

Stephen F. Austin State University Family and Medical Leave Act of 1993

EMPLOYEE INFORMATION:

Name of Employee: _____

Employee ID: _____

Department: _____

Date HR was notified by employee: _____

Reason for Seeking Leave: _____

Type of Leave Requested: Continuous Intermittent FOR Self Dependent

Dates of Leave: _____

If seeking intermittent leave to work a reduced schedule, specify details: _____

ACKNOWLEDGEMENT:

I, _____, have requested a leave of absence from work that may be covered by the Family and Medical Leave Act, beginning on _____ (date).

I fully understand the following information:

- (1) This leave and any subsequent leave related to this condition will count against my annual leave entitlement under the Act. The FMLA policy contains all applicable entitlement limits to FMLA leave.
- (2) If my leave is being taken for my own serious health condition or because of the serious health condition of my spouse, parent, or child, I understand that I must provide medical certification to the University as soon as possible.
- (3) I have received a medical certification form from the University to give to my Health Care provider. I understand that if I do not provide the University with an accurate, complete medical certification in a timely manner my leave may be delayed until the University receives the certification or denied.
- (4) I understand that I will be required to continue my share of the Health Benefits Premium, which I have read and signed. The University may not increase or alter my insurance premiums why I am using FML.
- (5) I understand that if I take leave because of my own serious health condition, I will have to provide the University with a Fitness-for-Duty certification before I can return to work. The certification will pertain only to the condition that caused me to take FMLA leave.
- (6) I understand that at the end of my leave, I have the right to be restored to the same or an equivalent job.
- (7) I understand that FMLA policy requires me to contact my department on every Monday (unless otherwise agreed upon), and HR on the first and third Monday of each month.
- (8) I understand that if I have any further questions about leave under the FMLA, I may contact Becky Garrett @ Human Resources, ext. 1288.

Employee Signature

Date

Family and Medical Leave

Original Implementation: August 5, 1993

Last Revision: April 12, 2016

Employees are eligible to take family/medical leave within any 12 month period and be restored to the same or an equivalent position upon return from leave, provided that the employee has worked for the state of Texas for at least twelve (12) months and for at least 1,250 hours within the previous twelve (12) month period. Leave without pay may begin after all available applicable paid leave has been exhausted and will be included in the twelve (12) weeks of Family and Medical Leave Act (FMLA) time. Applicable Sick Leave Pool benefits, donated sick leave, and leave resulting from Workers' Compensation claims (See Workers Compensation Coverage, Policy 12.23) will be included in the twelve (12) week period.

Reasons for Family/Medical Leave

Eligible faculty and staff may take up to 12 workweeks of leave in a 12-month period of family/medical leave for any of the following reasons:

1. The birth of a child or placement of a child with the employee for adoption or foster care;
2. To care for a spouse, child, or parent who has a serious health condition;
3. For a serious health condition that makes the employee unable to perform the essential functions of his or her job; or
4. For any “qualifying exigency” arising out of the fact that a spouse, son, daughter, or parent is a military member on covered active duty or has been notified of an impending call to covered active duty status.

An eligible employee may also take up to 26 workweeks of leave during a single 12-month period to care for a covered servicemember with a serious injury or illness, when the employee is the spouse, son, daughter, parent, or next of kin of the servicemember.

For purposes of FMLA, a rolling twelve (12) month period will be measured backward from the date leave begins.

Leave because of birth of a child or placement of a child with the employee for adoption or foster care must be completed within the twelve (12) month period beginning on the date of birth or placement. An employee is allowed to use sick leave for the period of time that is certified by the physician to recover from childbirth. While an employee may take additional time off under FMLA (including annual leave, or leave without pay), the employee may not use sick leave for this additional time unless the employee or the child is actually sick. In addition, spouses

employed by Stephen F. Austin State University who request leave because of these reasons or to care for an ill parent may only take a combined total of twelve (12) weeks during any twelve (12) month period.

Sick leave may be used in conjunction with FMLA leave when a child under the age of three is adopted regardless of whether the child is actually sick at the time of adoption. Furthermore, an employee, who is the father of a child, may use his sick leave in conjunction with the child's birth only if the child is actually ill, or to care for his spouse while she is recovering from labor and delivery.

