Before completing the following application, please contact the Leave Coordinator/Admin at your location to check FMLA eligibility and initiate a claim. Please allow 5-7 business days for processing. All FMLA notifications are sent to your Company email.

All FMLA inquires/questions, please call: 1-877-450-9087

Employee's Serious Health Condition

Application under Family and Medical Leave Act ("FMLA")

State Laws will also apply where appropriate

SECTION 1: EMPLOYEE'S REQUIRED STATEMENT FOR EMPLOYEE'S OWN CONDITION

SECTION 1 TO BE COMPLETED BY THE EMPLOYEE

The FMLA requires that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. You may contact the Southwest FMLA Team at HDQ at 1-877-450-9087 if you have questions about your FMLA claim. **Fax this completed form to 1-877-404-4637**.

Employee Name Rene Stelzer Rousseau Employee # 46654 Date of Birth 04-23-1964

Work Location HDQ-4SY Position Analyst

Requested Leave start date 10-15-13 to 11/15/13 Claim # SWA47469

Is this a **new** leave request? ☒ **Yes** ☐ **No** ***or*** Is this a **renewal** of a previous leave? ☐ **Yes** ☒ **No**

Provide your typical weekly work schedule when not on leave: ☒ **Fulltime** ☐ **Parttime** ____ **hours/week** ____ **days/week**

Employee Acknowledgement and Signature (Read carefully and completely before signing below)**:**

By voluntarily signing this FMLA application below, I acknowledge that I have read this form, understand it and the following:

- *Southwest's FMLA Eligibility Notice and the Employee Rights & Responsibilities Notice (posted on SWALife>About Me>My Life Events>FMLA Leave) are incorporated by reference.*
- *I have not made and will not make alterations to the Healthcare Provider's Statement, Section 2, of this Application.*
- *All notifications regarding my FMLA application and claim will be sent via email addressed to my Company email address.*
- *I authorize Southwest's FMLA Team at HDQ &/or Southwest's third party medical services referral advisor, to call me at my phone number provided below and leave a voice mail message with information or questions regarding my FMLA leave application.*
- ***I authorize Southwest's FMLA Team at HDQ &/or Southwest's third party medical services referral advisor and my healthcare provider to discuss my FMLA application herein for purposes of clarification and/or authentication of the Healthcare Provider's Statement below and/or to clarify/understand the meaning (medical necessity) for any intermittent or reduced schedule leave requested. I further authorize both my health care provider and Southwest's FMLA Team or its third party medical services referral advisor to release to a medical provider performing a second or third opinion examination of my FMLA certification all relevant medical information in their possession pertaining to the serious health condition at issue. I understand that if I decline to give this authorization or my application is incomplete or insufficient, it may necessarily result in a delay and/or denial of my FMLA leave request.***

EMPLOYEE SIGNATURE: *Rene Rousseau* Date 10/29/2013

Employee Phone No. (214) 213-6638 Company email address reenie.rousseau@wnco.com

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SECTION 2: TO BE COMPLETED BY THE EMPLOYEE'S HEALTHCARE PROVIDER

Your patient/our Employee has requested FMLA leave from Southwest Airlines. Please answer ***all*** applicable parts fully and completely, limiting your responses to the serious health condition for which the Employee is seeking leave. **Please sign the form on page 3. Once fully completed, please fax pages 1-3 of this form to 1-877-404-4637**.

Part A - Designate Type of FMLA Leave Medically Necessary: ***(Treatment does not include eye, dental or routine physical exams.)***

☐ **Continuous (Taken in a single block of time):** Start Date (mm/dd/yy) _____ End Date (mm/dd/yy) _____

☒ **Intermittent (Taken in periodic, separate intervals of time):** Start Date (mm/dd/yy) 10/15/2013 End Date (mm/dd/yy) 10-28+13

☐ **Reduced Schedule (Taken as reduced work time or hours):** Start Date (mm/dd/yy) 10/31/2013 End Date (mm/dd/yy) 11/15/2013

Part B - Medical Facts: (regarding medical necessity for FMLA leave from work)

State the medical facts of the serious health condition causing the Employee to be unable to perform his/her job duties. (See job and typical work schedule above): _____

_____

Diagnosis: _____

(provide in California only if Patient/Employee allows; do not provide in Connecticut)

Symptoms: _____

Treatment Regimen: _____

Employee's Serious Health Condition

Application under Family and Medical Leave Act ("FMLA")

State Laws will also apply where appropriate

Employee Name: Rene Stelzer Rousseau (Employee, please complete) **Employee #:** 46654 (Employee, please complete) **Job Title:** Analyst (Employee, please complete)

