Alameda-Contra Costa Transit District

Administrative Regulation No. 210A: Extended Leave Return to Work Guidelines and Procedures

Issuing Officer: General Manager **Date of Adoption:** 10/14/2020 **Most Recent Amendment:** N/A **See Also:** BP 211	**Subject Category:** Section 200: Human Resources **Subsection:** General **Control Department(s):** Human Resources

I. PURPOSE:

The purpose of this Administrative Regulation is to facilitate the expedient and smooth transition back to work following an employee's continuous leave of absence of 30 or more calendar days. This Administrative Regulation is further intended to provide employees information and guidance regarding their responsibilities and the process for returning to work following a continuous leave of absence of 30 or more calendar days.

Nothing in this regulation is intended to be inconsistent with applicable collective bargaining agreements.

II. PERSONS AFFECTED:

All District employees. District collective bargaining agreements shall take precedence over this Administrative Regulation if a conflict exists. Represented employees should review their collective bargaining agreement and/or speak to their union representative for additional clarity on applicable procedures.

III. DEFINITIONS:

"Extended Leave Facilitator" means the single point of contact for employees returning from a continuous leave of absence of 30 or more calendar days. Extended Leave Facilitator is a working job title, not classification, for the purposes of this Administrative Regulation.

"Medical Documentation" means documentation from a treating physician stating that the employee is either (1) able to perform the essential functions of their position without any medical restrictions or (2) has medical restrictions that adversely impact the employee's ability to perform the essential functions of their position. If the medical provider determines that an employee has medical restrictions, the Medical Documentation shall state the nature and expected duration of those restrictions. Nothing in this regulation seeks the disclosure of the employee's diagnosis.

IV. REGULATION

A. Return to Work Options

1. Full duty, no restrictions: An employee who seeks to return to work without work related restrictions must provide Medical Documentation evidencing the ability of the employee to perform the essential functions of their assigned position with no restrictions, including all necessary certifications.

2. Modified Work: Modified work may be temporarily available for an employee who has provided Medical Documentation demonstrating that the employee cannot perform the essential functions of their assigned position.

    a. Modified work will only be available to employees who have provided sufficient information for the District to determine that the need for a modified work plan is temporary and that the employee will be able to resume the essential functions of their assigned position.

    b. Employees will only be offered a modified work assignment if they will be available for the duration of that assignment; if an employee has a multi-day planned or unplanned absence (including but not limited to pre-planned vacations) after beginning a modified work assignment, the District reserves the right to reassign the modified work to another employee.

    c. The District will consider modified work options beginning with the employee's current assigned location. The District has sole discretion to offer any modified work assignment at any District work location.

    d. Modified work assignments should not exceed 60 calendar days unless otherwise agreed upon between the District and the employee.

3. Reasonable Accommodation: Reasonable accommodations may be available for an employee who can perform the essential functions of their assigned position with or without an accommodation.

    a. Employees are expected to cooperate with all requirements of the reasonable accommodation process, including but not limited to:

        i. Completing and returning the reasonable accommodation request form;
        ii. Providing all supporting Medical Documentation;
        iii. Engaging in the interactive process; and
        iv. Being responsive to all communications from the District.

    b. The District will review reasonable accommodation requests on a case by case basis to determine its ability to provide a reasonable accommodation.

4. Lactation Accommodation: Lactation accommodations may be available for an employee who requests an accommodation to express milk during the workday.

a. Lactation accommodations are available for up to one year after the birth of an employee's child.
b. Refer to Board Policy 211 for the District's Lactation Accommodation Policy.

5. CBA Provisions – Employees may be eligible for return to work options set forth in a Collective Bargaining Agreement. Nothing in this Administrative Regulation limits an employee's rights under the CBA.

B. **Extended Leave Facilitator Responsibilities:**

1. The Extended Leave Facilitator shall coordinate with appropriate District departments to facilitate an employee's return to work. Extended Leave Facilitator is a working job title, and the District classification utilized for the Extended Leave Facilitator shall be determined by Human Resources based on the duties and business need.

