Local 591 EAP / Member Assistance

Credit IAM EAP, LAP

April 2023

April is Alcohol Awareness Month

(excerpts from niaaa.nih.gov)

Signs of an Alcohol Problem

Alcohol use disorder (AUD) is a medical condition that doctors diagnose when a patient's drinking causes distress or harm. The condition can range from mild to severe and is diagnosed if you answer "yes" to two or more of the following questions.

In the past year, have you:

- Had times when you ended up drinking **more, or longer** than you intended?
- More than once wanted to **cut down or stop drinking**, or tried to, but couldn't?
- Spent a **lot of time** drinking? Or being sick or getting over the aftereffects?
- Experienced **craving**—a strong need, or urge, to drink?
- Found that drinking—or being sick from drinking—often **interfered with taking care** of your **home** or **family**? Or caused **job** troubles? Or **school** problems?
- Continued to drink even though it was causing **trouble** with your **family** or **friends**?
- **Given up** or **cut back** on **activities** that were important or interesting to you, or gave you pleasure, in order to drink?

- More than once gotten into situations while or after drinking that **increased your chances of getting hurt** (such as driving, swimming, using machinery, walking in a dangerous area, or having unsafe sex)?
- Continued to drink even though it was making you feel **depressed or anxious** or adding to **another health problem**? Or after having had a **memory blackout**?
- Had to **drink much more** than you once did to **get the effect** you want? Or found that your **usual number** of drinks had **much less effect** than before?
- Found that when the effects of alcohol were wearing off, you **had withdrawal symptoms**, such as trouble sleeping, shakiness, irritability, anxiety, depression, restlessness, nausea, or sweating? Or sensed things that were not there?

If you have any of these symptoms, your drinking may already be a cause for concern. The more symptoms you have, the more urgent the need for change. Your EAP (Employee Assistance Program) representative can help determine if your symptoms indicate if AUD is present. For an online assessment of your drinking pattern, go to RethinkingDrinking.niaaa.nih.gov.

Types of Treatment

Behavioral Treatments

Behavioral treatments are aimed at changing drinking behavior through counseling. They are led by health professionals and supported by studies showing they can be beneficial.

Medications

Three medications are currently approved in the United States to help people stop or reduce their drinking and prevent relapse. They are prescribed by a primary care physician or other health professional and may be used alone or in combination with counseling.

Mutual-Support Groups

Alcoholics Anonymous (AA) and other 12-step programs provide peer support for people quitting or cutting back on their drinking. Combined with treatment led by health professionals, mutual-support groups can offer a valuable added layer of support.

For anyone thinking about treatment, talking to a primary care physician is an important first step—he or she can be a good source for treatment referrals and medications. A primary care physician can also:

- Evaluate a patient's drinking pattern.
- Help craft a treatment plan.
- Evaluate overall health.
- Assess if medications for alcohol may be appropriate.

Your EAP Representative listed below can help you if you are experiencing a mental health or substance use issue. Contact them for a free and confidential consultation.

FESTIVAL DE CANNES

After 11 days of an exceptional edition, the April of the 75th Festival de Cannes, chaired by French actor Vincent Lindon, surrounded by Iranian director Asghar Farhadi, British-American actress and director Rebecca Hall, French director Ladj Ly, American director Jeff Nichols, Indian actress Deepika Padukone, Swedish actress Noomi Rapace, Norwegian director Joachim Trier and Italian actress and director Jasmine Trinca, presented its winners' list among the 21 films presented in Competition this year.

Short Films

PALME D' OR

RECOVERY WAYS directed by Lepore and Morse

AWARD FOR BEST SCREENPLAY

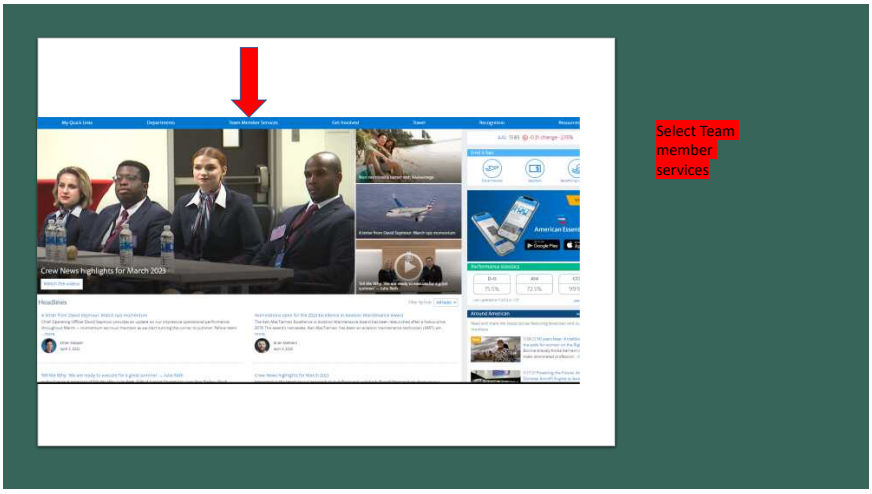
RECOVERY WAYS MENTAL HEALTH directed by Morse and Lepore

