TRAIN AND ENGINE

FAMILY MEDICAL LEAVE / FAMILY MILITARY LEAVE (FML)

Dear Employee,

Please read this letter carefully. It is your responsibility to follow the outlined steps to initiate family medical leave / family military leave. If you do not complete the application for leave and submit the complete provider certification (if leave is due to a serious health condition), we will be unable to process your request. For a planned leave, notify both APS (toll free) at 1-888-257-3407 and your supervisor of your actual last day of work and first day of leave 30 days prior to taking leave. In the event of an unplanned leave, please contact your supervisor and APS Healthcare as soon as possible.

At this time, the time off of work you have requested will be counted as family medical leave / family military leave. If it is later determined that you are not eligible for family medical leave / family military leave or this absence does not meet the requirements under family medical leave, your time off may not be counted as family medical leave / family military leave and the absence will be treated as unexcused.

Norfolk Southern has contracted with APS Healthcare to administer and manage family medical leave / family military leave for certain Norfolk Southern employees such as yourself. You must complete the enclosed application and return it to APS Healthcare as soon as possible. Also, if your leave is due to a serious health condition either for you or your family member, you must take the provider certification form to the treating healthcare provider for completion. The completed forms must be submitted to APS by mail or fax **within 15 days** of your request

APS Healthcare
Disability Department
300 North Executive Drive
Suite 300
Brookfield, WI 53005
FAX: 262-787-2507
FMLNorfolk@apshealthcare.com

APS will provide on-going assistance to you while you are on leave and may contact you and/or your physician concerning your request for family medical leave.

Finally, if you are absent due to your own serious health condition, please utilize the attached fitness for duty form when a return to work date is identified.

If you have any questions or concerns, you may contact APS at 1-888-257-3407 or Paul Strickland in the Norfolk Southern HR Department at 1-757-629-2441.

Enclosures:
(1) Notice of Rights and Obligations under the Family and Medical Leave Policy
(2) Request form
(3) Certification of Healthcare Provider form or Military Leave Certification
(4) Fitness For Duty [if applicable]

FMLA Request Form / Family Military Request Form
Request for Family Care or Medical Leave

Eligible employees are entitled under the Family and Medical Leave Act (FMLA) Act to up to 12 weeks of unpaid, job protected leave for certain family and medical reasons. Family Military Leave allows up to 12 weeks for qualifying exigencies when a National Guard or Reserve service person is called to duty or on active duty, or up to 26 weeks unpaid leave to care for a covered service member who has a serious injury or illness incurred in the line of duty during a single 12-month period. Submit this request form at least 30 days before the leave is to commence, when practicable. When submission of the request 30 days in advance is not practicable, submit the request as early as is practicable. The employer reserves the right to deny or postpone leave for failure to give appropriate notice when such denial/postponement would be permitted under federal or state law.

Please fill out all information in this form.

Today's Date: ____________________

Employee Information:

Last Name ____________________ First Name ____________________ MI _____

Date of Birth ____________________ Employee Number ________________

Home Address ____

City ____________________ State ______ Zip Code ____________________

Home Phone ____________________ Phone number where you can be reached during your leave ____________________

Workplace Information:

Company: Norfolk Southern

Supervisor Name ____________________ Department ____________________

Supervisor email address____________________Supervisor phone number____________________

Eligibility:

1) Counting any periods of time that you worked for the company (whether they were consecutive or not), have you worked for the company for a total of 12 months or more? ☐Yes ☐No
2) What is your weekly work schedule? ____________________
3) Please list number of hours worked each day ____________________
4) During the past 12 months, have you worked at least 25 hours per week? ☐Yes ☐No

Reasons For Requesting Leave:

☐Personal serious health condition

☐Serious health condition of family member (please list name and relationship)

Name ____________________

Relationship: ☐Spouse ☐Son or Daughter ☐Parent ☐other________________

☐Birth of a child, expected delivery date ____________________

☐Adoption of a child or placement of a child for foster care

Child's name ____________________

Scheduled date of adoption or placement ____________________

☐A family member has been called to, or is currently on active duty

☐A family member in the Armed Services has a serious illness or injury incurred in the line of duty