2. The Extended Leave Facilitator can be reached at (510) 891-7117 or ExtendedLeaves@actransit.org.

C. **Employee Responsibilities:**

1. Provide a return to work status update to the Extended Leave Facilitator following all medical appointments and/or when a change in status has occurred.

2. Contact the Extended Leave Facilitator to confirm return to work or request an extension of leave five (5) days prior to scheduled return to work date; provide supporting Medical Documentation to Extended Leave Facilitator for extension requests.

3. If returning from maternity leave or baby bonding leave, notify the Extended Leave Facilitator if a lactation accommodation will be needed at least ten (10) business days prior to return from leave.

4. If returning from leave following the District's Substance Abuse Program, work with the Substance Abuse Professional and Compliance Unit to coordinate return to work. Contact: actalcoholdrugcompliance@actransit.org.

D. **Triage Process**

1. This process is applicable to:

a. Modified Work
b. Reasonable Accommodations
c. Lactation Accommodations

2. The purpose of the triage process is to discuss potential options that will allow an employee with restrictions to return to work.

3. When the Extended Leave Facilitator is notified that an employee is returning to work with restrictions, they will be responsible for scheduling a triage. The triage may include members of the following teams:

    a. Legal
    b. Leave Management
    c. Industrial Injury
    d. Drug and Alcohol
    e. Training
    f. Employee's manager/supervisor
    g. Extended leave Facilitator

V. ATTACHMENTS

A. Lactation Accommodation Form
B. Reasonable Accommodation Form
C. FMLA/CFRA Request Form

Approved by:

Michael A. Hursh, General Manager
Alameda-Contra Costa Transit District

Post-Pregnancy Accommodation Request Form

The District has an accommodation process to assist employees in transitioning from maternity leave back to work following the birth of a child. Lactation accommodation – which allows a nursing mother to express milk during her workday – can be part of that process. If you need such an accommodation, or any accommodation related to post-pregnancy and childbirth medical conditions, complete this form and submit it to the Leave Management Department.

(Last Name)	**(First Name)**	**(M.I.)**	**Badge No.:**
Address: (Street)	**(City)**	**(State)**	**(Zip)**
Telephone No.:	**(Home)**	**(Cell)**	
Hire Date:	**Current Position:**	**Lactation Request Date:**	**Childs Birthdate:**
Last Date Worked:	**Department:**	**Anticipated Return Date:**	**Supervisor Name:**

1. Please provide the estimated frequency and duration needed for you to express milk during your workday (i.e.every four (4) hours for approximately 25 minutes):

2. Do you need additional time beyond your regularly scheduled break(s) and /or lunch break to express milk?

Yes: ☐ **No:** ☐

Post-Pregnancy Accommodation Request Form

3. Please check all days for which you require a lactation break and enter the approximate times that you will take your breaks:

Monday ☐	Tuesday ☐	Wednesday ☐	Thursday ☐	Friday ☐	Saturday ☐	Sunday ☐
Times:	Times:	Times:	Times:	Times:	Times:	Times:

In the event you would like an accommodation related to post-pregnancy and childbirth medical conditions, complete questions 4-10.

4. Explain the post-pregnancy accommodation and childbirth medical condition that is needed?

5. What functional limitation do you believe need to be accommodated? Check all appropriate categories.

Partial loss of vision	☐	Handling/fingering	☐	Learning	☐
Total loss of vision	☐	Pushing /pulling	☐	Hearing	☐
Feeling/sensing	☐	Squatting / bending	☐	Talking	☐
Operating foot pedal	☐	Reduced concentration	☐	Reading	☐
Decreased Stamina	☐	Balancing	☐	Carrying	☐
Memory Loss	☐	Sitting	☐	Reaching	☐
Grasping	☐	Climbing	☐	Lifting	☐
Walking	☐	Standing	☐	Kneeling	☐
Other - specify:					
Sides of Body involved (if applicable):	Right side: ☐ _____		Left side: ☐ _____		Both Sides: ☐ _____

