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?

All forms are available on HR website.

- **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. Contact HR with questions.

What are PLU's rights?

- 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 1/1/20

Human Resources
Pacific Lutheran University
Tacoma, WA 98447
Ph: 253-535-7185
Fax: 253-535-8431

LEAVE OF ABSENCE REQUEST

Section I: TO BE COMPLETED BY THE EMPLOYEE

Employee Name: ____ **PLU ID:** ________________________

Department: ____ **I am:** [ ] Staff [ ] Faculty

Begin Date for Leave: ______________________________ **End Date:** ___________________________________

Type of Leave Requested: *Check all that apply* [ ] FMLA [ ] PFML [ ] Personal Leave of Absence

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:

For Staff:
[ ] With PLU pay using accumulated sick and/or vacation
[ ] Without PLU pay

For Faculty:
[ ] Contingent
[ ] Tenured/tenure-track
[ ] If tenure-track, would you like your tenure clock stopped for the academic year? [ ] Yes [ ] No

A Certification of Health Care Provider is required for all medical leaves including maternity/paternity leave. *Certification or other necessary documentation should be sent directly to Human Resources.*

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.

Comments or Conditions of Approval:

For staff leaves, please send this ORIGINAL form to Human Resources. For faculty leaves, the second page of this form must be completed and approved by the Dean before sending to Human Resources.

Department Head Signature: _______________________________________ Date: _____________________

Section III: TO BE COMPLETED BY HUMAN RESOURCES

Leave Approved By: ____ Date: _____________________

For Personal Leave only*:* _____With Benefits _____Without Benefits

Course Assignment Sheet

(required for faculty only)

Academic Year: ______________

Please include all courses scheduled for the academic year in which leave is being requested.

TERM	COURSE	CREDITS	LOAD*	FTE*	REQUESTING LEAVE?
					Yes No
					Yes No
					Yes No
					Yes No
					Yes No
					Yes No
					Yes No
					Yes No
					Yes No
					Yes No
					Yes No
					Yes No
	TOTAL for the Academic Year:				

*Standard Course Load and FTE Assignment:

- 4-credit course = 1.00 course load = .167 FTE
- 3-credit course = 0.75 course load = 0.125 FTE
- 2-credit course = 0.50 course load = 0.083 FTE
- 1-credit course = 0.25 course load = 0.042 FTE

If the course load and/or FTE assigned to any course listed above does not correspond to this standard, please explain:

Notes/other information (ex. change of sabbatical schedule):

Dean Signature: ____ Date: ___________________

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

U.S. Wage and Hour Division

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

OMB Control Number: 1235-0003
Expires: 8/31/2021

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):

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____

____

____

CONTINUED ON NEXT PAGE

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:

   ____

   ____

   ____

   ____

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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.