Requested Leave Details:

Type of Leave Requested:

☐Continuous: **Continuous Leave means you will not be coming in to work from the day you start leave until the day your leave ends.**

From date ____________________ To date ____________________

Please indicate date you expect to return to work ____________________

☐Intermittent: **Intermittent leave is not continuous. Intermittent leave is for employees who require a reduced work schedule (either full or partial days).**

Please describe the schedule you wish to request ____

____

***Medical Information*:**

Healthcare Provider Name and specialty ____________________ Phone ____________________ Fax ____________________

Notice to Employee:

A leave involving a serious health condition requires a Healthcare Provider Certification form completed by the healthcare provider and submitted to APS Healthcare. The Provider Certification is due 15 days from the date you notify us of your request for leave. Failure to submit the Provider Certification may result in delay or denial of your request. Any costs associated with the completion or submission of the certification is the responsibility of the employee.

If this leave request is for your own serious health condition, you must have your physician/healthcare provider complete the certification.

If this leave request is for a family member's serious health condition, you must have the patient's physician/healthcare provider complete the certification.

Employee Signature: ____________________ Date: ____________________

Fax completed form to APS Healthcare 1-262-787-2507

Updated 04/14/2011

FAMILY / MEDICAL LEAVE
CERTIFICATION OF HEALTHCARE PROVIDER
(Must be completed and signed by Treating Physician)

Employee Name:	Employer Name: Norfolk Southern.	
1. **Name of Patient (if different than employee)**	2a. **Patient date of birth** :	2b. **Relationship of Patient to Employee:** ☐Self ☐Parent ☐Spouse ☐Dependent Child ☐ Age of Child

If there are multiple serious health conditions, a separate form must be completed for each condition for which FML is being requested.
Be as specific as you can; terms such as "lifetime", "unknown" or "indeterminate" may not be sufficient to determine FML coverage. Limit your responses to the condition for which the employee is seeking leave.

3. **Circle appropriate FMLA category**:	4. **Medical Facts:** (What are the medical facts that support the patient's serious health condition?)
a. Hospital Care b. Absence Plus Treatment c. Pregnancy d. Chronic Conditions Requiring Treatment e. Permanent/Long-term Conditions Requiring Treatment f. Multiple Treatments (Non-Chronic Conditions)	
5a. **Date(s) of onset and duration of condition:**	5b. Date(s) of patient's **present incapacity**:

➲6. **NOTE: Please indicate type of leave requested**
[ ] **Continuous**: Give duration of time off work: ______________________________
[ ] **Intermittent**: Please estimate episodic leave
Frequency of illness episodes: ______________________________
Duration of illness episodes: ______________________________

7. **Prescribed treatment regimen and schedule**:
[ ] Office visits: #________ per ____________________
[ ] Therapy visits: #_________ per ____________________
[ ] Prescription medication: ____________________
[ ] Referral to other providers (who): ____________________
[ ] Surgery (date): ____________________
[ ] Procedure (type/date): ____________________
[ ] Other treatments (type/dates): ____________________
____

EMPLOYEE'S OWN SERIOUS HEALTH CONDITION:

8. Is in-patient hospitalization of the employee required?	9. Is employee able to perform work of any kind?
[ ] Yes (give dates)____________________ [ ] No	[ ] Yes [ ] No

10a. Is employee able to perform [ ] sedentary work [ ] light work (up to 20 lbs lifting) [ ] medium work (Up to 50 lbs lifting)
10b. If not, please describe employee's restrictions and their duration:
Restrictions (include need for reduced work schedule):
____

FAMILY MEMBER'S SERIOUS HEALTH CONDITION:

11. Will the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation?
[ ] Yes [ ] No

12. Is the employee's presence necessary or would it be beneficial for the care of the patient? (This may include psychological comfort.)
[ ] Yes [ ] No

13. Estimate the period of time care is needed or the employee's presence would be beneficial to care for the patient.

14. **Print name of Treating Physician**:	**Address of Treating Physician:**
15. **Field of specialization, if any:**	**Office Telephone #:**
➲ **Treating Physician Signature**:	Date Signed:

