Caesars Entertainment
Human Resources Shared Services Center
3535 Las Vegas Boulevard, South
Las Vegas, NV 89109

Employee Name

Employee Address

LEAVE OF ABSENCE
Notice of Eligibility and Rights & Responsibilities

To be eligible for FMLA, an employee must have worked for an employer for at least 12 months, have worked at least 1,250 hours in the 12 months preceding the leave, and work at a site with at least 50 employees within 75 miles.

SECTION 1: NOTICE OF ELIGIBILITY

To: **Employee Name** Date: **Today's Date**

Employee ID#: **Employee 800#** Leave ID: **xxxxxxxxxxxx**

From: Human Resources Shared Services Center (HRSSC)

Phone: 877-511-HR4U Fax: 702-794-3385

On you informed us that you needed leave beginning on for:

X **(Leave Reason)**

Based on the information provided, you are eligible to apply for leave. However, you must complete the approval process before leave can be granted.

This notice is to inform you that you:
Are eligible for FMLA leave (See Section 2 for information on enclosed documents and Section 3 for Rights and Responsibilities)

If you have any questions, please contact the Human Resources Shared Services Center at 1-877-511-HR4U, or view the FMLA poster located in your Human Resources Office

SECTION 2: INFORMATION REGARDING ENCLOSED DOCUMENTS

Step 1: Complete and return the following documentation
- Request for Leave of absence – to be completed by employee
- Certification of Health Care Provider – to be completed by employee and health care provider

We require that you submit a timely, complete, and sufficient certification to support a request for a leave of absence due to a serious health condition. Failure to provide a complete and sufficient medical certification; may result in a denial and/or delay of your leave of absence request. Please be advised that you must return this form to the HR Shared Services Center within 15 calendar days from receipt of this form or 30 days prior to the start of your leave, whichever is later.

Step 2: You will receive notice that your request is either approved or denied. If the leave request is denied, we will tell you why.

If you have any questions, please contact the Human Resources Shared Services Center at 1-877-511-HR4U, or view the FMLA poster located in your Human Resources Office

SECTION 3: RIGHTS AND RESPONSIBILITIES FOR TAKING LEAVE

Please note you will have the following rights and responsibilities, in connection to your request and/or approval for a leave:

New leave for your own serious health condition or to care for a family member

You have submitted a request for a leave of absence. ***However, in order for us to determine whether your absence qualifies as FMLA leave or any other leave type, you must return the Request for Leave of Absence and Certification of Health Care Provider documents together within 15 calendar days from receipt of this form or 30 days prior to the start of your leave, whichever is later.*** (Additional time may be granted in some circumstances.) If sufficient information is not provided in a timely manner, your leave may be denied.

Once we obtain the Request for Leave of Absence and Certification of Health Care Provider form, we will inform you, within 5 business days, whether your leave will be designated as FMLA leave and count towards your FMLA leave entitlement. If you have any questions, please contact the Human Resources Shared Services Center at 877-511-HR4U.

Your health care provider may send or fax medical documentation to your employer; however it remains your responsibility to follow up with the Human Resources Shared Services Center to ensure all appropriate documentation is received.

It is your responsibility to call out to your department in accordance with the Attendance Policy until your leave of absence has been approved. Failure to properly notify your department of your absence, tardy, early out, etc. may result in attendance points and/or other disciplinary action, up to and including separation of employment.

Engaging in employment outside the Company while on leave (without Company approval) will be considered voluntary resignation without notice.

In all states where allowed, please be advised that FMLA runs concurrently with, and is not in addition to, any form of paid leave. If this leave is in any way associated with any work-related illness or injury, you must report any and all such prior occurrences to the Company in accordance with Company Policy

Company Paid Disability Benefits

Unless otherwise elected, the Company will maintain your current benefit elections during your leave under the same terms as active employees, provided you continue to make your premium co-payments. If you are receiving PTO or Vacation, the contributions will be withheld directly from your paycheck. You will receive payment notices from the Caesars Benefits Service Center for pay periods when you do not have sufficient income to cover the contributions. Your contributions are due within 30 days of the billing date. If contributions are not paid in a timely manner, your benefits will be terminated. You can contact the Caesars Benefits Service Center at 866-236-3487 for any benefit questions. If you are part time, your insurance premium will be collected upon your return. Please contact Starbridge at 800-754-1896 if you have any questions regarding part time benefits.

You understand that your leave will be unpaid unless you or the Company elects to substitute available paid benefits (e.g. PTO/Vacation, disability, and worker's compensation) during the course of your leave.

Caesars 401k elections stay the same. However, if you are on an approved leave of absence, including military duty, the plan administrator may grant a grace period (up to 12 months). During the period you are on leave, you are not required to make loan payments. Loan payments will be made up when you return; your prior loan payment amount will increase to cover your missed payments

Short-Term Disability pay is a Company provided benefit for full-time non-union employees, which you may or may not be eligible to receive subject to medical verification of your own health condition. ***You are responsible for initiating the claim by*** contacting Prudential at 1-866-SICK PAY (742-5729) if you are covered by Caesars benefit's plan.

State Disability and State Paid Leave Benefits

Forms can be obtained from the State specific DOL website or by calling the Employee Service Center. Follow the directions on the form as to what you may need to complete and what your Health Care Provider must complete. If the form requires employee information the forms can be mailed or faxed to the HR Shared Service Center at the address in Section 2 of this document. The Employer's portion of the form will be completed and the form will be returned to you for submission to the State.

