



Dear Flight Attendant:

Attached is the US Airways Health Care Provider Form. This form is to be used when applying for the following medical leaves of absence.

FMLA – This type of medical leave requires that a Flight Attendant work at least 625 hours in the previous year and be employed for at least 1 year with the company. If you meet these requirements, you have a total of 12 weeks of job protected time to use in a rolling calendar year. This leave can be used for your medical condition or that of a qualified family member. FMLA can be used for a block leave of time (6 or more days off) or intermittently (1 to 5 days off) for a recurring condition.

Medical Leave – This leave is used for a Flight Attendant who does not qualify for FMLA. The Flight Attendant can apply for a medical leave for a condition that requires 6 or more days off work. **This is not a job protected time leave.** After the first 30/31 days of the leave, the Flight Attendant begins to lose longevity. In addition, this leave is not available for the care of a qualified family member. You must qualify for FMLA to care for a qualified family member.

Qualifying Family Member – A qualifying family member is defined as a spouse, a minor child or a parent who has a serious health condition and the Flight Attendant is the primary caregiver.

If you have any questions regarding leaves of absence, please contact the InFlight Administration office at 480-693-3239. We will be happy to assist you.

Sincerely,

The InFlight Administration Office
US Airways

HEALTH CARE PROVIDER FORM INSTRUCTION SHEET

The Health Care Provider Form is used for all medical leaves of absence. FMLA guidelines include yourself or a qualifying family member when you are the sole caretaker of that family member. The leave can be for a **block** of time off or used **intermittently** depending on the direction of your physician. (A **Block Leave** is defined as 6 or more days off, returning to work no earlier than the 7th day. An **Intermittent Leave** would be considered 1 to 5 days off at a time for a chronic condition as defined by the attending physician.)

The Health Care Provider Form is also used when an employee needs to apply for a medical leave of absence and does not qualify for FMLA time.

The Top Portion of Page 1

This section must be completed by the employee. You must complete the following: **name, badge number (C#), signature, date** and the **patients name if other than yourself**.

Section A

This section must be completed by **the attending physician**. Your physician will need to include **#2**, medical facts to support the leave and **#3**, a start and end date to your leave of absence. If the end date draws near and you are unable to return to work, your physician will need to complete updated paperwork to extend your leave.

Section B

Please have your physician complete this entire section including **#3**, a return to work date. If your return to work date is unknown, please have your physician complete **#6**, your next evaluation date.

Section C

This section should be completed for the care of an ill family member. **This type of leave is only available if you qualify for FMLA**. If you are unsure of your qualification, please contact the InFlight Administration office at **480-693-3239**.

Section D

This section must be completed in its entirety by **the attending physician**. This includes the **attending physician's signature and contact phone number**.

If any of these sections are incomplete, your leave of absence may be denied or delayed. If you have any questions, please contact InFlight Administration at 480-693-3239.

US Airways InFlight Administration

**USAIRWAYS
HEALTH CARE PROVIDER'S FORM**

Employee's Name: _____ Date: _____

Position: _____ Badge Number: _____

Patient's Name (if other than employee): _____

This documentation is for my own health condition (physician to complete Sections A, B, & D)

This documentation is for the health condition of a family member (physician to complete sections A, C, & D; employee to complete question #5 in Section C)

Authorization To Release Medical Information:

I hereby authorize a health care provider representing my employer to contact the undersigned health care provider for purposes of clarification and authenticity of this medical certification. Also, I understand that any and all fees resulting from the completion of this form are my responsibility.

Employee's Signature

Date

SECTION A – MEDICAL FACTS

Evaluation Date: _____ Date Condition Commenced: _____

1. A description of what is meant by a "Serious Health Condition" under the federal Family and Medical Leave Act (FMLA) is attached. Does the patient's condition qualify under any of the categories described? If so, please circle the appropriate category number.

