FMLA PACKET

FAMILY MEMBER'S SERIOUS HEALTH CONDITION

This Family Leave Packet includes:
1) Family Leave Policy
2) Certification of Health Care Provider for Employee's Serious Health Condition (WH-380-E)

Employee Responsibilities:

- The employee must submit a written request at least 30 days prior to the commencement of leave in cases where the leave is foreseeable and make reasonable efforts in scheduling leave to avoid disrupting the work unit. The request should be directed to the supervisor and Human Resources. If an employee becomes aware of a need for Family Leave less than 30 days in advance, the employee must provide notice as soon as practical.
- Family Leave requests must be supported by a Certification of Health Care Provider form (attached).
- Section I is completed by Human Resources and the supervisor. o Section Il is completed by the employee.
- Section Ill is completed by the treating health care provider.
- The employee must return the completed certification form to Human Resources.

Failure to provide medical certification in a timely manner may delay the commencement of leave or result in denial of the request for Family Leave.

FAMILY LEAVE

Eligibility Any regular employee who has completed 12 months of benefits-eligible employment may request Family Leave, which is unpaid, job-protected leave. The "rolling" 12-month method is used for calculating Family Leave, which is measured backward from the date an employee uses any Family Leave. Each time an employee takes Family Leave the remaining entitlement would be any balance of the 12 weeks.

Leave Requirement-Family Leave may be granted for: (1) the birth of a child or placement of an adopted or foster child; or (2) the serious health condition of the employee or the employee's spouse, child or parent. Leave may be taken for the birth or placement of a child only within 12 months of that birth or placement. When available, all appropriate paid leave must be used prior to the commencement of unpaid leave.

Basic Family Leave A maximum of 12 weeks may be granted for the following reasons:

- A serious health condition that makes the employee unable to perform his/her job;
- To care for the employee's spouse, son, daughter, or parent, who has a serious health condition;
- Incapacity due to pregnancy, prenatal medical care or child birth; or
- To care for the employee's child after birth, or placement for adoption or foster care.

Leave may be taken for the birth or placement of a child only within 12 months of that birth or placement. Appropriate paid leave will run concurrently with Family Leave. When available, all appropriate paid leave must be used prior to the commencement of unpaid Family Leave.

Military Family Leave 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 sessions, and attending post-deployment reintegration briefings.

A special leave entitlement 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 duty that may render the service member medically 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.

Leave Requests Employees must submit a written request at least 30 days prior to the commencement of leave in cases where the leave is foreseeable and the employee must make reasonable efforts in scheduling leave to avoid disrupting the work unit. When an employee becomes aware of a need for Family Leave less than 30 days in advance, the employee must provide notice as soon as practical.

Intermittent Leave for a serious health condition may be taken intermittently or the employee may work a reduced schedule if "medically necessary." Leave may be taken on an intermittent basis or work schedule may be reduced for the birth or placement of a child only if the employer agrees to the arrangement.

Certification Family Leave requests must be documented by a health care provider's certification of a serious health condition for the employee or that of a family member (spouse, child, or parent). Recertification will be required as needed. A Certification of Health Care Provider form is available in the Office of Human Resources or can be downloaded at the Human Resources website under Employee Forms. For paid sick leave to be used for absences relating to childbirth, personal illness, or the illness of a family member covered by the Sick Leave policy, a health-care provider's certification is also necessary (see "Sick Leave" section). A copy of the adoption papers and an indication of the expected return-to-work date in the written leave request are sufficient to document the use of Family Leave for adoption purposes. Failure to provide medical certification in a timely fashion may delay the commencement of leave or result in denial of the request for Family Leave.

Serious Health Condition A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of his/her job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than three consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Pay Status Absences in excess of accrued sick leave (when appropriate) and annual leave are unpaid. Although there are some exceptions (e.g., absences connected to work-related injuries), the university generally is not able to hold jobs for more than 12 weeks. If an employee is unable to return to work at the end of the 12 week Family Leave absence, employment will be terminated.

Benefits Eligibility During an approved Family Leave, an employee remains eligible to continue in the medical, FSA, life, accidental death & dismemberment, long-term disability, and tuition remission plans. Continued eligibility is contingent upon timely receipt of the employee premium contribution. Employees on unpaid leave must make arrangements to pay for the cost of their benefit premiums out of pocket. Arrangements for paying such premiums should be made with the Office of Human Resources prior to the commencement of the leave. The university will continue to contribute its portion of the total premium.

Certification of Health Care Provider for Family Member's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

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

OMB Control Number: 1235-0003
Expires: 5/31/2018

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees' family members, 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.

Employer name and contact: _____

_____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your family member or his/her 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 to care for a covered family member with a serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Your name: _____
First Middle Last

Name of family member for whom you will provide care: _____
First Middle Last

Relationship of family member to you: _____

If family member is your son or daughter, date of birth: _____

Describe care you will provide to your family member and estimate leave needed to provide care:

_____

_____

_____

_____ _____
Employee Signature Date

CONTINUED ON NEXT PAGE

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. 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 patient needs leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e). Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address:_____

Type of practice / Medical specialty: _____

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

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

   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: _____

   Was medication, other than over-the-counter medication, prescribed? ___No ___Yes.

   Will the patient need to have treatment visits at least twice per year due to the condition? ___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. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ___No ___Yes.

   Estimate the beginning and ending dates for the period of incapacity: _____

   During this time, will the patient need care? __ No __ Yes.

   Explain the care needed by the patient and why such care is medically necessary:

5. Will the patient require follow-up treatments, including any time for recovery? ___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:

   _____

   Explain the care needed by the patient, and why such care is medically necessary: _____

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? __ No __ Yes.

   Estimate the hours the patient needs care on an intermittent basis, if any:

   _____ hour(s) per day; _____ days per week from _____ through _____

   Explain the care needed by the patient, and why such care is medically necessary:

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ____No ____Yes.

   Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

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

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

   Does the patient need care during these flare-ups? ____ No ____ Yes.

   Explain the care needed by the patient, and why such care is medically necessary: _____

_____ ____ ___

_____ ____ ___

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Health Care Provider **Date**

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 20 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 Ave., NW, Washington, DC 20210.
DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.