Southern

Southern West Virginia Community and Technical College

IMPORTANT NOTICE TO FACULTY REQUESTING MEDICAL LEAVE DUE TO EMPLOYEE'S SERIOUS HEALTH CONDITION

NAME: Date:

This notice will serve as a reminder that faculty employees who are unable to work for a period of thirty (30) calendar days will be taken off the institution's payroll at the end of the 30-day period (See SCP-2006 § 6.5.4). This policy also requires employees who have been absent longer than two consecutive work weeks, due to medical reasons for themselves or a family member, complete a request for medical leave and the supporting physician's statement. Failure to comply with policy may result in the employee being removed from the payroll.

If your disability continues longer than thirty (30) calendar days, you will need to make a claim for benefits with the group long-term disability plan (if you are a participant in this plan). You should also file a claim for disability benefits with the Social Security Administration and your group retirement plan.

This period of medical leave will count toward entitlement of the Family and Medical Leave Act of 1993 (FMLA) as applicable, which provides up to 12 weeks job-protected leave to eligible employees for certain family and medical reasons. This period of medical leave also counts toward entitlement provided by the WV Parental Leave Act, as applicable.

Please refer to SCP-2006 for additional information regarding Employee Leave.

Contact:

Debbie Dingess in the Human Resources Office
(304.896.7416 or debbied@southern.wvnet.edu)

Southern
SOUTHERN WEST VIRGINIA
COMMUNITY AND TECHNICAL COLLEGE
www.southern.wvnet.edu

REQUEST FOR MEDICAL LEAVE OF ABSENCE OR MILITARY FAMILY LEAVE

Name: _____ **Employee ID No**: _____

Title: _____ **Dept**: _____

I hereby request a leave of absence as follows:

Beginning Date: _____ **Ending Date:** _____

Purpose of Leave:

- ☐ The birth of a child, or placement of a child with you for adoption or foster care
- ☐ Your own serious health condition
- ☐ You are needed to care for your spouse, child, or parent due to his/her serious health condition
- ☐ Qualifying exigency arising out of the fact that your spouse, son or daughter, or parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves
- ☐ You are the spouse, son or daughter, parent, or next of kin of a covered servicemember with a serious injury or illness

I understand that while on an approved Leave of Absence, I am required to continue to pay my respective proportionate share of health/life/hospitalization/drug insurance coverage premium cost. I further understand that if the approved leave continues after 12 consecutive months, I may be required to pay the full cost of coverage (employee and employer's share).

I further understand that prior to my return to work, I am required to submit to my employer the *Return to Work Authorization /Medical Release* form from the treating licensed physician (except in the case of Military Family Leave due to qualifying exigency).

I further understand that the extent of this leave will count toward entitlement of the Family and Medical Leave Act (FMLA), which provides up to 12 weeks job-protected leave to eligible employees for certain family and medical reasons and up to 26 weeks job-protected leave to eligible employees to care for a covered servicemember under the Military Family Leave entitlement. See the attached publication by the U.S. Department of Labor entitled "*Employee Rights and Responsibilities Under the Family and Medical Leave Act*" (WHD Publication 1420).

I further understand that any extension of this leave must be requested in writing by completing a new Request for Medical Leave of Absence or Military Family Leave and provide a new Certification, and be submitted for the President's approval prior to the expiration of this approved leave.

I understand that approval of this Request does not guarantee payment of wages, leave or other compensation and that all policies, rules, and laws in regard to leave payment apply.

****IMPORTANT****

This request form MUST be accompanied by either a *Certification of Health Care Provider* (DOL Form WH-380-E or WH-380-F), *Certification of Qualifying Exigency* (DOL Form WH-384), or a *Certification for Serious Injury or Illness of Covered Servicemember* (Form WH-385)