1 2 3 4 5 6 NO

2. 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:

3. Please state the probable duration of the condition. **From:** _____ **To:** _____

4. Will it be necessary for the employee to take leave only intermittently or to work less than a full schedule during this leave? If so, please describe the prescribed schedule:

SECTION B – EMPLOYEE'S OWN SERIOUS HEALTH CONDITION

1. Is the employee able to perform the essential physical functions of his/her position? **YES** **NO**

2. Is the employee able to perform work of any kind? **YES** **NO**

3. Please specify the date the employee may return to work: _____

4. Will the employee have restrictions upon his/her return to work? **YES** **NO**

If yes, please refer to Essential Physical Functions on page 4, and indicate applicable restrictions below:

- No lifting over ____ lb.
- No kneeling or squatting
- No reaching above shoulder level
- No repetitive waist bending
- No climbing of stairs or ladders
- No operating of motor vehicles
- No work above ground level
- No operating of mobile equipment
- No work around high speed or moving machinery
- Should be sitting ____% of the time
- Other: _____
- No push or pull over ____ lb.
- Should be considered permanent

5. How long do you anticipate the employee will have these restrictions? **From:** _____ **To:** _____

6. Re-evaluation date: _____

A "Serious Health Condition" means an illness, injury, impairment, or physical or mental condition that involves 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 or subsequent treatment in connection with or consequent to such inpatient care.
2. **ABSENCE PLUS TREATMENT** – A period of incapacity of more than three consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that involves:
 - a) Treatment 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
 - b) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of a health care provider.
3. **PREGNANCY** – Any period of incapacity due to pregnancy, or for prenatal care. (NOTE: An employee's own incapacity due to pregnancy is covered as a serious health condition under FMLA but not under CFRA.)
4. **CHRONIC CONDITIONS REQUIRING TREATMENT** – A chronic condition which:
 - a) 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;
 - b) Continues over an extended period of time (including recurring episodes of a single underlying condition); and
 - c) May cause episodic rather than continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.)
5. **PERMANENT/LONG-TERM CONDITIONS REQUIRING SUPERVISION** – A period of incapacity 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 of, 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 order 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 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).



Essential Physical Functions Information (check applicable box)

Inflight CSR

- Repetitive Squat (20 Reps)
- Sustained Crouch (1 minute)
- Push/Pull/Move:
16' up/down ramp 200 lb – beverage cart
Pull-up end 200 lb – beverage cart
- Carry/Move:
25' front 35 lb – 2x
25' one-hand 35 lb – 2x
- Lift/Move:
Floor to 33" – 35 lb – 2x
33" to 65" – 35 lb – 5x
- DOT Standards
Vision each eye 20/40
Color and peripheral
Audio
40dB @ 500, 1000, 2000 Hz

Ramp

- Repetitive Squat (20 reps)
- Sustained Crouch (1 minute)
- Push/Pull/Move:
Luggage cart/partially loaded 600 lb
- Carry:
25' front – 70 lb / 50 lb x 5 min
25' one-hand – 70 lb / 50 lb x 5 min
- Lifting/Move:
Floor to 33" – 70 lb (belt loader) / 50 lb x 5 min
Floor to 40" – 50 lb (bin) / 35 lb x 5 min
33" to 54" – 50 lb (top bag cart) / 35 lb x 5 min
- DOT Standards
Vision (Snellen) each eye 20/40
Audio
40dB @ 500, 1000, 2000 Hz

AWA Mail Clerk & CSR Mail Clerk

- Repetitive Squat (20 reps)
- Sustained Crouch (1 minute)
- Kneeling (2 min)
- Push/Slide/Move:
51 lb box copy paper 10' across floor
- Push 300 lb loaded mail cart
- Carry/Move:
50 lb 5'
- Lift/Move:
Box copy paper
51 lb 5x (in 1 min)
70 lb Floor to 33"
- DOT Standards
Vision (Snellen) each eye 20/40
Audio
40dB @ 500, 1000, 2000 Hz

