FMLA PACKET

EMPLOYEE'S SERIOUS HEALTH CONDITION

Name: _____ **Department Name:** _____

Social Security Number: _____ **DOB:** _____ **DOH:** _____

I hereby submit my request for a leave under the Family and Medical Leave Act of 1993 effective on the _____ day of _____, 20 ____ through the _____ day of _____, 20 ____, inclusive, for the following reason.

Nature of Leave:

_____ Birth/Adoption/Foster Care of a child

_____ Medical Condition

_____ Personal

_____ Spouse

_____ Child

_____ Parent

I understand that my leave, if approved, is subject to the following conditions:

1. All leaves must be supported by proper documentation prior to approval. Proper documentation for medical and/or family includes a physician's statement as to the nature of the injury or illness, the expected length of the disability and the date of next treatment of estimated date of return.
2. The maximum time period of leave may be granted is up to twelve (12) weeks.
3. Employees unable to return to work within the approved time period are required to produce sufficient evidence to support an extension prior to the expiration date of their current leave.
4. Employees who are out medical and/or family leave must maintain periodical contact with their supervisor as agreed upon until they receive notice that the request for a leave is approved.

_____
Employee Signature

_____ _____
Immediate Supervisor Vice President

_____ _____
Major Area Supervisor Director of Human Resources

_____
President

This Family Leave Packet includes:

1) Employee's Responsibilities
2) Supervisor's Responsibilities
3) Family Leave Policy
4) Certification of Health Care Provider for Employee's Serious Health Condition (WH-380-E)
5) Job Description – *added by Human Resources at the time of leave request when possible*

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.
    - Section II is completed by the employee. The employee will submit the certification form (and revised job description if available) to the health care provider for completion.
    - Section III is completed by the treating health care provider (after essential job functions are noted by the supervisor)
    - 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.

Supervisor Responsibilities:

- It is the supervisor's responsibility to review the employee's job description (attached), so that the treating physician may appropriately assess the employee's work status.
- If the job description is not attached OR if the job description does not list the essential job functions, the supervisor should indicate the employee's essential job functions in Section I (employer section) of the Certification of Health Care Provider for Employee's Serious Health Condition (WH-380-E).
- The supervisor should indicate the employee's job title and regular work schedule in Section I.
- After noting the essential functions (on the job description or on the certification

form) the supervisor should promptly return the packet to the employee for submission to their health care provider.

- The health care provider will then be able to identify the employee's essential job functions in order to determine the employee's current work status and ability to return to work.

Family Leave Policy

On August 5, 1993, the Family and Medical Leave Act of 1993 became effective. The law requires employers with 50 or more employees to offer their workers up to 12 weeks of unpaid leave for their own illnesses, to care for the employee's spouse, son, daughter, or parent with a serious health condition, or the birth or adoption of a child.

Eligibility: To be eligible to take family leave, the Family and Medical Leave Act (FMLA) states that an employee must have worked for Wiley College for at least 12 months and for at least 1,250 hours during the year preceding the start of the leave. Exempt employees are presumed to have met the 1,250 hours of service requirement as long as they have worked for the College at least 12 months. Employers must maintain pre-existing health coverage during the leave period and must reinstate the employee to the same or an equivalent job when the leave period ends.

Employees requesting Family and Medical Leave are required to expend their paid accrued leave before taking unpaid Family and Medical Leave. The use of paid leave will not extend the twelve-week maximum length of Family and Medical Leave.

Employees who meet the eligibility criteria for leave are required to provide the following documentation in support of their request for leave:

- Medical certification to support a claim for leave for an employee's own serious health problem. The certification must include a statement that the employee is unable to perform the functions of the position.

- For leave to care for a seriously ill child, spouse or parent, the certification must include an estimate of time the employee may be needed to provide care. Periodic re-certifications may be required during the leave.

- When medically necessary, an employee may request leave on an intermittent or reduced leave schedule. If leave is requested on this basis, Wiley College reserves the right to re-assign or transfer the employee to another position temporarily to accommodate the employee's request and to meet the College's needs when necessary. In this instance, employees will be re-assigned to positions that are equivalent in pay and benefits. Upon return from leave, employees will be returned to their former position or to an equivalent position with equivalent pay, benefits, and other employment terms and conditions.

- Spouses who are both employed by Wiley College are entitled to a combined total of twelve weeks (rather than twelve weeks each) for the birth or adoption of a child. They

are entitled to twelve weeks individually when caring for their spouse, child, parent, or if they themselves have a serious health problem.

When the need for leave is foreseeable, such as births, adoptions, or scheduled medical treatment, the employee must provide reasonable prior notice (30 days, or as much as practical) and make every effort to schedule leave so that it does not disrupt College operations. In cases of employee illness, employees are required to provide periodic updates (on the 1st and 15th of each month) of their leave status and intent to return to work.

Employees who are granted leave under this policy are advised that the College will continue pre-existing employee health care coverage. An employee on unpaid Family or Medical Leave will not accrue annual or sick leave. However, the time an employee is on Family or Medical Leave will be counted as continued service (i.e., no break in service) for other benefit plans.

All requests for Family and Medical Leaves due to serious health conditions shall include the following:

- the date that the condition began,
- the probable duration of the condition,
- the appropriate medical factors from the health care provider regarding the illness or condition.

Wiley College
Office of Human Resources
711 Wiley Avenue
Marshall, TX 75670
Phone: 903-927-3345
Fax: 800-514-4218
Email: hr@wileyc.edu

Certification of Health Care Provider for Employee'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 due to a serious health condition to submit a medical certification issued by the employee's health care provider. 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 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: _____

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. 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. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

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. 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). 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: _____

   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 or 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 to his/her medical condition, including any time for treatment and recovery? ___No ___Yes.

   If so, estimate the beginning and ending dates 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:

   _____

   Estimate the part-time or reduced work schedule the employee needs, if any:

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

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:

   _____

   _____

   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

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.**