_____
Employee's Signature Date

I recommend approval of this leave __Yes __No

_____
Supervisor's Signature Date

I recommend approval of this leave __Yes __No

_____
Unit Administrator's Signature Date

I recommend approval of this leave __Yes __No

_____
Human Resources Administrator's Signature Date

☐ Approved ☐ Denied

_____
President or Designee's Signature Date

Revised 3/16/2010

RESERVED FOR HUMAN RESOURCES DEPARTMENT USE ONLY

DO NOT WRITE IN THIS BOX

I. **Date leave commenced** _____ **Expected end date** _____

II. **Non-Faculty Employees Only:**

1. Verification of Leave Balances as of _____ *(Date)*

Annual Leave _____ days

Sick Leave _____ days

2. Exhaustion of all sick/annual leave as of _____
(Date & Time)

3. Date Catastrophic Leave Request Form Sent _____
(30 days prior to expiration of leave)

4. Applied for Catastrophic Leave? ❑ **YES** ❑ **NO** ❑ **N/A**

III. **Date notification letter sent:** _____

IV. **Verification of receipt of monthly physician's statement:**

Month *(List below)*	*Date Rec'd in HR*	*Month* *(List Below)*	*Date Rec'd in HR*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

V. **Verification of receipt of monthly insurance premiums:**

Month *(List below)*	*Date Rec'd in HR*	*Month* *(List Below)*	*Date Rec'd in HR*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

VI. **Date of Actual Return to Work/Duty:** _____
OR
Date extension of leave requested: _____

Southern
SOUTHERN WEST VIRGINIA
COMMUNITY AND TECHNICAL COLLEGE
www.southern.wvnet.edu

FACULTY ABSENCE REQUEST / REPORT

Name _____ Campus_____

Date of Absence: _____
If less than full day, also indicate time.

Section A **Planned Absence**

1. Reason for Absence_____

_____

2. Class(es) will be covered by:

_____ Colleague _____ _____ Guest Lecturer _____

_____ Division Chair/Campus Director _____ Special Class Assignment

_____ Make-up time

3. Duties to be missed:

_____ Office Hours _____ Registration _____ Advising

_____ Scheduled Meeting (s) _____ Commencement _____ Other

Section B **Unplanned Absence**

1. Reason for Absence _____

_____

2. Was Division Chairperson notified prior to Absence? _____ Yes _____ No

_____
Employee Signature Date

_____
Supervisor Signature Date

Revised 3/16/2010

Southern
SOUTHERN WEST VIRGINIA
COMMUNITY AND TECHNICAL COLLEGE
www.southern.wvnet.edu

RETURN TO WORK AUTHORIZATION
MEDICAL RELEASE FORM

PHYSICIAN - COMPLETE IN ENTIRETY:

Patient's Name: _____

I hereby certify that the above-named employee has been under my professional care for:

_____

_____
(Diagnosis)

Illness commenced: _____
(Date)

Employee is able to return to work on: _____
(Date)

Describe the functional limitations/restrictions, if any, caused by this condition:

_____

_____
(Functional limitations listed may require an analysis of employee's Position Information Questionnaire (PIQ) for ADA accommodation)

Duration of limitations/restrictions, if any: ❒ Permanent ❒ Temporary

If temporary, indicate time period: _____

_____
Signature of Physician

_____
Printed Name

_____
Address of Physician

_____
Telephone Number of Physician

Revised 3/16/2010

Certification of Health Care Provider for Employee's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division

U.S. Wage and Hour Division

OMB Control Number: 1215-0181
Expires: 12/31/2011

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.

Employer name and contact: Southern WV Community & Technical College, PO Box 2900 Mount Gay, WV 25637 (304) 896-7416

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. 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.**

EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- for incapacity due to pregnancy, prenatal medical care or child birth;
- to care for the employee's child after birth, or placement for adoption or foster care;
- to care for the employee's spouse, son, daughter or parent, who has a serious health condition; or
- for a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible 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 servicemember 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.*

***The FMLA definitions of "serious injury or illness" for current servicemembers and veterans are distinct from the FMLA definition of "serious health condition".**

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months*, and if at least 50 employees are employed by the employer within 75 miles.

***Special hours of service eligibility requirements apply to airline flight crew employees.**

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

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 as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- interfere with, restrain, or deny the exercise of any right provided under FMLA; and
- discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulation 29 C.F.R. § 825.300(a) may require additional disclosures.

For additional information:
1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627
WWW.WAGEHOUR.DOL.GOV

U.S. Department of Labor | Wage and Hour Division

WHD Publication 1420 · Revised February 2013