Leave Extension or Return to Work

If you miss 5 or more days of work and the leave is for your own health condition, you may not return to work until you have submitted a fitness for duty certificate (a release from your Health Care Provider stating you are capable of performing the essential functions of your position, with or without a reasonable accommodation) to the Human Resources Shared Services Center. The fitness for duty certificate must be submitted as soon as issued by your physician in order to arrange your return to work schedule

As a condition of employment, you may be required to report at least every 30 days as to your status and intent to return to work. Periodically during the course of your leave, you may also be asked to provide additional medical certification.

You will be reinstated to the same and/or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA-protected leave. (If your leave extends beyond the end of your FMLA entitlement, or you are approved for Caesars Medical Leave or Personal Leave, you do not have return rights.)

If you do not return to work following FMLA leave for a reason other than: (1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; (2) the continuation, recurrence or onset of a covered service member's serious injury or illness which would entitle you to FMLA leave; or (3) other circumstances beyond your control, at the company's discretion, you will be required to reimburse us for our share of health/life/disability coverage paid on your behalf during your FMLA leave, if applicable.

* Medical leave of absence ceases on the day the doctor releases you to return to work or the end of the leave period under the Company's policy, whichever is sooner.

If approved, and the circumstances of your leave change and you are able to return to work earlier than the date approved, you will be required to notify us at least two work days prior to the date you intend to report for work.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

1. **Authorization**: I, **Employee Name,** hereby authorize _____ (Provider Name) to disclose to the Caesars Employee Service Center (ESC), the following protected health information ("PHI"):

any and all records, notes (other than psychotherapy notes), prescriptions, physician's orders and information, without limitation, concerning examinations, diagnoses, treatment, counseling or other care administered to me. This authorization includes all records relating to any alcohol or drug problem, any mental, emotional or other psychiatric problem (other than psychotherapy notes).

2. **Purpose of the Disclosure: Employee Health Condition/Intermittent leave** ***and*** **Employee Name,** to determine eligibility for Federal and/or State Family Medical Leave (FML) law and/or pursuant to a company leave policy.

3. **Revocation Rights**: I understand that I have the right to revoke this Authorization at any time by sending a written notice of revocation to the health care provider identified in paragraph 1, above. I understand that the revocation will become effective upon receipt. I understand that any PHI disclosed pursuant to this Authorization before the effective date of a revocation will not be subject to the revocation.

4. **Further Disclosure**: I understand that once the health care provider identified in paragraph 1, above, discloses PHI pursuant to this Authorization, the PHI may no longer be protected under federal law, and the recipient may further disclose the PHI which it receives pursuant to this Authorization without my consent to the extent permitted by applicable state law.

5. **Expiration Date**: I understand that this Authorization will expire upon completion of the need for leave requested above in item #2.

6. **Genetic Information**: 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 an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. *'[if the authorization is directed to an employer-selected health care provider, "provide any genetic information when responding to" with "request any genetic information in connection with any examination conducted for purposes of providing in response to"]* 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.

7. I understand that neither treatment, payment, enrollment, nor eligibility for benefits will be conditioned on my signing this Authorization.

8. I understand that I am entitled to receive a copy of this Authorization.

Signature:_____ Date: _____

Return completed form to:
Caesars' HR Shared Services Center – phone 1-877-511-HR4U / FAX 702-794-3385
Address 3535 Las Vegas Boulevard, South, Las Vegas, NV 89109

Employee Name 800xxxxxx

FMLA LEAVE CERTIFICATION FORM FOR EMPLOYEES OWN SERIOUS HEALTH CONDITION

Please be advised that you must return this form to the HR Shared Services Center within 15 calendar days from receipt of this form or 30 days prior to the start of your leave, ABSENT EXTENUATING CIRCUMSTANCES.

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SECTION I: For Completion by the EMPLOYER

Employer name: _____ Employer Contact: Employee Service Center (ESC) 1-877-511-4748

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions: _____

_____

Check if job description is attached: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request.

Your name: _____
First Middle Last

SECTION III. For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

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 an individual or family member of the individual, except as specifically allowed by this 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 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.

Provider's name: _____ Practice/Specialty: _____

Business address: _____

Telephone: (_____) _____ Fax: (_____) _____

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PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

Probable duration of condition:_____

Mark below as applicable:
Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
____No ___ Yes. If so, dates of admission:

_____

Date(s) you treated the patient for condition:

_____

Will the patient need to have treatment visits at least twice per year due to the condition? ___ No ___ Yes.

Was medication, other than over-the-counter medication, prescribed? ____ No ____ Yes.

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
___ No ____ Yes. If so, state the nature of such treatments and expected duration of treatment:

_____

2. Is the medical condition pregnancy? ___ No ___ Yes. If so, expected delivery date: _____

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions of a job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition: ____ No ____ Yes.

If so, identify the job functions the employee is unable to perform:

_____

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

_____

_____

_____

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due his/her medical condition, including any time for treatment and recovery? ___ No ____ Yes.

If yes, provide:

Begin date for period of incapacity: _____ **Anticipated end date** for the period of incapacity: _____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ____ No ____ Yes.

If so, are the treatments or the reduced number of hours of work medically necessary?
____ No ___ Yes.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

_____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions?
___ No _____ Yes.

Is it medically necessary for the employee to be absent from work during the flare-ups?
_____ No _____ Yes. If so, explain:

_____

_____

I. If you responded **YES** to **QUESTION 6** OR **QUESTION 7** please provide the duration of related incapacity that the patient may have over the next 1 - 12 months:

Anticipated From DATE _____ **Through** DATE_____

II. Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of episodic flare-ups and the duration of related incapacity that the patient may have over the date range provided in (I.) above (e.g., 1 episode every 3 months lasting 1-2 days; 2 episodes every week lasting 2-3 hours per episode):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or ____ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____ _____

Signature of Health Care Provider **Date**

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Employee Name 800xxxxxx