

What You Need To Know About...

FAMILY AND MEDICAL LEAVE ACT (FMLA)

PURPOSE

The **Family and Medical Leave Act of 1993 (FMLA)** is a United States federal law requiring covered employers to provide employees job-protected and unpaid leave for qualified medical and family reasons. FMLA leave allows eligible employees to request up to 12 weeks of unpaid leave in a 12-month period for specified family and medical reasons. For purposes of calculation, Shepherd University uses a “rolling” 12-month period measured backward from the date an employee uses any FMLA leave. FMLA leave is not the same thing as West Virginia’s Parental Leave law.

ELIGIBILITY

In order to meet eligibility requirements, an employee must have worked at Shepherd University for at least 12 months and must have worked at least 1,250 hours during the previous 12-month period immediately preceding the commencement of the leave. Both men and women are eligible for FMLA.

PROCEDURE

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice the same day or the next business day. The Human Resources Office will notify the employee within five business days after receiving the request as to whether or not the leave will be designated as FMLA.

Employees must submit a completed Request for Family and Medical Leave Act (FMLA) form to the Human Resources Office. Employees must also submit a Medical Leave Verification form within 15 days of the request completed by an appropriately licensed treating health care provider. The physician’s signature is required, as opposed to the signature of a member of the physician’s staff.

Recertification may be requested in special circumstances such as the employee requests an extension of leave, circumstances have changed significantly regarding the existing leave, and the employer receives information casting doubt on the stated reason for absence. Certifications and recertification are at the employee’s expense. If the employee does not produce the certification, then the employee will be considered to be out of compliance with leave policies.

PROCESS

Employees on FMLA must exhaust all accrued sick leave prior to going on unpaid leave (see “Leave” section of this document to clarify pregnancy leave). Employees also have the option of using their annual leave. FMLA leave runs concurrent with paid and unpaid leave. Written notification will be provided to the employee by the Human Resources Office noting the date the FMLA leave begins.

Some basic reasons for requesting FMLA include: (1) birth of a son or daughter, and to care for the newborn child; (2) placement of a child for adoption or foster care; (3) care of a family member with a serious health condition and for which you are one of the primary care givers (spouse, child (under 18), parent, or in loco parentis); or (4) your own serious health condition;

FMLA will run concurrently with qualifying absences due to parental leave, catastrophic leave, workers’ compensation leave, or other applicable personal or medical leaves of absence.

MILITARY EXIGENCY OR CAREGIVER LEAVE

Employees whose spouse, son, daughter, or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is: (1) 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; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness.

DURATION

Employees may take up to 12 weeks of FMLA leave in a 12-month period. Employees may take FMLA leave on a continual or intermittent basis when medically necessary due to a serious health condition. Intermittent leave can involve parts of days, a few days off each week, or a reduced workweek. Intermittent leave must interfere as little as possible with the employee's job duties.

INSURANCE

Eligible employee's health insurance will be continued as long as the employee is on paid leave. Once the employee exhausts sick leave and is placed on unpaid leave, group health insurance may be continued provided the employee pays their share of premium costs of such health insurance. Arrangements must be made with the Payroll Office for such payments.

LEAVE

All accrued sick leave must be exhausted when taking FMLA leave. An employee will be on approved unpaid Medical Leave of Absence once their paid leave is exhausted. The employee may be placed on the hourly payroll when they have depleted their leave, at least until they have accrued five days of annual leave. The decision as to whether an employee is paid through the hourly payroll or the salaried payroll is at the discretion of the supervisor.

The University policy for pregnancy on normal births is to allow six weeks of sick leave, if available, to be used. Following that period annual leave may be used. Spouses and partners of women giving birth generally may take up to two weeks of sick leave in order to provide care to the mother and/or baby. Following that two-week period annual leave would have to be applied by the spouse or partner if s/he wishes to extend his/her absence unless extenuating medical circumstances exist.

RETURN TO WORK

Before employees return to work, they must present to the Human Resources Office or to their supervisor a Medical Release to Return to Work form signed by the treating physician. If the form is presented to the supervisor, then the supervisor must forward the release to the Human Resources Office.

At the expiration of FMLA leave, the employee shall be reinstated without any loss of any rights, to their vacant position or a comparable position. Failure of the employee to report promptly at the expiration of approved FMLA leave, except for satisfactory reasons submitted and approved in advance, shall be cause for termination of employment by the institution.