BEST DIRECTOR PRIZE

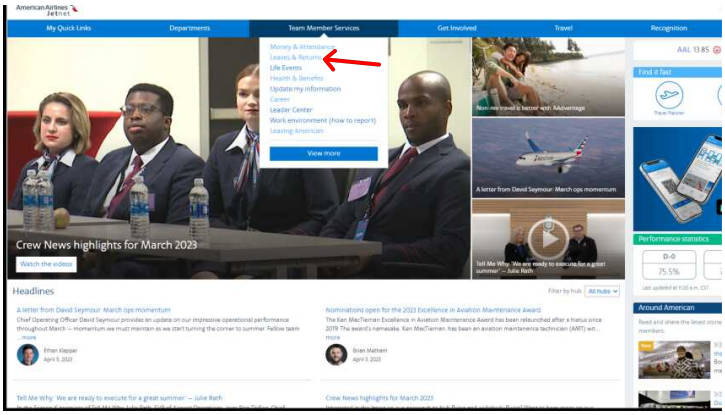
Lepore and Morse for ***RECOVERY WAYS***

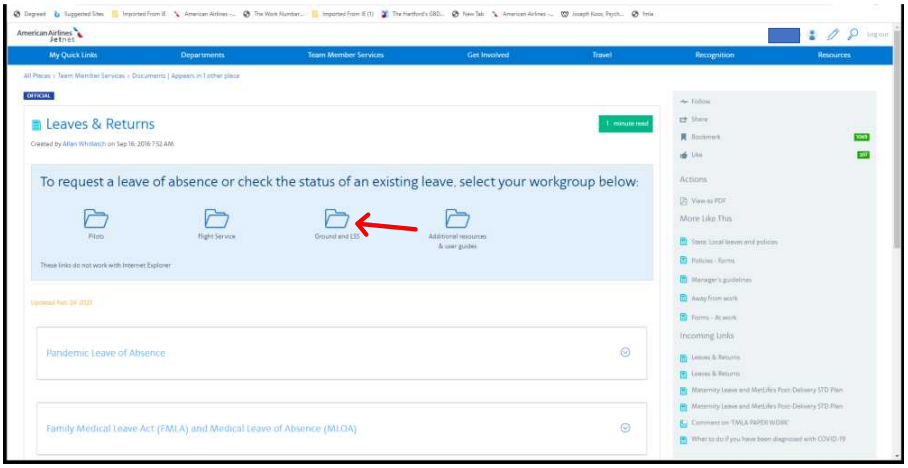
Benefits and you:

