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 John Wyatt @ Human Resources, ext. 4075.

_____ _____

Employee Signature Date

Family and Medical Leave (E-58)

Original Implementation: August 5, 1993
Last Revision: January 31, 2012

Employees are eligible to take up to twelve (12) weeks of 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). Applicable Sick Leave Pool benefits and leave resulting from Workers' Compensation claims (See Workers Compensation Coverage Policy E-55) will be included in the twelve (12) week period. For purposes of FMLA, a rolling twelve (12) month period will be measured backward from the date leave begins.

Reasons for Family/Medical Leave

Eligible faculty and staff may take family/medical leave for any of the following reasons:

1. The birth of a child and in order to care for such child;
2. The placement of a child with the employee for adoption or foster care;
3. To care for a spouse, son, daughter, or parent with a serious health condition; or,
4. Because of the employee's own serious health condition which renders the employee unable to perform the job functions essential to the employee's position.

Leave because of reasons (1) or (2) 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 infant is actually sick. In addition, spouses employed by Stephen F. Austin State University who request leave because of reasons (1) or (2) 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), if the employee uses all available and appropriate paid vacation and sick leave while taking the parental leave. 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.

Military Caregiver Leave (also known as Covered Servicemember Leave): Under the military family leave entitlements, eligible employees who are family members of covered servicemembers will be able to take up to 26 workweeks of leave in a "single 12-month period" to care for a covered servicemember with a serious illness or injury incurred in the line of duty on active duty. This 26 workweek entitlement is a special provision that extends FMLA job-protected leave beyond the normal 12 weeks of FMLA leave. This provision also extends

FMLA protection to additional family members (i.e., next of kin) beyond those who may take FMLA leave for other qualifying reasons.

Qualifying Exigency Leave: The second military leave entitlement helps families of members of the National Guard and Reserves manage their affairs while the member is on active duty in support of a contingency operation. This provision makes the normal 12 workweeks of FMLA job-protected leave available to eligible employees with a covered military member serving in the National Guard or Reserves to use for "any qualifying exigency" arising out of the fact that a covered military member is on active duty or called to active duty status in support of a contingency operation. The Department's final rule defines qualifying exigency by referring to a number of broad categories for which employees can use FMLA leave:

1. Short-notice deployment;
2. Military events and related activities;
3. Childcare and school activities;
4. Financial and legal arrangements;
5. Counseling;
6. Rest and recuperation;
7. Post-deployment activities;
8. Additional activities not encompassed in the other categories, but agreed to by the employer and employee.

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 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 director of Human Resources. 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 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 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 that the employee is fit to resume work. Return to Work Medical Certification Forms (Attachment C) 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 - Parent includes biological parents and individuals who acted as the employee's parents, but does not include parents-in-law.

Son or Daughter - Son or daughter, legally recognized, includes 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.

Serious Health Condition - A serious health condition means any illness, injury, impairment, or physical or mental condition that involves: (1) any incapacity or treatment in connection with inpatient care; (2) an incapacity 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 - Continuing treatment means: (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 - 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" - "Needed to care for" a family member encompasses: (1) physical and psychological care; 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" - The phrase "unable to perform the functions of the employee's job" means 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.

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 for Serious Injury or Illness of Covered Servicemember - - for Military Family Leave (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

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

Notice to the EMPLOYER INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a serious injury or illness of a covered servicemember to submit a certification providing sufficient facts to support the request for leave. 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. § 825.310. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees or 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.

SECTION I: For Completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the Employee Is Requesting Leave INSTRUCTIONS to the EMPLOYEE or COVERED SERVICEMEMBER: Please complete Section I before having Section II completed. The FMLA permits an employer to require that an employee submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a serious injury or illness of a covered servicemember. If requested by the employer, your response is required to obtain or retain the benefit of FMLA-protected leave. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to do so may result in a denial of an employee's FMLA request. 29 C.F.R. § 825.310(f). The employer must give an employee at least 15 calendar days to return this form to the employer.

SECTION II: For Completion by a UNITED STATES DEPARTMENT OF DEFENSE ("DOD") HEALTH CARE PROVIDER or a HEALTH CARE PROVIDER who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed on Page 2 has requested leave under the FMLA to care for a family member who is a member of the Regular Armed Forces, the National Guard, or the 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. For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty that may render the servicemember medically unfit to perform the duties of his or her office, grade, rank, or rating.

