



Southern West Virginia Community and Technical College

**IMPORTANT NOTICE
REGARDING YOUR REQUEST
FOR MEDICAL LEAVE
DUE TO EMPLOYEE'S
SERIOUS HEALTH CONDITION**

NAME:

Date:

This will serve as official notification that your medical leave counts 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.

Policy SCP-2006 Employee Leave 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.

Once your leave is approved, you will remain on the institution's payroll until the expiration of your sick and annual leave. Prior to this expiration date you may wish to request Catastrophic Leave, wherein other employees may donate leave time to you so as not to disrupt your receipt of income.

If your disability is continuous for six (6) months, 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.

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)



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)

I recommend approval of this leave ___Yes ___No

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

Approved Denied

Human Resources Administrator's Signature Date

President or Designee's Signature Date

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:**

<u>Month</u> (List below)	<u>Date Rec'd in HR</u>	<u>Month</u> (List Below)	<u>Date Rec'd in HR</u>
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

<u>Month</u> (List below)	<u>Date Rec'd in HR</u>	<u>Month</u> (List Below)	<u>Date Rec'd in HR</u>
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

VI. Date of Actual Return to Work/Duty: _____

OR

Date extension of leave requested: _____



Employee Name _____

Date Submitted _____

Request for Leave

	Annual Leave	Sick Leave	Other: _____
Date(s):			
Time(s):			
Number of Hours to be Charged to Leave:			

Request to Attend Meeting/Seminar

I. Name of Meeting or Seminar _____

II. Date/s _____

III. Time _____

IV. Estimated Length of Meeting _____

V. Meeting Location _____

FMLA Notice

The extent of your leave used for medical reasons counts 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.

Overtime and Compensatory Time

For requests and approvals for Compensatory Time and to work Overtime, please refer to SCP-2575 and SCP-2575.A.

ATTENTION SUPERVISOR

Please hold the Original copy until the end of the month. Attach the original to the employee's Time Card and forward to Human Resources. Make one copy for your records and one copy to return to the employee.

Employee Signature Date

Approved by Supervisor Date



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

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



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: _____

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.

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 servicemember 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



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