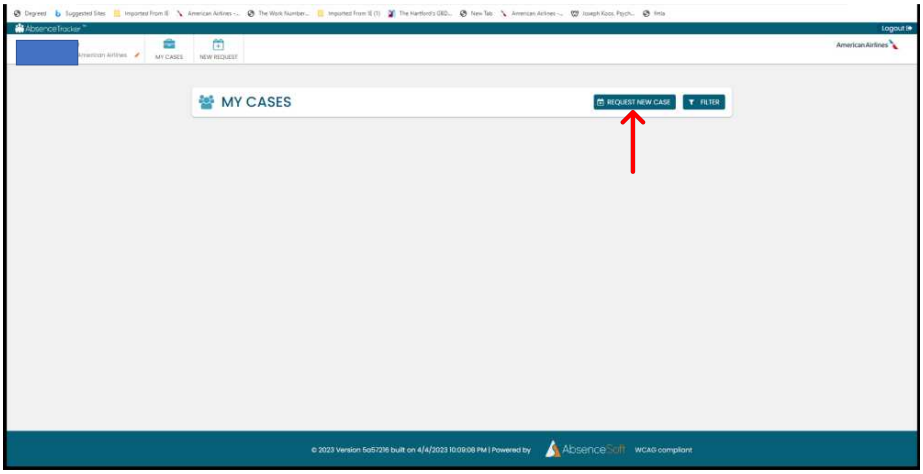
Jetnet step by step FMLA

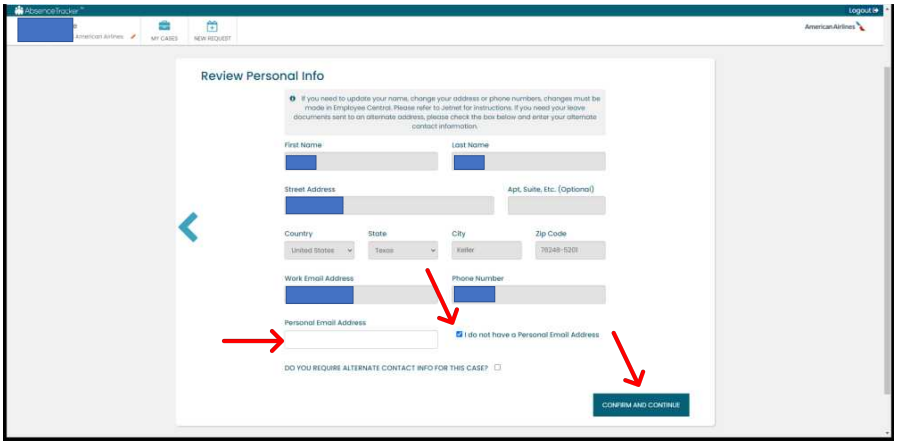


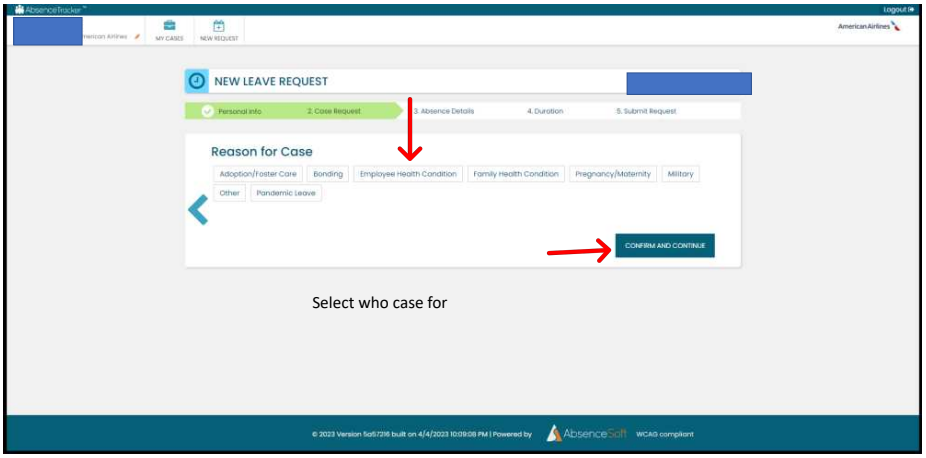
Leaves and returns



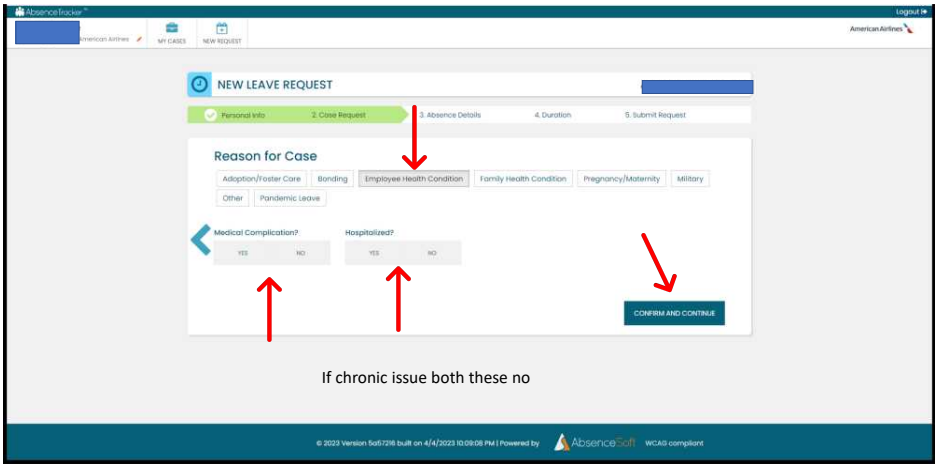




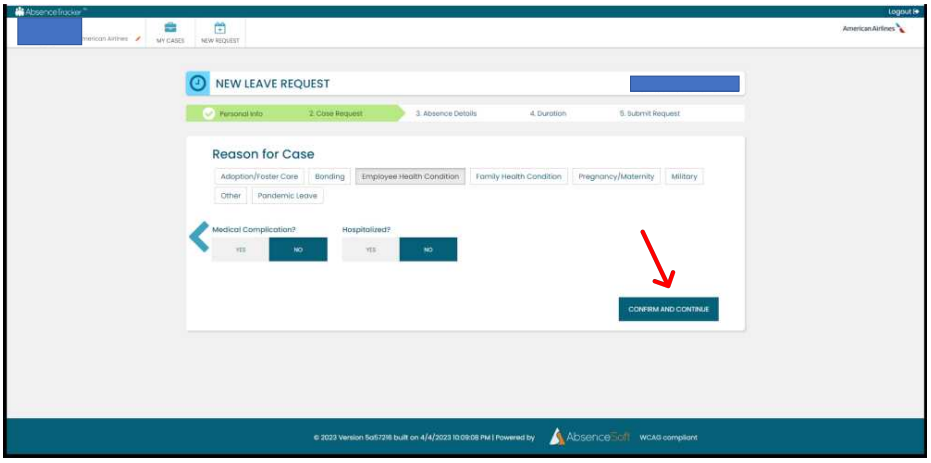


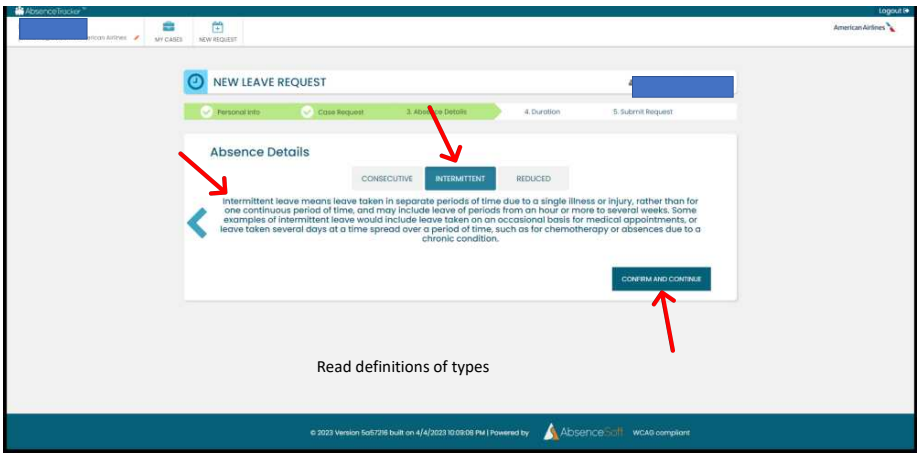


Select who case for

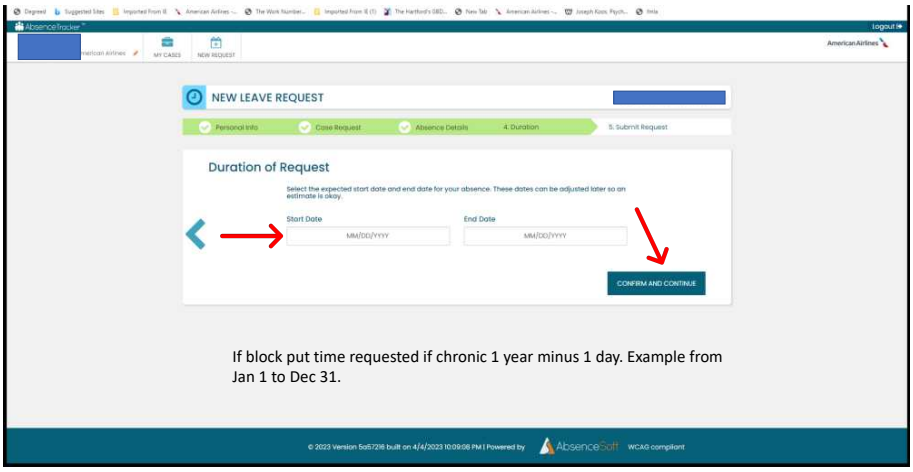


If chronic issue both these no

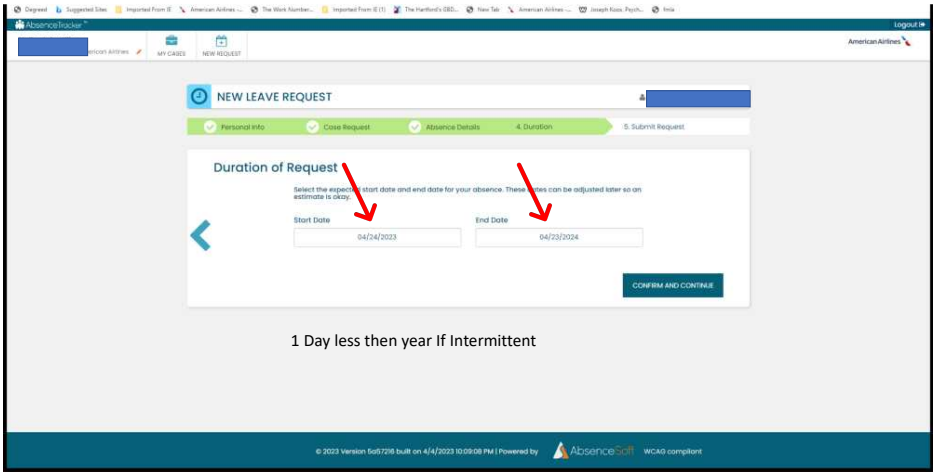




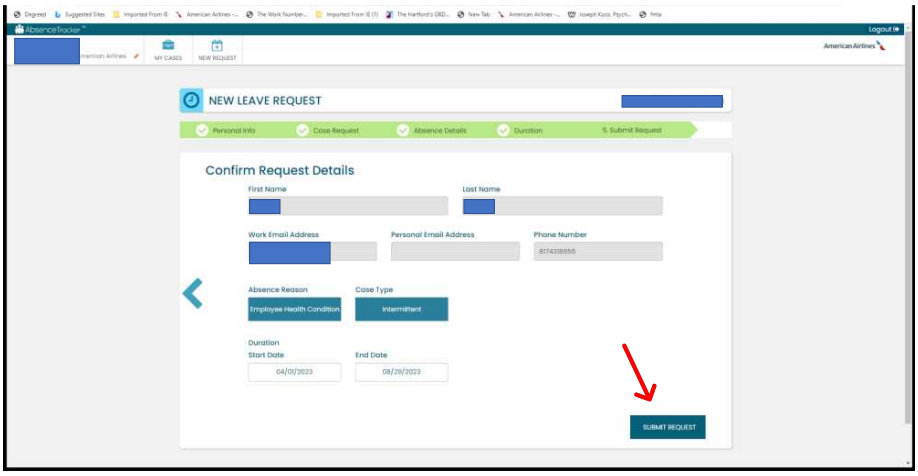
Read definitions of types

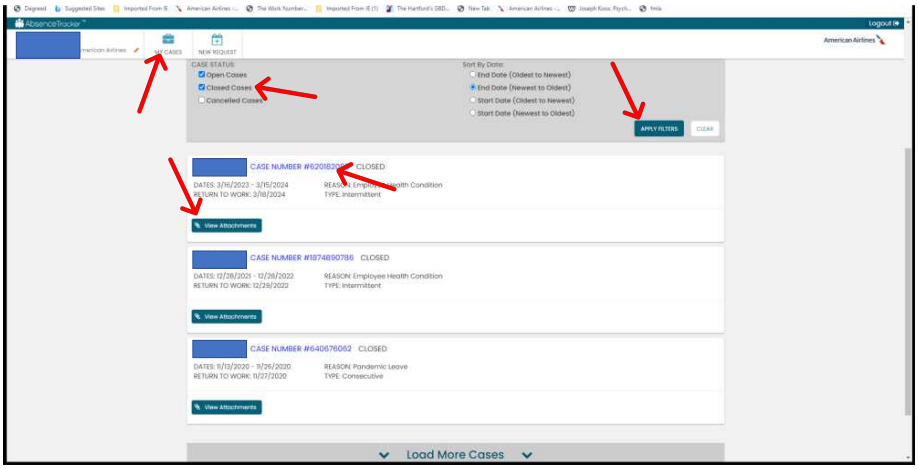


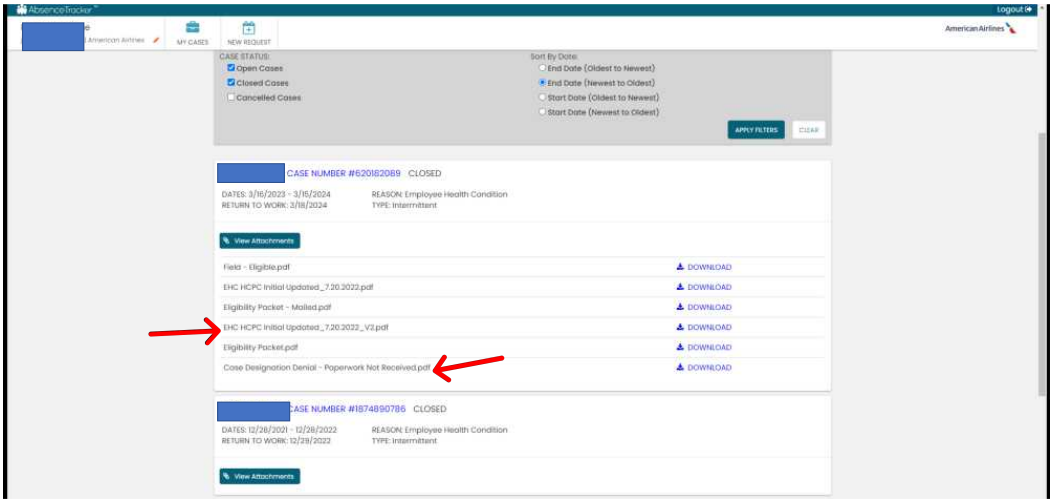