A complete and sufficient certification to support a request for FMLA leave due to a covered servicemember's serious injury or illness includes written documentation confirming that the covered servicemember's injury or illness was incurred in the line of duty on active duty and that the covered servicemember is undergoing treatment for such injury or illness by a health care provider listed above. 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.

Certification for Serious Injury or Illness of Covered Servicemember - - for Military Family Leave (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

U.S. Wage and Hour Division

SECTION I: For Completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the Employee Is Requesting Leave: (This section must be completed first before any of the below sections can be completed by a health care provider.)

Part A: EMPLOYEE INFORMATION

Name and Address of Employer (this is the employer of the employee requesting leave to care for covered servicemember):

_____

Name of Employee Requesting Leave to Care for Covered Servicemember:

_____
First Middle Last

Name of Covered Servicemember (for whom employee is requesting leave to care):

_____
First Middle Last

Relationship of Employee to Covered Servicemember Requesting Leave to Care:
☐ Spouse ☐ Parent ☐ Son ☐ Daughter ☐ Next of Kin

Part B: COVERED SERVICEMEMBER INFORMATION

(1) Is the Covered Servicemember a Current Member of the Regular Armed Forces, the National Guard or Reserves? ☐ Yes ☐ No

If yes, please provide the covered servicemember's military branch, rank and unit currently assigned to:

_____

Is the covered servicemember assigned to a military medical treatment facility as an outpatient or to a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients (such as a medical hold or warrior transition unit)? ☐ Yes ☐ No If yes, please provide the name of the medical treatment facility or unit:

_____

(2) Is the Covered Servicemember on the Temporary Disability Retired List (TDRL)? ☐ Yes ☐ No

Part C: CARE TO BE PROVIDED TO THE COVERED SERVICEMEMBER

Describe the Care to Be Provided to the Covered Servicemember and an Estimate of the Leave Needed to Provide the Care:

_____

SECTION II: For Completion by a United States Department of Defense ("DOD") Health Care Provider or a Health Care Provider who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider. If you are unable to make certain of the military-related determinations contained below in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator). (Please ensure that Section I above has been completed before completing this section.) Please be sure to sign the form on the last page.

Part A: HEALTH CARE PROVIDER INFORMATION

Health Care Provider's Name and Business Address:

_____

Type of Practice/Medical Specialty: _____

Please state whether you are either: (1) a DOD health care provider; (2) a VA health care provider; (3) a DOD TRICARE network authorized private health care provider; or (4) a DOD non-network TRICARE authorized private health care provider: _____

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

PART B: MEDICAL STATUS

(1) Covered Servicemember's medical condition is classified as (Check One of the Appropriate Boxes):

☐ **(VSI) Very Seriously Ill/Injured** – Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

☐ **(SI) Seriously Ill/Injured** – Illness/injury is of such severity that there is cause for immediate concern, but there is no imminent danger to life. Family members are requested at bedside. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

☐ **OTHER Ill/Injured** – a serious injury or illness that may render the servicemember medically unfit to perform the duties of the member's office, grade, rank, or rating.

☐ **NONE OF THE ABOVE** (Note to Employee: If this box is checked, you may still be eligible to take leave to care for a covered family member with a "serious health condition" under § 825.113 of the FMLA. If such leave is requested, you may be required to complete DOL FORM WH-380 or an employer-provided form seeking the same information.)

(2) Was the condition for which the Covered Service member is being treated incurred in line of duty on active duty in the armed forces? ☐ Yes ☐ No

(3) Approximate date condition commenced: _____

(4) Probable duration of condition and/or need for care: _____

(5) Is the covered servicemember undergoing medical treatment, recuperation, or therapy? ☐ Yes ☐ No. If yes, please describe medical treatment, recuperation or therapy:

PART C: COVERED SERVICEMEMBER'S NEED FOR CARE BY FAMILY MEMBER

(1) Will the covered servicemember need care for a single continuous period of time, including any time for treatment and recovery? ☐ Yes ☐ No
If yes, estimate the beginning and ending dates for this period of time: _____

(2) Will the covered servicemember require periodic follow-up treatment appointments?
☐ Yes ☐ No If yes, estimate the treatment schedule: _____

(3) Is there a medical necessity for the covered servicemember to have periodic care for these follow-up treatment appointments? ☐ Yes ☐ No

(4) Is there a medical necessity for the covered servicemember to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)? ☐ Yes ☐ No If yes, please estimate the frequency and duration of the periodic care:

_____

_____

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, in accordance with 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 AV, NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE PATIENT.**