Employees with less than 12 months of state service and/or less than 1,250 hours of work in the 12 months immediately preceding the start of leave are entitled to a parental leave of absence, not to exceed 12 weeks (480 hours). The employee must first use all available and applicable paid vacation and sick leave while taking parental leave prior to going on leave without pay. Such parental leave may only be taken for the birth of a natural child or the adoption or foster care placement with the employee of a child under three years of age. The leave period begins with the date of birth or the adoption or foster care placement.

Notice of Leave

If the need for family/medical leave is foreseeable, the employee must give thirty (30) days prior written notice. If this is not possible, the employee must give notice within one to two working days of learning of the need for leave or as soon as practicable. Failure to provide such notice may be grounds for delay of leave. Where the need for leave is not foreseeable, the employee is expected to notify the supervisor and Human Resources within 1 to 2 working days of learning of the need for leave, except in extraordinary circumstances. Requests for Family/Medical Leave forms are available from Human Resources. Employees should use these forms when requesting leave.

Medical Certification

If an employee is requesting leave because of their own or a covered relation's serious health condition, the employee and the relevant health care provider must supply appropriate medical certification. Medical Certification Forms may be obtained from Human Resources. The form must be returned to the director of Human Resources or designated leave administrator within fifteen (15) days after the date leave is requested. Failure to provide requested medical certification in a timely manner may result in denial of leave until the certification is provided. The university, at its expense, may require an examination by a second health care provider designated by the university. If the second health care provider's opinion conflicts with the original medical certification, the university, at its expense, may require a third, mutually agreeable, health care provider to conduct an examination and provide a final and binding opinion. The university may require subsequent medical re-certification on a reasonable basis.

Reporting While on Leave

If an employee takes FMLA because of a personal serious health condition or to care for a covered relation, the employee must contact the supervisor at least once each week, or as often as requested by the supervisor, regarding the status of the condition and the intention to return to work. The supervisor is responsible for reporting this information to the leave administrator. Additionally, the employee is required to call Human Resources on the 1st and 3rd Monday of each month during their leave to report their leave and/or return to work status. Failure to communicate with the supervisor and Human Resources on the approved reporting schedule may result in denial of leave.

Leave Is Unpaid

Family/medical leave is unpaid leave after applicable vacation and sick leaves have been exhausted. Employees may apply for sick leave from the Sick Leave Pool which, if approved, will be included within the FMLA period. Employees may be eligible for short or long-term disability payments and/or workers' compensation benefits under the provisions of those plans. This leave time will also be included in the twelve (12) week period of FMLA. The use of applicable paid leave time does not extend the twelve (12) week leave period.

Medical and Other Benefits

During an approved family/medical leave, the university will maintain the state contribution for the employee's health benefits as if the employee continues to be actively employed. During periods of paid FMLA leave, the university will deduct the employee's portion of the insurance premiums as a regular payroll deduction. If the employee's FMLA leave is unpaid, the employee's portion of the premium must be paid by the employee through the benefits manager in Human Resources. The employee's insurance coverage will cease if the premium payment is more than thirty (30) days late. If the employee elects not to return to work at the end of the FMLA leave period, the employee will be required to reimburse the university for the cost of the premiums paid by the university for maintaining coverage during the leave, unless the employee cannot return to work because of a serious health condition or other circumstances beyond the employee's control. An employee on FMLA is not entitled to accrue state service credit for any full calendar months of leave without pay taken while on FMLA and does not accrue vacation or sick leave for such months of leave without pay.

Intermittent and Reduced Schedule Leave

Leave because of a serious health condition may be taken intermittently (in separate blocks of time due to a single health condition) or on a reduced leave schedule (reducing the usual number of hours worked per work week or work day), if medically necessary. A reduced schedule is subject to availability depending on the business need of the department or the university. If

leave is unpaid, the university will reduce the employee's salary based on the amount of time actually worked. In addition, while the employee is on an intermittent leave or reduced schedule, the university may temporarily transfer the employee to an alternative position which better accommodates recurring leave and which has equivalent pay and benefits.