SHEPHERD UNIVERSITY
REQUEST FOR FAMILY AND MEDICAL LEAVE ACT (FMLA) LEAVE

Employee's Name: _____

Home Address: _____

Home Phone Number: _____

It is the responsibility of the employee to provide appropriate medical verification (<http://www.shepherd.edu/hrweb/forms.html>) so that a request for leave can be evaluated. The medical leave verification must be completed by an appropriately licensed treating health care provider verifying the employee's request. (The physician's signature is required, as opposed to the signature of a member of the physician's staff.) This completed form must accompany the employee's request for parental or FMLA leave.

Leave requests must be submitted to the Human Resources Office.

FAMILY MEDICAL LEAVE ACT REQUEST:

I hereby request a Family Medical Leave Act (FMLA) from Shepherd University for the following date(s):

Start Date: _____ End Date: _____

Reason for Request: _____

I understand that my request may be denied. I understand that I must exhaust all my sick leave any may use my annual leave. I will not receive pay for FMLA once my leave is exhausted. I further understand that I will be billed for payment to continue any insurance benefits through Shepherd University. Failure to provide payment will result in the cancellation of benefits.

I certify that the above statements are true. I authorize Shepherd University to obtain information necessary to evaluate this request.

Employee's Signature

Date

Shepherd University Medical Leave Verification

Employee's Name: _____

Home Address: _____

Home Phone Number: _____

Physician's Statement (if leave is being requested for Employee):

Medical Condition of Employee: _____

Diagnosis: _____

Prognosis: _____

Duration and Treatment Plan: _____

Employee needs to be off work from _____ through and including _____

Physician's Statement (if leave is being requested for a family member):

Medical Condition of Patient (Family Member): _____

Diagnosis: _____

Prognosis: _____

Duration and Treatment Plan: _____

Relationship of Patient to Employee: _____

Employee needs to be off work consecutively from _____ through and including _____

AND/OR

Employee needs to be off work intermittently from _____ through and including _____

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Physician's Signature (Must be signed by physician, not staff)

Date

Name of Physician (please print)

Physician's Phone Number

I hereby grant permission for my medical records to be released to the Human Resources Office, Shepherd University, PO Box 5000, Shepherdstown, WV, 25443. (Phone 304-876-5299; Fax 304-876-5197)

Employee's Signature

Date

Shepherd University Medical Release to Return to Work

Patient's Name: _____ is released to return to work on _____ with the following restrictions:

_____ No restrictions required

_____ Restricted hours per day: This specified limit _____

_____ Restricted days per week: This specified limit _____

_____ Restricted weight lifting: No greater than: 50 lbs. 20 lbs. 10 lbs. 5 lbs. Other _____

Restrictions during a work shift

Bending/Stooping 0-3 hours 1-3 hours 3-5 hours 5-8+ hours No restriction

Pulling/Pushing 0-3 hours 1-3 hours 3-5 hours 5-8+ hours No restriction

Overhead Reaching 0-3 hours 1-3 hours 3-5 hours 5-8+ hours No restriction

Sitting 0-3 hours 1-3 hours 3-5 hours 5-8+ hours No restriction

Standing 0-3 hours 1-3 hours 3-5 hours 5-8+ hours No restriction

If other limitations please specify: _____

These restrictions are to be in effect starting _____ through and including _____

These limitations are: **Permanent** **Temporary**

May resume regular duties on _____ **OR** will be re-evaluated on _____

Physician's Signature (Must be signed by physician, not staff)

Date

Name of Physician (please print)

Physician's Phone Number

I hereby grant permission for my medical records to be released to the Human Resources Office, Shepherd University, PO Box 5000, Shepherdstown, WV, 25443. (Phone 304-876-5299; Fax 304-876-5197)

Employee's Signature

Date

It is the employee's responsibility to submit this form to the Department of Human Resources prior to returning to work. Shepherd University will take the suggestions that medical providers make into consideration, but it is the employer's decision as to whether requested accommodations can be met in a reasonable fashion. Employees will be notified by their supervisors if their duties can be modified to meet the restrictions described, or if such modifications cannot be made and they will need to remain off work on medical leave.