Post-Pregnancy Accommodation Request Form

6. Are you able to do the following?

Activity	Yes	No	Activity	Yes	No
Simple grasping	☐	☐	Reach or work above the shoulder level	☐	☐
Power grasping	☐	☐	Reach or work below should level	☐	☐
Pushing and Pulling	☐	☐	Sit for an extended period of time	☐	☐
Fine manipulation	☐	☐			

7. Are you able to use your feet to operate foot controls or for repetitive movement? Yes☐ No :☐

8. Are you able to lift & carry Yes:☐ No:☐ with what frequency?

Lifting	Frequency		Carrying	Frequency
		10lbs. or less		
		11 to 25lbs		
		26 to 50lbs		
		76 to 100lbs		
		Over 100lbs		

9. Are you able to:

Activity	Yes	No	Description
Drive cars, trucks, forklifts or other moving equipment	☐	☐	
Work near hazardous equipment and machinery	☐	☐	
Walk on uneven ground	☐	☐	
Tolerate exposure to dust, gas or fumes	☐	☐	
Tolerate exposure to extremes in temperatures or humidity	☐	☐	
Work at heights	☐	☐	

Post-Pregnancy Accommodation Request Form

10. Is there additional information you feel might be helpful in your accommodation request?

Employee Signature:	**Badge#:**	**Date:**

Employee Request for Accommodation Form

Please complete this form if you believe you have a disability[1] and wish to request a reasonable accommodation (e.g., equipment, schedule modification, LOA) which would enable you to properly and safely perform your current job. If additional space is needed, attach a separate sheet. Please attach the **job description** for your position and have your health care provider complete the attached Medical Certification. Please send completed forms to the Leave Management Department at leavemanagementdepartment@actransit.org or via fax (510)239-5815. If you need assistance with this process, are having difficulty obtaining a copy of your job description or have questions about completing this form, please send an email to leavemanagementdepartment@actransit.org.

EMPLOYEE INFORMATION

EMPLOYEE NAME (Last, First, MI)	EMPLOYEE'S PHONE NUMBER	Badge No.	☐ Job Description attached (***required***)

JOB TITLE	DEPARTMENT	SUPERVISOR'S NAME	SUPERVISOR'S PHONE NUMBER

1. BRIEFLY DESCRIBE ANY LIMITATION(S), INCLUDING MENTAL OR EMOTIONAL, THAT LIMIT YOUR ABILITY TO DO YOUR JOB (*Please do not provide a diagnosis*)[2]:

2. BRIEFLY DESCRIBE THE SPECIFIC ACCOMMODATION BEING REQUESTED (i.e., please describe the accommodation(s) you believe are needed to enable you to perform the essential functions of this job; you must be able to perform all of the essential functions either with or without accommodation):

3. EXPLAIN HOW THE REQUESTED ACCOMMODATION WOULD ASSIST YOU IN PERFORMING THE ESSENTIAL FUNCTIONS OF YOUR JOB:

4. DURATION OF ACCOMMODATION (i.e., how long do you believe you will need the accommodation?):

START DATE	END DATE

I hereby certify that all statements made above are true to the best of my knowledge and belief. I understand that AC Transit will determine whether, based on state or federal law, it can provide a reasonable accommodation. I further understand that I am expected to cooperate in the interactive process of identifying and selecting an accommodation, and I agree to cooperate promptly with any requests for medical examination or testing and to release to authorized AC Transit personnel and agents the medical records necessary to evaluate my request for accommodation.