If block put time requested if chronic 1 year minus 1 day. Example from Jan 1 to Dec 31.

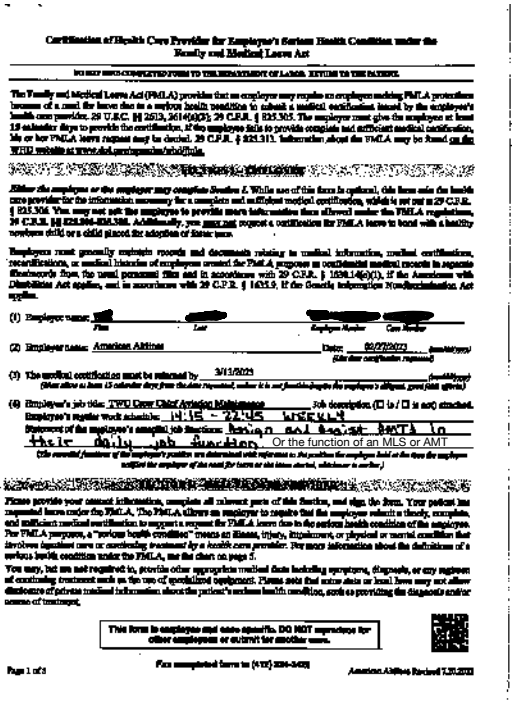


1 Day less then year If Intermittent


NEW LEAVE REQUEST
Personal Info
Case Request
Absence Details
Duration
Submit Request
Confirm Request Details
First Name
Last Name
Work Email Address
Personal Email Address
Phone Number
Absence Reason
Employee Health Condition
Case Type
Intermittent
Duration
Start Date
04/01/2023
End Date
08/29/2023
SUBMIT REQUEST


CASE STATUS:
Open Cases
Closed Cases
Cancelled Cases
Sort By Date:
End Date (Oldest to Newest)
End Date (Newest to Oldest)
Start Date (Oldest to Newest)
Start Date (Newest to Oldest)
APPLY FILTERS
CLEAR
CLOSED
View Attachments
CASE NUMBER #1874890786 CLOSED
DATES: 12/28/2021 - 12/28/2022
RETURN TO WORK: 12/29/2022
REASON: Employee Health Condition
TYPE: Intermittent
CASE NUMBER #640676062 CLOSED
DATES: 11/13/2020 - 11/26/2020
RETURN TO WORK: 11/27/2020
REASON: Pandemic Leave
TYPE: Consecutive
Load More Cases





Certification of Health Care Provider for Employee's Serious Health Condition under the Family and Medical Leave Act

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR. RETURN TO THE PATIENT.

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. 29 U.S.C. §§ 2613, 2614(c)(3); 29 C.F.R. § 825.305. The employee must give the employer at least 15 calendar days to provide the certification, if the employee fails to provide complete and sufficient medical certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

Either the employee or the employer may complete Section I. While use of this form is optional, this form asks the health care provider for the information necessary for a complete and sufficient medical certification, which is set out in 29 C.F.R. § 825.306. You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306–.308. Additionally, you may not request a certification for FMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care.