Quality Control

- Repetitive Squat (20 reps)
- Sustained Crouch (1 minute)
- Kneeling (2 min)
- Carry/Move:
25' front – 40 lb
25' one hand – 40 lb
- Lift/Move:
Floor to 33" – 40 lb
33" to 54" – 25 lb
- DOT Standards
Vision (Snellen) each eye 20/40
Audio
40dB @ 500, 1000, 2000 Hz

Field Station CSR

- Repetitive Squat (20 reps)
- Sustained Crouch (1 minute)
- Push/Pull/Move:
Luggage cart/partially loaded 600 lb
- Static Pull 100 lb
- Carry/Move:
25' front 70 lb
25' one-hand 70 lb
- Lift/Move:
Floor to 33" – (belt loader) 70 lb
Floor to 40" (bin) 50 lb
33" to 54" (top bag cart) 50 lb
- DOT Standards
Vision (Snellen) each eye 20/40
Audio
40dB @ 500, 1000, 2000 Hz

Ticket/Gate CSR

- Repetitive Squat (20 reps)
- Sustained Crouch (1 minute)
- Push/Pull/Move:
Passenger in wheelchair
(Jetway incline) 200 lb
- Carry/Move:
25' front – 75 lb
25' one-hand – 70 lb
- Lifting/Move:
Floor to 18" – 70 lb
18" to 33" – 100 lb
- DOT Standards
Vision each eye 20/40
Color and peripheral
Audio

Maintenance

- Repetitive Squat (20 reps)
- Sustained Crouch (1 minute)
- Kneeling (2 min)
- Push/Pull/Move:
Pull (static) – 50 lb
- Carry/Move:
25' front – 50 lb
25' one-hand – 50 lb
- Lift/Move:
Floor to 33" – 50 lb
33" to 54" – 25 lb
- DOT Standards
Vision (Snellen) each eye 20/40
Audio
40dB @ 500, 1000, 2000 Hz
- Manual Dexterity
Hand/Fingers

InFlight Administration Medical Leave of Absence Checklist

US Airways InFlight Administration
52S-INF
4000 Sky Harbor Blvd.
Phoenix, AZ 85034
Phone: 480-693-3239
Fax: 480-693-3201

Request for Medical Leave of Absence - Health Care Provider Form

The Family Medical Leave Act of 1993 (FMLA) entitles you to 12 weeks of job-protected time if you meet the minimum number of hours worked (625) in the last 12 months and your condition is a qualifying medical condition. If you meet the eligibility guidelines under FMLA, FMLA will run concurrently with your medical leave of absence, Short Term Disability leave, occupational injury or intermittent leave of absence.

_____ Should you need a medical leave of absence, your physician will need to complete a Health Care Provider's (HCP) Form or the following information from your physician on doctor's stationery:

- Name of employee (not added by employee).
- Actual date(s) seen by the medical provider(s).
- Medical explanation of why your continued absence is necessary.
- Any physical or mental limitations that prevent you from performing the essential functions of your job.
- Length of time you will need to remain off work, including the estimated time of your entire absence.
- Treatment plan. (Detail information regarding continuing regimen of treatment.)
- Prognosis for recovery.
- Name, address, and telephone number of medical provider.
- Signature of medical provider.

HCP forms may be obtained in the Crew Service Center, on Compass, by request through InFlight Administration (480-693-3239) or your supervisor.

_____ Ensure that you have signed and dated the Health Care Provider form in the appropriate section.

_____ Return the HCP form along with the Supplemental Sick Payout Request form, if applicable (see attached) to InFlight Administration within 14 days of your request for leave of absence.

***Once HCP form is received in our office, you will be assigned a Medical Coordinator who will be responsible for the processing and management of your medical leave of absence. As additional medical documentation may be necessary in order to approve your request for a medical leave of absence, you are responsible for covering the operation until such time your leave of absence has been approved and you see your line has been adjusted to reflect medical leave of absence.