Returning From Leave

If the employee takes leave because of a personal serious health condition, the employee is required to provide medical certification to their supervisor and the leave administrator that the employee is fit to resume work. Return to Work Medical Certification Forms may be obtained from Human Resources. Employees failing to provide the Return to Work Medical Certification Form will not be permitted to resume work until it is provided.

Definitions

For the purpose of this policy, the following definitions

apply. Applicable Paid Leave - Sick leave and vacation accruals.

Spouse - Those recognized as spouses by the state of Texas.

Parent - Includes biological parents and individuals who acted as the employee's parents, but does not include parents-in-law.

Child/Son or Daughter - Legally recognized, including biological, adopted, foster children, stepchildren, and legal wards, who are under eighteen (18) years of age or eighteen (18) years of age or older and incapable of self-care because of mental or physical disability. For purposes of qualifying exigency leave, an employee's son or daughter on covered active duty refers to a child of any age.

Serious Health Condition - Any illness, injury, impairment, or physical or mental condition that involves: (1) any incapacity or treatment in connection with inpatient care; (2) any incapacity or treatment requiring absence of more than three calendar days and continuing treatment by a health care provider; or, (3) continuing treatment by a health care provider of a chronic or long-term condition that is incurable or will likely result in incapacity of more than three days if not treated.

Continuing Treatment - Includes: (1) two or more treatments by a health care provider; (2) two or more treatments by a provider of health care services (i.e., physical therapist) on referral by or under orders of a health care provider; (3) at least one treatment by a health care provider which results in a regimen of continuing treatment under the supervision of the health care provider (i.e., a program of medication or therapy); or, (4) under the supervision of, although not actively

treated by, a health care provider for a serious long-term or chronic condition or disability which cannot be cured (i.e., Alzheimer's or severe stroke).

Health Care Provider - Includes: licensed medical (MD) and osteopathic (OD) doctors, podiatrists, dentists, clinical psychologists, optometrists, chiropractors authorized to practice in the State, nurse practitioners and nurse-midwives authorized under state law, and Christian Science practitioners.

"Needed To Care For" - Encompasses: (1) physical and psychological care for a family member; and, (2) where the employee is needed to fill in for others providing care or to arrange for third party care of the family member.

"Unable to Perform the Functions of the Employee's Job" - Describes when an employee is (1) unable to work at all; or, (2) unable to perform any of the essential functions of their position. The term "essential functions" is borrowed from the Americans with Disabilities Act (ADA) to mean "the fundamental job duties of the employment position," and does not include the marginal functions of the position.

"Qualifying Exigencies" – Describes situations arising from the military deployment of an employee's spouse, son, daughter, or parent to a foreign country. Qualifying exigencies for which an employee may take FMLA leave include issues arising from the military member's short notice deployment; or making alternative child care arrangements for a child of the military member when the deployment of the military member necessitates a change in the existing child care arrangement; attending certain military ceremonies and briefings; attending counseling for the employee, the military member, or the child of the military member; or taking leave to spend time with a military member on Rest and Recuperation leave during deployment; or making financial or legal arrangements to address a covered military member's absence; or certain activities related to care of the parent of the military member while the military member is on covered active duty; or any other event that the employee and employer agree is a qualifying exigency.

"Short Notice Deployment" – deployment within seven or less days of notice.

"Covered Servicemember" – A current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness. "Covered servicemember" also includes veterans discharged under conditions other than dishonorable within the five-year period before you first take military caregiver leave to care for that veteran. A serious injury or illness is one that is incurred by a servicemember in the line of duty on active duty that may cause the servicemember to be medically unfit to perform the duties of his or her office, grade, rank, or rating. A serious injury or illness also

includes injuries or illnesses that existed before the servicemember's active duty and that were aggravated by service in the line of duty on active duty.

Cross Reference: The Family and Medical Leave Act of 1993 (FMLA), 29 C.F.R. § 825; Tex. Gov't Code § 661.912

Responsible for Implementation: Vice President for Finance and Administration

Contact for Revision: Director of Human Resources and General Counsel

Forms: Family/Medical Leave Request for Leave Form, Certification of Physician or Practitioner Form, Family/Medical Leave Return to Work Medical Certification Form

Board Committee Assignment: Academic and Student Affairs

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



OMB Control Number: 1235-0003
Expires: 2/28/2015

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.

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 _____

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. 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 as 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.