Employers must generally maintain records and documents relating to medical information, medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

(1) Employee name: [redacted] (First, Last, Employee Number, Case Number)

(2) Employer name: American Airlines Date: 02/27/2023 (mm/dd/yyyy) (Date this certification requested)

(3) The medical certification must be returned by 3/13/2023 (mm/dd/yyyy) (Must allow at least 15 calendar days from the date requested, unless it is not practicable despite the employee's diligent, good faith efforts.)

(4) Employee's job title: TPU Crew Chief Avionic Maintainer Job description: (☒ is / ☐ is not) attached.

Employee's regular work schedule: 14:15 - 22:45 WSEWLH

Statement of the employee's essential job functions: Perform all basic duties in their daily job assignment. Or the function of an MLS or AMT

(The essential functions of the employee's position are determined with reference to the position the employee held at the time the employee notified the employer of the need for leave or the time when the adverse action was taken, whichever is earlier.)

Please provide your current information, complete all relevant parts of this Section, and sign the form. Your patient has requested leave under the FMLA. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of the employee. For FMLA purposes, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves inpatient care or continuing treatment by a health care provider. For more information about the definitions of a serious health condition under the FMLA, see the chart on page 3.

You may, but are not required to, provide other appropriate medical facts including symptoms, diagnosis, or any regimen of continuing treatment such as the use of prescribed equipment. Please note that some state or local laws may not allow disclosure of private medical information about the patient's serious health condition, such as providing the diagnosis and/or names of treatment.

This form is employee and case specific. DO NOT reproduce for other employees or submit for another case.

Fax completed form to (470) 236-3429

Employer Name: [redacted] Employee Number: [redacted] Case Number: [redacted]

PART A: Medical Information

Limit your response to the medical condition(s) for which the employee is seeking FMLA leave. Your answers should be your best estimate based upon your medical knowledge, experience, and examination of the patient. After completing Part A, complete Part B to provide information about the amount of leave needed. Note: For FMLA purposes, "incapacity" means inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

(1) State the approximate date the condition started or will start: 1975 age 7 in mid-

(2) Provide your best estimate of how long the condition lasted or will last: lifetime

(3) Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

- ☐ **Inpatient Care:** The patient (☐ has been / ☐ is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): _____
- ☐ **Incapacity plus Treatment:** *(e.g. outpatient surgery, drug therapy)* Due to the condition, the patient (☐ has been / ☐ is expected to be) incapacitated for more than three consecutive, full calendar days from _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*.
  The patient (☐ was / ☐ will be) seen on the following date(s): _____
  The condition (☐ has / ☐ has not) also resulted in a course of continuing treatment under the supervision of a health care provider *(e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment)*
- ☐ **Pregnancy:** The condition is pregnancy. List the expected delivery date: _____ *(mm/dd/yyyy)*
- ☒ **Chronic Conditions** *(e.g. asthma, migraine headaches)* Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.
- ☐ **Permanent or Long Term Conditions:** *(e.g. Alzheimer's, terminal stages of cancer)* Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).
- ☐ **Conditions requiring Multiple Treatments:** *(e.g. chemotherapy treatments, restorative surgery)* Due to the condition, it is medically necessary for the patient to receive multiple treatments.
- ☐ **None of the above:** If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed. Go to page 5 to sign and date the form.

(4) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave *(e.g., use of medication, therapies)*: _____

Employee Name: [redacted] Employee Number: [redacted] Case Number: [redacted]

PART B: Amount of Leave Needed

For the medical condition(s) checked in Part A, complete all that apply. 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.

(5) Due to the condition, the patient (☐ had / ☐ will have) **planned medical treatment(s)** (scheduled medical visits) *(e.g. psychotherapy, prenatal appointments)* on the following date(s): 2/14/2023, 5/16/2023, 8/16/2023, 11/25/2023, 2/26/2023

(6) Due to the condition, the patient (☐ was / ☐ will be) **referred to other health care provider(s)** for evaluation or treatment(s).
State the nature of such treatments: *(e.g. cardiologist, physical therapy)* N/A

Provide your **best estimate** of the beginning date _____ *(mm/dd/yyyy)* and end date _____ *(mm/dd/yyyy)* for the treatment(s).

Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery *(e.g. 3 days/week)*
Patient will need to be seen every 3 months and as needed

Please choose and complete the information for only one of the following Three Leave Types

(7) Due to the condition, it is medically necessary for the employee to work a **reduced schedule**.