EMPLOYEE AUTHORIZATION & SIGNATURE

☐	If this box is checked, I hereby grant permission for my physician to discuss any accommodations directly with AC Transit.	**EMPLOYEE SIGNATURE**	**DATE SIGNED**

[1] See attached definition of disability.
[2] The Genetic Information Nondiscrimination Act of 2008 ("GINA") prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members. In order 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 services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Medical Certification Form for Accommodation

TO THE HEALTHCARE PROVIDER: The employee listed below has requested a job accommodation and has authorized the Company to obtain a medical certification regarding whether the employee may have a disability according to applicable law (see attached definition) and a medical opinion regarding what, if any, reasonable job accommodations are necessary to enable the him or her to perform the essential functions of the job. **Please do not provide a diagnosis** (*please also refer to the GINA notice in the footnote on page 1*). If you have questions regarding the nature of the job duties or questions about the completion of this form, please send an email to the Leave Management Department at leavemanagementdepartment@actransit.org.. The completed form may be returned to the Leave Management Department at leavemanagementdepartment@actransit.org or via fax (510)239-5815.

EMPLOYEE INFORMATION

EMPLOYEE NAME (Last, First, MI)	JOB TITLE	☐ Job Description attached ***(required)***

Medical Inquiry – Please answer these questions to help determine disability and reasonable accommodation.

INSTRUCTIONS: ***Please review the attached job description, discuss the essential job duties with the employee, and provide complete and detailed responses to the questions below.***

1. Is the employee able to perform the essential job functions of this position with or without reasonable accommodation?

   Yes ☐ No ▣

2. Without disclosing the underlying nature or diagnosis of any disability, please describe the employee's limitations that are interfering or preventing him or her from performing any specific job function identified in the attached job description, including the severity, duration or expected duration of the limitation:

3. Please describe, with specificity, what adjustment(s) to the work environment or accommodation would enable the employee to perform the essential functions of his/her current position:

4. Will it be necessary for the employee to be off work?

Yes: ☐		Intermittent: ☐	
No: ☐		Continuous: ☐	

If ***yes***, please indicate the nature of the absence
If *intermittent*, please provide the frequency and duration of absences:

HEALTHCARE PROVIDER INFORMATION AND SIGNATURE

I am licensed by (State): _____

T PRACTICE AS:

Doctor of Medicine ☐ Doctor of Osteopathy☐ Physician's Assistant ☐ Nurse Practitioner ☐	Clinical Psychologist ☐ Clinical Social Worker ☐ Chiropractor ☐ Physical Therapist ☐	Podiatrist ☐ Dentist ☐ Nurse Midwife☐

Other *(please describe):*

I have reviewed the health status of the above-mentioned individual with respect to his/her capability to perform the functions of the position described on the enclosed Job Description. My responses to the questions above are based on my review of and are provided on the basis of my own medical opinion.

HEALTHCARE PROVIDER'S SIGNATURE	HEALTHCARE PROVIDER'S PRINTED NAME	DATE SIGNED

LICENSE NO.	TELEPHONE NO.	FAX NUMBER	ADDRESS

DISABILITY DEFINITION

(d) "Disability" shall be broadly construed to mean and include any of the following definitions:

(1) "Mental disability," as defined at Government Code section 12926, includes, but is not limited to, having any mental or psychological disorder or condition that limits a major life activity. "Mental disability" includes, but is not limited to, emotional or mental illness, intellectual or cognitive disability (formerly referred to as "mental retardation"), organic brain syndrome, or specific learning disabilities, autism spectrum disorders, schizophrenia, and chronic or episodic conditions such as clinical depression, bipolar disorder, post-traumatic stress disorder, and obsessive compulsive disorder.

(2) "Physical disability," as defined at Government Code section 12926, includes, but is not limited to, having any anatomical loss, cosmetic disfigurement, physiological disease, disorder or condition that does both of the following:

(A) affects one or more of the following body systems: neurological; immunological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive; digestive; genitourinary; hemic and lymphatic; circulatory; skin; and endocrine; and

(B) limits a major life activity.

(C) "Disability" includes, but is not limited to, deafness, blindness, partially or completely missing limbs, mobility impairments requiring the use of a wheelchair, cerebral palsy, and chronic or episodic conditions such as HIV/AIDS, hepatitis, epilepsy, seizure disorder, diabetes, multiple sclerosis, and heart and circulatory disease.

