name of Health Care Provider or Christian Science Practitioner) (Patient's name)

is under my care for ____Bone Marrow Donation _____Organ Donation treatment.

Accordingly, I confirm that:

My area of medical practice is:_____

1. The health condition commenced on _____ and has the probable duration through _____.
2. The patient was/is being treated on an ___inpatient ____outpatient basis.

3. Was the procedure/treatment scheduled in advance or on an emergency basis? If scheduled in advance, please indicate how many days in advance the treatment was scheduled.
   Scheduled in advance_____ Emergency basis _____
   Date scheduled:_____

- Is the employee unable to work to work at this time _____yes ____no
- If the employee is able to work please describe limitations here:_____

  _____
- Is the employee limited in the number of hours per day he/she may work? ____yes ____no
  If yes, please describe the limitation_____.
- Is an intermittent or reduced leave schedule needed? If yes, please describe:_____

  _____

  _____
- Was medication, other than over-the-counter medication, prescribed? ___No ___Yes

Notice: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibit employers and other entities covered by GINA Title II from requesting or requiring genetic information from an individual or family member of the individual, except as specifically allowed by law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic service and genetic information of a fetus carried by an individual or individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Dated this _____ day of _____, 20__

_____ _____
Signature of Health Care Provider Telephone & Fax Number

_____ _____
Address City/State

Medical Authorization Release

I, _____ , herby authorize the above-reference health care provider, or others to which I am directed to for care relative to the health condition set forth above, to confer with medical representatives of the City of Appleton to clarify or supplement any information set forth herein without liability. I also authorize the use or disclosure of my health information (which may also be referenced as protected health information "PHI") as described in this authorization. I also agree to provide such further authorizations as the Company may request to process and classify my requested time off for FMLA purposes.

HIPAA Authorization

I understand that I have the right to revoke this authorization at any time by notifying my supervisor or the Human Resources Department. I also understand that the revocation will only become effective after it is received and recorded by the City of Appleton. I understand that any use or disclosure made prior to the time that such revocation becomes effective will not be affected by that revocation. If I do not revoke this authorization, it will expire at the end of my FMLA leave or shortly thereafter if additional time is needed to process documentation related to my leave (for example, verification of fitness for duty). If the City of Appleton's representatives require additional information related to my health condition after my leave request and all related documentation is completed, they must request that new authorization be signed by me.

I understand that I am entitled to receive a copy of this authorization form and acknowledge receipt of one.

Dated this_____day of _____, 20__

_____
Signature
(print name):_____

Patient Name: _____
Current Job: _____
Physician Name (please print):
_____
Phone: _____ Fax: _____

Date you saw patient: ___-___-____ Time In: _____ Injury Date: ____-____-____

Full Time☐	2nd shift☐	Mon ☐	Fri.☐
Part Time☐	1st shift☐	Sun.☐	Thurs ☐
Seasonal ☐	3rd shift ☐	Tues ☐	Sat☐
Temporary ☐	Swing ☐	Wed ☐	

Next scheduled work day ____ Shift _____
Shift Supervisor: _____

Patient Description of Injury:_____
_____

Diagnosis: _____
_____

Treatment:_____

Prescription strength meds orders ☐ Yes ☐ No
Meds: _____

Plan: _____

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DISPOSITION:
1. ☐ Patient is unable to work at this time.
2. ☐ Recommend his/her return to work with no limitations on (DATE): _____
3. ☐ He/She may return (DATE) _____ with a daily time limitation of _____ and/or with the following limitations until _____ or until re-evaluation on _____.

CHECK ONLY AS RELATES TO ABOVE CONDITION

☐ SEDENTARY WORK. Lifting 10 pounds maximum and occasionally lifting and/or carrying such articles as dockets, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met.

☐ LIGHT WORK. Lifting 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree or when it involves sitting most of the time with a degree of pushing and pulling of arms and/or leg controls.

☐ LIGHT MEDIUM WORK. Lifting 30 pounds maximum with frequent lifting and/or carrying of objects weighing up to 20 pounds.

☐ MEDIUM WORK. Lifting 50 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds.

☐ LIGHT HEAVY WORK. Lifting 75 pounds maximum with frequent lifting and/or carrying of objects weighing up to 40 pounds.

☐ HEAVY WORK. Lifting 100 pounds maximum with frequent lifting and/or carrying of objects weighing up to 50 pounds.

N=Never/Not Able F=Frequent up to 30x/hr.
O=Occasional up to 4 times/hr. C=Constant over 30x/hr.
Specify Restrictions for 24 day

	N	O	F	C			
Sitting/Driving					Lab Work	Yes __	No __
Standing/Walking							
Climbing					X - Rays	Yes __	No __
Bending							
Kneeling/Squatting/Crawling							
					R	L	BIL
Reaching-Horiz./push-pull							
Reaching-Vert./above shoulder							
Gross Handling							
Finger Manipulation							
Single Grasping							
Repetitive Foot Movement							

OTHER INSTRUCTIONS AND/OR LIMITATIONS:

SCHEDULED APPOINTMENTS:

SCHEDULED APPOINTMENTS:

☐ Referral ☐ Clinic _____ Date: _____ Time: _____ ☐ Referral ☐ Clinic _____ Date: _____ Time: _____

Time Out: _____ ☐ Called Employer Date _____Signature _____

I hereby authorize my attending physician and/or hospital to release any information or copies thereof acquired in the course of my examination or treatment for the injury identified on this form to my employer or his representative.

PATIENT'S SIGNATURE Date PHYSICIAN'S SIGNATURE Date