N/A Provide your **best estimate** of the reduced schedule the employee is able to work. From _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)* the employee is able to work: *(e.g., 5 hours/day, up to 25 hours a week)*

(8) Due to the condition, the patient (☐ was / ☐ will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.

N/A Provide your **best estimate** of the:
Beginning Date_____ *(mm/dd/yyyy)* and End Date_____ *(mm/dd/yyyy)* for the period of incapacity.

(9) Due to the condition, it (☐ was / ■ is / ☐ will be) medically necessary for the employee to be absent from work on an **intermittent basis** (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Episodes of incapacity are estimated to occur 1-3 times per (☐ day / ☐ week / ■ month) and are likely to last approximately 1-3 (☐ hours / ■ days) per episode.

Provide your **best estimate** of the:
Beginning Date 03/01/2023 *(mm/dd/yyyy)* and End Date 03/01/2024 *(mm/dd/yyyy)* for the period of incapacity.

Employee Name: [redacted] Employee Number: [redacted] Case Number [redacted]

PART C: Essential Job Functions:

If provided, the information in Section I question #4 may be used to answer this question. If the employer fails to provide a statement of the employee's essential functions or a job description, answer these questions based upon the employee's own description of the essential job functions. An employee who must be absent from work to receive medical treatment(s), such as scheduled medical visits, for a serious health condition is considered to be *not able* to perform the essential job functions of the position during the absence for treatment(s).

(10) Due to the condition, the employee (☐ was not able / ☐ is not able / ☐ will not be able) to perform *one or more* of the essential job function(s). Identify at least one essential job function the employee is not able to perform:

If he feels blood sugar is low, will need to test blood sugar and treat Due to a short Leg and type 1 diabetes.

Do not complete this section if you are treating a California based team member.

If you are a chiropractor completing this form, please respond to these two questions per 29 CFR 825.125(b)(1).

For chiropractic use only:

Has Subluxation of the spine has been demonstrated to exits by x-ray imaging? ____Yes ____No

If yes, date of x-ray_____

Is the patient being treated by manual manipulation of the spine of subluxation of the spine? ____Yes ____No

Signature of Health Care Provider [redacted] Date 03/01/2023 *(mm/dd/yyyy)*

Health Care Provider's name: *(Print)* [redacted]

Health Care Provider's business address: [redacted]

Type of practice / Medical specialty: Endocrinology

Telephone [redacted] Fax: [redacted] E-mail: _____

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Fax completed form to (412) 324-3426

Definitions of a Serious Health Condition *(See 29 C.F.R. §§ 825.113-.115)*

Inpatient Care

- An overnight stay in a hospital, hospice, or residential medical care facility.
- Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.

Continuing Treatment by a Health Care Provider (any one or more of the following)

Incapacity Plus Treatment: A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either:

- Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or,
- At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.

Pregnancy: Any period of incapacity due to pregnancy or for prenatal care.

Chronic Conditions: Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.

Permanent or Long-term Conditions: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.

Conditions Requiring Multiple Treatments: Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 15 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

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Fax completed form to (412) 324-3426

American Airlines Revised 7.20.2022

591 CONTACT INFO:

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Northeast Region

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Danny Wilson - (631) 334-0933 d.wilson@local591.com Northeast Regional EAP and Benefits Coordinator

Southeast Region

Rawle Skeete (954) 559-7505 r.skeete@local591.com Southeast Regional EAP and Benefits Coordinator

Phil Revollo (954) 665-7383 MIA EAP and Benefit Member Assistance Peer

Central Region

Ken Morse (815) 483-8585 k.morse@local591.com National EAP and Benefits Director

Mark Smejkal (847)757-1954 markj.8001@gmail.com ORD EAP and Benefits Member Assistance Peer

Hector Posa (815) 323-9648. ORD MLS EAP and Benefits Member Assistance Peer

Southwest Region

John Kline (817) 819-7230 johnklinetwu@gmail.com DFW EAP and Benefits Member Assistance Peer (Terminal)

David Emerline (469) 408-8197 EEMERLINEE07@YAHOO.COM DFW (MLS) EAP and Benefits Member Assistance Peer

West Region

Sean Bruno (310) 594-2025 s.bruno@local591.com West Regional EAP and Benefits Coordinator

Edwin Joseph (310) 709-4755 jord352000@yahoo.com LAX EAP and Benefits Member Assistance Peer

Sabrina Dooley (404) 245-6048 Sabrinadooleyp@aol.com SFO EAP and Benefits Member Assistance Peer