* * *

(9) "Disability" does not include:

(A) excluded conditions listed in the Government Code section 12926 definitions of mental and physical disability. These conditions are compulsive gambling, kleptomania, pyromania, or psychoactive substance use disorders resulting from the current unlawful use of controlled substances or other drugs, and "sexual behavior disorders," as defined at section 11065(q), of this article; or

(B) conditions that are mild, which do not limit a major life activity, as determined on a case-by-case basis. These excluded conditions have little or no residual effects, such as the common cold; seasonal or common influenza; minor cuts, sprains, muscle aches, soreness, bruises, or abrasions; non-migraine headaches, and minor and non-chronic gastrointestinal disorders.

Family Medical Leave Act (FMLA)/California Family Rights Act (CFRA)

Request Form – Employee's Serious Health Condition

Note: Please complete this form in its entirety. Have your Supervisor review and sign this form. You must also have a physician or other licensed health care professional complete the Medical Certification Form (MCF). **NOTE: The Leave Management Department cannot grant final approval of your FMLA/CFRA application until a complete and sufficient Medical Certification Form signed by a physician, or other licensed health care professional, is received within 15-days of submitting a FMLA/CFRA Request Form.**

Section I - Employee Information

Employee's Name:_____ Employee Badge No.:_____
Last Name First Name Middle

Date of Hire:_____ Job Title:_____ Job Status: ☐Full Time ☐Part Time

Address while on leave: _____
Street/Apt # City State Zip Code

Mailing Address ***(If different than above)***:_____
Street/Apt # City State Zip Code

Telephone Number while on leave: _____ Home Telephone Number _____

Department/Division:_____ Days Off Work: ☐Sun ☐Mon ☐Tue Wed ☐Thurs ☐Fri ☐Sat

Supervisor's Name:_____ Supervisor's Job Title: _____

Type of Leave Requested: ☐ Continuous ☐ Intermittent Leave State Date:_____ Leave End Date: _____

Reason for Leave:

Have you taken FMLA/CFRA in the past twelve (12) months? ☐ Yes - Leave Date: _____ ☐ No

Section II – Important Information Regarding Your Leave of Absence

If you have multiple concurrent serious health conditions, you must complete a FMLA/CFRA Request Form and Medical Certification Form (MCF) for each serious health condition. Additionally, if you currently have an existing FMLA/CFRA Plan Year established due to another serious health condition, for yourself or a qualifying family member, the same Plan Year start and end dates will apply for each qualifying reason.

- **If you wish to coordinate FMLA/CFRA with your accrued sick leave, you must complete a Sick Leave Coordination Authorization Form and return it to the Leave Management Department.**
  - **For ATU:** At the employee's option, she/he may choose not to use sick leave while on leave under the FMLA/CFRA.

- **If you are an unrepresented employee, or represented by AFSCME or IBEW, accrued sick leave will be charged whenever you are absent from work due to illness or non-occupational injury before use of other accrued leave. You must use accrued sick leave until exhausted, then accrued vacation under some circumstances (for more details, please refer to your respective Collective Bargaining Agreement if represented, or Board Policy 296 if unrepresented).**
  - **For AFSCME:** if you have a debilitating medical condition verified by a physician requiring an absence greater than four (4) consecutive weeks, you may elect to preserve the following accruals of: 56 hours of sick and 40 hours of vacation.

- **You have the right under FMLA/CFRA to use up to twelve (12) weeks of leave in a twelve (12)-month period. The twelve (12)-month period measures forward from the first date of FMLA/CFRA leave usage.**

- **If a husband and wife or previously designated domestic partners both work for the District, they may be limited to an aggregate of twelve (12) workweeks of leave during any twelve (12) month period, if leave is taken for the birth of a child, or to care for a child after child birth.**

Employee's Signature _____ Date _____

Supervisor/Manager's Signature _____ Date _____

AC TRANSIT RESERVES THE RIGHT TO RETURN AND/OR REJECT INCOMPLETE FORMS