Family Medical Leave Act (FMLA)

What is FMLA?

FMLA is the Family Medical Leave Act which entitles eligible employees to take up to 12 weeks of unpaid, protected* time off in a 12 month period for:

- The birth or adoption of a child (including foster care placement)
- Serious health condition of the employee *OR* of a spouse, child, or parent of an employee
- Military exigency arising out of the fact that your spouse, child, or parent is on/called to active duty as a member of the Regular Armed Forces, National Guard or Reserves
- Care of a spouse, child, parent, or next of kin who is a service member or qualified veteran with a serious injury or illness incurred in the line of duty (employees may take up to 26 weeks of leave in a 12 month period)

*Employees receive reinstatement to the same job or one with similar pay and status upon return, exemption from disciplinary action for time missed, and continued health benefits if employee pays normal contribution amount.

Who is eligible for FMLA?

- Employees who have worked at PLU for at least 1 year, **AND**
- At least 1250 hours worked in the past 12 months

What constitutes a "serious health condition"?

A period of incapacity for more than 3 consecutive days and any subsequent period of incapacity relating to the same condition. Some examples include:

- Overnight hospital care and any subsequent treatment
- An absence of three plus days involving visits to a health care provider, possibly with continuing treatment
- Chronic conditions including periodic or regular health care visits (including pregnancy)

These are only examples, not a complete list. To determine whether leave being sought qualifies for FMLA please check with HR.

What is a "qualifying exigency"?

Qualifying exigencies may include, but are not limited to: attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

How does the process work?

- **Employee should submit a PLU leave of absence request form to Human Resources, signed by supervisor,** at least 30 days prior to the date leave is scheduled to begin (if leave is foreseeable) or as soon as practicable.
- **Have medical certification completed by a doctor**; return to HR. A physician's certificate is required for all medical leaves including maternity/paternity. *Note: other documentation may be necessary to determine leave eligibility.*
- During leave employee should stay in contact with supervisor; this is especially important for intermittent leave or if there is a change in the intended return to work date.
- If leave was for an employee's own condition, **provide a PLU return to work release, signed by doctor** to HR ***prior*** to returning to full duty.
- Report time away from work accurately on timecard; FMLA-vacation(FV), FMLA-sick(FS), FMLA-leave without pay(FL)

All forms are available on HR website, under Document & Forms. **Please use PLU's forms**.

What are PLU's rights?

- Requiring that employee's use sick and vacation pay concurrently with FMLA absences
- To review all information, including doctor's statements, to determine compatibility with program requirements
- To fill the team member's position, if necessary, as long as the team member is placed in a position of similar pay and status upon return
- Requiring the employee to make insurance payments while on leave, and to collect insurance premium payments if the team member chooses not to return to work
- To deny benefits for late, retroactive, or unqualified requests

Who should I contact if I have questions or to receive more information?

PLU Human Resources #253-535-7185 www.plu.edu/humr

This is a brief summary of FMLA. It is not intended to provide you with a full description. If you have questions about FMLA that are or are not covered here, please contact PLU's Human Resources at x7185.

Updated 11/04/10

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Fax: 253-535-8431

LEAVE OF ABSENCE REQUEST

Section I: TO BE COMPLETED BY THE EMPLOYEE

Employee Name:_____

Employee PLU ID: _____

Department: _____

Effective Dates:
Beginning Date: _____ End Date: _____

For Staff and Administrators:
[ ] With pay using accumulated sick and/or vacation leave.
(FMLA policy states that sick and vacation leave must be used before leave is without pay.)
[ ] Without pay.

Reason for Requesting Leave:
[ ] Employee's health
[ ] Maternity/paternity leave (including adoption)
[ ] To care for an ill family member
[ ] Military exigency
[ ] To care for an injured service member
[ ] Other, please explain:

Employee's Signature: _____ Date: _____

Section II: TO BE COMPLETED BY DEPARTMENT HEAD

I recommend that this leave request be:
[ ] Approved.
[ ] Approved conditionally. (If checked, please indicate conditions below.)
[ ] Denied.

A physician's certificate is required for all medical leaves including maternity/paternity leave. Certificate or other necessary documentation is attached:
[ ] Yes.
[ ] No.

Comments or Conditions of Approval:

Department Head/Officer Signature: _____ Date: _____

**** Please retain a COPY of this form for your records and forward the ORIGINAL to the Human Resources office.****

Section III: TO BE COMPLETED BY HUMAN RESOURCES

Leave Approved By: _____ Date: _____

For Personal Leave only*:* _____With Benefits _____Without Benefits

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CERTIFICATION OF HEALTH CARE PROVIDER

PART A: FOR COMPLETION BY THE EMPLOYEE

1. Employee Name: _____ 2. PLU ID#: _____

3. **If leave is needed to care for a seriously ill family member, complete the following**:
Patient Name: _____ Relationship to Employee: _____ If a child, DOB: _____

I shall personally provide care for my family member as described herein which will take the noted amount of time. If leave is to be taken intermittently or on a reduced leave schedule, I have provided a schedule of time I will be away from work and a reduced leave schedule as appropriate. (Additional pages may be attached as necessary):

Signature: _____ Date: _____

PART B: TO BE COMPLETED BY HEALTH CARE PROVIDER

4. Page 2 lists six categories that describe what is meant by a "**serious health condition"** under the Family and Medical Leave Act. Does the patient's condition (for which FMLA is being sought) qualify under any of the categories described? If so, please check applicable category: (1)_____ (2)_____ (3)_____ (4)_____(5)_____ (6)_____ None_____
5. Describe the **medical facts** that support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories.