The sections below are to be completed by the treating Health Care Provider only (continued)

Part B - Medical Facts (cont.) (See Employee's job and typical work schedule on page 1)

1. Is the Medical Condition Pregnancy? Yes☐ No☒
   a. Expected delivery date:_____
   b. Is the patient currently incapacitated due to pregnancy? Yes☐ No☒ , or for prenatal care? Yes☐ No☑
2. Approximate date condition commenced:

   _____
3. List the date(s) of any overnight inpatient stay due to patient's incapacity or subsequent treatment for this condition:

   _____
4. Is the patient under your continuing supervision (such as a long-term, permanent condition)? Yes ☑ No☐
5. Date(s) you treated or examined the patient for ***this*** condition within the ***last 12 months*** (including any current exam): _____
6. Was prescription medication ***prescribed*** by you for ***this*** condition? Yes☒ No☐
7. Was therapy ***prescribed*** by you for ***this*** condition? Yes☒ No☐
8. Was a procedure/treatment ***performed*** by you for ***this*** condition? Yes☒ No☐
9. Will any treatment(s) or exam(s) be needed in the ***next 12 months*** due to ***this*** condition? Yes ☑ No ☐

   If yes, provide number of treatment(s) or exam(s) in next 12 months: _____
10. When is the patient's ***next*** appointment with you for ***this*** condition? Scheduled appt. date: _____

    Or, if unknown, approximate appointment date: _____
11. Will this condition cause episodic or periodic flare-ups? Yes☐ No☐

    If yes, is it necessary for the patient to lose time from work due to this condition? Yes☒ No☐

    Describe why. _____

    _____
12. **Chiropractor Information (required for healthcare providers that are chiropractors):** Did you provide treatment to the Patient/Employee consisting of manual manipulation of the spine to correct a subluxation as demonstrated to exist?

    Yes☐ No ☒

Employee's Serious Health Condition

Application under Family and Medical Leave Act ("FMLA")

State Laws will also apply where appropriate

Employee Name: Rene Stelzer Rousseau (Employee, please complete) **Employee #:** 46654 (Employee, please complete) **Job Title:** Analyst (Employee, please complete)

The section below is to be completed by the treating Health Care Provider only (continued):

Part C - Amount of Intermittent or Reduced Schedule Leave Needed ***(Only if designated as a non-continuous leave on pg. 1)***

Intermittent Leave Frequency/Duration: (Please see the Employee's job and typical work schedule on pg. 1).

Based upon the ***patient's medical history*** and your knowledge of the medical condition, estimate the frequency of ***episodes, flare-ups or medical treatments*** and the duration of related incapacity and medical necessity for intermittent leave from work that the patient may have during the Employee's "typical" work schedule over the next 6 to 12 months.

(Example: 1 episode per month lasting 1-2 days, not to exceed 2 days per month (1 episode X 2 days = 2 days per month):

Frequency: 1 episodes per ☐ week ☒ month ☐ year (***choose one)***

Duration: 120 hours ***or*** 15 day(s) per episode (or less, as needed)

Reduced Schedule Leave: (Please estimate the reduced work schedule the Employee's condition necessitates. See Employee's typical work schedule on page 1)**.**

Patient/Employee ***can*** work the following reduced work schedule:

Days per week _____ Hours per day _____

NOTICE TO HEALTHCARE PROVIDERS**:** 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, Southwest asks 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 test, the fact that an individual or an individual 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. *Genetic information as defined by GINA does* **not** *include an Employee's diagnosed disease, disorder, or pathological condition, nor the signs or symptoms of the Employee's diagnosed condition and such information may be provided in support of the Employee's leave application.*

EXCEPTION TO NOTICE ABOVE: If you are completing a medical certification relating to an Employee's request for leave (1) to care for a covered family member with a serious health condition or (2) due to a serious injury or illness of a covered military service member, it is acceptable to provide the family medical history related to the individual in need of care.

Part D – Healthcare Provider Signature Block (***All*** fields must be completed):

Form Completed Date: 10/13/2013 **Specialty or area of practice:** Eye Physician & Surgeon
Specialist in retina and vitreous growth.

SIGNATURE of Healthcare Provider: _____

Print/type name of Healthcare Provider: Dr Shashi Dharma MD, FACS

Current Address 4845 South I-35, Bryden Profession Plaza II, Corinth Pkwy **City** Corinth **State** TX **Zip** 76205

Telephone number (940) 269-4230 **Fax number** (940) 269-4229