Medical Updates

_____ Your line will be coded appropriately for the timeframe indicated on the HCP form or medical information provided by your doctor. If InFlight Administration does not receive an update either extending your leave of absence or returning you to work by the date indicated on the medical documentation, a UL (Unauthorized Leave) code will be added to your line until such time that additional documentation is provided to cover your absence.

Short Term Disability – Benefits are administered by Hartford.

_____ If you want to apply for Short Term Disability Benefits, call Hartford at 1-800-289-9140 once you have submitted the HCP form to InFlight Administration. Be prepared to provide the following information:

- Nature of medical condition
- Physician's name, address, phone and fax numbers
- Job description (Make sure your physician is aware of the physical requirements of your job and the inability to modify your work schedule to accommodate physical limitation.)
- Supervisor's name, phone and fax numbers (480-693-3201)
- Your home address

Hartford will send you a certification letter with your approved length of disability. You should receive your first check within 10 – 12 days and each week thereafter. You must call Hartford every 30 days throughout your leave to update them on the status of your medical condition. Failure to do so will result in disruption of paid benefits.

While on paid FMLA, all health insurance premiums will continue to be payroll deducted. While on STD, or on an unpaid medical leave of absence, you are responsible for reimbursing the Company for your share of the premiums.

While on FMLA and STD you and your dependents may travel space-available on US Airways but not on other carriers including US Airways Express. However, leaves of absence greater than 180 days will result in the suspension of the employee's pass travel privileges (such as when STD rolls to LTD). You may apply for emergency travel by contacting your Inflight Supervisor. Dependent and parent travel privileges are not affected by your leave.

Return to Work

_____ When you are released to return to work, your treating physician will need to provide additional documentation returning you to work without restriction. Please fax to InFlight Administration. (Your release must be received in our office prior to 0900 on the 16th of the month in order for you to be eligible to bid for the next month's schedule. The release must make you available for at least half of the bid month.

In addition, you must contact Bid Admin within 24 hours of your release to confirm your work schedule.



U-S AIRWAYS

**F/A Request for Supplementing Pay while on FMLA (STD or OJI)
Utilizing Sick Bank Time**

There is a statutory 5-day waiting period before Short Term Disability (STD) benefits begin. Trips/duty periods missed during the statutory 5-day waiting period are automatically paid from the flight attendant's sick bank, provided there are enough hours in the flight attendant's sick bank. A flight attendant may choose to utilize either her/his disability benefits or sick leave while on medical leave; however, she/he may not use both at the same time. (Section 14-C-5)

If you are requesting intermittent FMLA for the care of a family member and you would like to be paid from your sick bank, you must submit this form. If, however, the intermittent leave is for your own medical condition, you will automatically be paid trips missed out of your sick bank.

Electing to use your sick bank beyond the 5-day statutory waiting period or for intermittent use for the care of a family member must be initiated prior to, or at the time you are submitting the paperwork for a Short Term Disability leave or intermittent leave for the care of a family member.

I am requesting to have the following trips(s) and or Reserve duty period(s) paid from my sick bank prior to beginning my STD leave:

Pairing # _____ Date: _____ Reserve Duty Period(s) _____ Date: _____
Pairing # _____ Date: _____ Reserve Duty Period(s) _____ Date: _____
Pairing # _____ Date: _____ Reserve Duty Period(s) _____ Date: _____
Pairing # _____ Date: _____ Reserve Duty Period(s) _____ Date: _____
Pairing # _____ Date: _____ Reserve Duty Period(s) _____ Date: _____

I am requesting to drop as many trip(s) or Reserve duty period(s) as necessary to exhaust my sick bank.

Today's date: _____ Employee C# _____
Name: _____ Signature: _____

Fax to InFlight Administration 480-693-3201

If you would like to be notified that we have received this form, please indicate preference of notification.

Phone: _____ Fax: _____

Co-Mail to T-4 Inflt C# _____ Email to: _____