6. Date condition commenced: _____ 7. Probable duration of condition: _____
8. Will the patient be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? [ ] YES [ ] NO
If yes, estimate the beginning and ending dates for the period of **incapacity**: _____
9. Will it be medically necessary for the employee to be off work on an intermittent basis or to work on a less than full schedule as a result of the condition (including treatment described in item 11)? [ ] YES [ ] NO
If yes, give probable schedule, frequency, and duration:

10. If the condition is a **chronic condition** (condition #4) or pregnancy, state whether the patient is presently incapacitated and the likely duration and frequency of **episodes of incapacity**:

11. If additional treatments will be prescribed for the condition, indicate probable number of treatments, interval between treatments, general description and duration of treatment, including referral to other provider of health services. Include schedule of treatments or dates of treatments (if known) if it is medically necessary for the employee to be off work on an intermittent basis or to work on a less than full schedule.
    a. By Health Care Provider:

    b. By another provider of health services if referred by Health Care Provider:

If certification is for *Employee's own serious health condition* (including pregnancy), complete the following:

	YES	NO	
12.	[ ]	[ ]	Is inpatient hospitalization of the employee required?
13.	[ ]	[ ]	Is employee able to perform work of any kind? (If "no" skip item 14)
14.	[ ]	[ ]	Is employee unable to perform one or more of the essential functions of the employee's position? (Answer after reviewing employee's job description/vacancy announcement or if none provided, after discussing with employee). If yes, please list the essential functions the employee is unable to perform:
15.	[ ]	[ ]	Is it necessary for the employee to be absent from work for treatment?

If certification is relating to care for the *Employee's Family Member* with a serious health condition, complete the following:

	YES	NO	
16.	[ ]	[ ]	Is inpatient hospitalization of the family member (patient) required?
17.	[ ]	[ ]	Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation?
18.	[ ]	[ ]	After review of the employee's signed statement, is the employee's presence necessary or would it be beneficial for the care of the patient? (This may include physical and/or psychological care.)

19. I estimate the period of time that the employee is needed to care for the seriously ill family member or during which the employee's presence would be beneficial to be:

20. Signature of Health Care Provider: _____ Date: _____

Typed/Printed Name of Health Care Provider:

Address & Phone Number:

Health Care Provider's Field of Specialization:

A **"Serious Health Condition"** means an illness, injury impairment, or physical or mental condition that involves one of the following:

1. **Hospital Care**
   Inpatient care (i.e. an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of *incapacity or subsequent treatment in connection with or consequent to inpatient care.
2. **Absence From Work Plus Treatment**
   (a) A period of *incapacity of more than three consecutive calendar days (including any subsequent treatment or period of *incapacity relating to the same condition), that also involves:
      1. **Treatment two or more times** by a health care provider within 30 days of the first day of the *incapacity, by a nurse or physician's assistant under the direct supervision of a health care provider, or by a provider of health care services (e.g. physical therapist) under orders of, or on referral by, a health care provider; or
      2. **Treatment** by a health care provider on at **least one occasion** which results in a **regimen of continuing treatment** under the supervision of the health care provider.
3. **Pregnancy**
   Any period of *incapacity due to pregnancy, or for prenatal care.
4. **Chronic Conditions Requiring Treatments**
   A Chronic condition which:
      1. Requires **periodic visits** (at least twice per year) for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;
      2. Continues over an **extended period of time** (including recurring episodes of a single underlying condition); and
      3. May cause **episodic** rather than a continuing period of *incapacity (e.g. asthma, diabetes, epilepsy, etc.).
5. **Permanent/Long-term Conditions Requiring Supervision**
   A period of *incapacity which is **permanent or long-term** due to a condition for which treatment may not be effective. The employee or family member must be **under the continuing supervision of, but need not be receiving active treatment by, a health care provider**. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.
6. **Multiple Treatments (Non-Chronic Conditions)**
   Any period of absence to receive **multiple treatments** (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for **restorative surgery** after an accident or other injury, **or** for a condition that **would likely result in a period of *incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment**, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), and kidney disease (dialysis).

*__Incapacity__, as used in these definitions, means inability to work, attend school, or perform other regular daily activities due to the serious health condition, treatment therefore or recovery therefrom.

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RETURN TO WORK RELEASE

EMPLOYEE'S NAME: _____ INJURY DATE: _____

Determination of return to work status

Please review the employee's job description carefully

☐ Worker **can fully perform the essential functions of the job with no restriction(s)** as of (date):_____.

☐ Worker **can perform the essential functions of the job with reasonable accommodation[s]** as of (date):_____.
Please Identify reasonable accommodation[s]:

_____

_____

_____

_____

☐ Worker **cannot currently perform the essential functions of the job** with or without accommodation, but is expected to be able to return to that position on (date)_____.

☐ Worker **cannot currently perform the essential functions of the job** with or without accommodation and it is uncertain and/or indefinite when the worker would be expected to be able to return to that position. (date):_____.

Doctor's Signature_____ _____
Print Name

_____ _____
Address Phone

_____ _____
Fax#

_____
Date

INTERNAL USE ONLY

___ Employee is cleared to work.

___ Employee is to be placed on inactive/extended leave status.