Please provide copy to employee and send copy to APS Healthcare by fax: 262-787-2507, or email: FMLNorfolk@apshealthcare.com

FITNESS FOR DUTY

EMPLOYEE ______________________________ **Employer: NORFOLK SOUTHERN**

___ May return to work with complete capabilities (no restrictions) on ___________________________.

___ May return to work with restrictions as indicated below on _________________.

Restrictions:

____

____
____

____
____

Comments

____
_____

Doctor's Signature __________________________________ Date ______________________

Please provide copy to employee and send copy to APS Healthcare by fax: 262-787-2507, or email: FMLNorfolk@apshealthcare.com

FAMILY AND MEDICAL LEAVE / FAMILY MILITARY LEAVE POLICY
NOTICE OF RIGHTS AND OBLIGATIONS
FOR AGREEMENT EMPLOYEES

The following information concerns your rights and obligations under the family and medical leave / family military leave law and will explain to you the consequences of your failure to meet these obligations. Please read the information carefully, and if you have any questions, please contact APS Healthcare at 1-888-257-3407 or the NS Medical Department at 1-800-552-2306, extension 2441.

1. Leave Entitlement: The actual amount of time you spend on family and/or medical leave will be subtracted from your 12 work weeks of leave entitlement. For the actual amount of time you spend on Family military leave see section 12.

2. Medical Certification: If your leave request is based on your own serious health condition or the serious health condition of your son, daughter, spouse or parent, you must provide a medical certification prepared by patient's treating physician. The medical certification is to be provided to APS Healthcare within fifteen (15) days of the request for leave.

3. Additional Certifications: For your own serious health condition, you may be required to submit to another examination, at NS's expense, by a healthcare provider selected by the company. If the second opinion differs from the initial certification, a third opinion that is final and binding on both parties will be mutually selected by you and the company and will be paid by the company.

4. Recertification: You must provide subsequent recertification, every 30 days as requested, that your serious health condition still prevents you from performing your job functions or that you are still needed to care for a family member with a serious health condition.

5. Intent to Return to Work: You may be required to provide NS or APS Healthcare with a periodic report on your status and intent to return to work.

6. Attending Physician's Return to Work Recommendation Record: If you are on medical leave because of your own serious health condition, you must provide *a written release to return to work* signed by your health-care provider to APS Healthcare and/or Norfolk Southern's Medical Department, before you can return to work.

7. Type of Leave: Specific questions concerning Norfolk Southern's policy regarding use of paid leave should be addressed to your supervisor or manager. If you are granted FMLA leave, you may elect whether or not to use available paid sick leave, personal leave or vacation but such use is not mandatory.

8. Maintenance of Health Care and Other Benefit Coverage: You will be required to pay for your portion of the employee cost for health care coverage during your leave on the same terms as if you were actively working. If you fail to make payments while on leave, your coverage may be terminated during the remaining portion of your leave. If paid leave is substituted for the unpaid leave, your share of the cost for health care coverage and other benefits will be paid through Norfolk Southern's normal payroll deduction method.

   Once the family and medical leave expires, you may be eligible for COBRA continuation coverage if you maintain coverage during the leave.

9. Employment Protection: Upon returning to work from family medical leave, you will be reinstated to the position you held prior to leave or, if your position is no longer available, to an equivalent position with equivalent pay, benefits and other terms and conditions of employment.

10. Recovery of Premiums: If you fail to return to work after your family or medical leave, you will be liable to Norfolk Southern for any health or other benefit coverage premiums paid on your behalf by Norfolk Southern during your leave.

11. Other employment: Any employee on a family or medical leave of absence may not work elsewhere, or engage in any activities inconsistent with the basis or medical circumstances upon which the leave was granted.

12. Military Family Medical 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 session, and attending post-deployment reintegration briefings. FML 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 that may render the service member medially 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.

13. 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. It should be practicable for the employee to provide notice of the need for leave by the next business day. [Regulation 825.302] 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 must inform the employer if the requested leave is for a reason for this FML was previously taken or certified. Employees also may be required to provide certification and periodic recertification supporting the need for leave.

** FMLA requests are processed through APS Healthcare, Inc.
1-888-257-3407