Southern

Southern West Virginia Community and Technical College

IMPORTANT NOTICE TO FACULTY REQUESTING MILITARY FAMILY LEAVE (COVERED SERVICEMEMBER)

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.

This period of medical leave counts toward entitlement of Military Family Leave under the Family and Medical Leave Act (FMLA), which provides up to 26 weeks job-protected leave during a single 12-month period for eligible employees to care for a covered servicemember who has a serious injury or illness incurred in the line of duty on active duty.

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

Contact Human Resources:

Doug Kennedy
304.896.7408 or doug.kennedy@southernwv.edu
or
Susan Ross
304.896.7445 or susan.ross@southernwv.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: _____

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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 for Serious Injury or Illness of a Current Servicemember for Military Caregiver Leave under the Family and Medical Leave Act

U.S. Department of Labor
Wage Hour Division

WAGE AND HOUR DIVISION

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR. RETURN TO THE PATIENT.

OMB Control Number: 1235-0003
Expires: 6/30/2023

The Family and Medical Leave Act (FMLA) provides that eligible employees may take FMLA leave to care for a covered servicemember with a serious illness or injury. The FMLA allows an employer to require an employee seeking FMLA leave for this purpose to submit a medical certification. 29 U.S.C. §§ 2613, 2614(c)(3). The employer must give the employee **at least 15 calendar days** to provide the certification. If the employee fails to provide complete and sufficient certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

SECTION I - EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, it asks the health care provider for the information necessary for a complete and sufficient medical certification. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. § 825.310. Recertifications are not allowed for FMLA leave to care for a covered servicemember. Where medical certification is requested by an employer, an employee may not be held liable for administrative delays in the issuance of military documents, despite the employee's diligent, good-faith efforts to obtain such documents.** An employer requiring an employee to submit a certification for leave to care for a covered servicemember **must** accept as sufficient certification invitational travel orders (ITOs) or invitational travel authorizations (ITAs) issued to any family member to join an injured or ill servicemember at the servicemember's bedside. An ITO or ITA is sufficient certification for the duration of time specified in the ITO or ITA.

Employers must generally maintain records and documents relating to medical information, 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, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

(1) Employee name: _____
First *Middle* *Last*

(2) Employer name: _____ Date: _____ *(mm/dd/yyyy)*
(List date certification requested)

(3) This certification must be returned by: _____ *(mm/dd/yyyy)*
(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee's diligent, good faith efforts.)

SECTION II - EMPLOYEE and/or CURRENT SERVICEMEMBER

Please complete all Parts of Section II before having the servicemember's health care provider complete Section III. The FMLA allows 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 your employer, your response is required to obtain or retain the benefit of FMLA-protected leave.

PART A: EMPLOYEE INFORMATION

(1) Name of the current servicemember for whom employee is requesting leave: _____

Employee Name: _____

(2) Select your relationship to the current servicemember. You are the current servicemember's:

☐ Spouse ☐ Parent ☐ Child ☐ Next of Kin

Spouse means a husband or wife as defined or recognized in the state where the individual was married, including a common law marriage or same-sex marriage. The terms "child" and "parent" include *in loco parentis* relationships in which a person assumes the obligations of a parent to a child. An employee may take FMLA leave to care for a covered servicemember who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave to care for a covered servicemember for whom the employee has assumed the obligations of a parent. No biological or legal relationship is necessary. "Next of kin" is the servicemember's nearest blood relative, other than the spouse, parent, son, or daughter, in the following order of priority: (1) a blood relative as designated in writing by the servicemember for purposes of FMLA leave, (2) blood relatives granted legal custody of the servicemember, (3) brothers and sisters, (4) grandparents, (5) aunts and uncles, and (6) first cousins.

PART B: SERVICEMEMBER INFORMATION AND CARE TO BE PROVIDED TO THE SERVICEMEMBER

(3) The servicemember (☐ is / ☐ is not) a current member of the Regular Armed Forces, the National Guard or Reserves. If yes, provide the servicemember's military branch, rank and unit currently assigned to: _____

_____

(4) The servicemember (☐ is / ☐ is not) 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. If yes, provide the name of the medical treatment facility or unit: _____

(5) The servicemember (☐ is / ☐ is not) on the Temporary Disability Retired List (TDRL).

(6) Briefly describe the care you will provide to the servicemember: *(Check all that apply)*

☐ Assistance with basic medical, hygienic, nutritional, or safety needs
☐ Psychological Comfort ☐ Physical Care
☐ Transportation ☐ Other: _____

(7) Give your **best estimate** of the amount of leave needed to provide the care described: _____

_____

(8) If a reduced work schedule is necessary to provide the care described, give your **best estimate** of the reduced work schedule you are able to work. From _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*. I am able to work: _____ *(hours per day)* _____ *(days per week)*.

SECTION III - HEALTH CARE PROVIDER

Please provide your contact information, complete all Parts of this Section fully and completely, and sign the form below. The employee listed at Section I has requested leave under the FMLA to care for a family member who is a current 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. Note: For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty in the Armed Forces or that existed before the beginning of the member's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces that may render the servicemember medically unfit to perform the duties of the servicemember's office, grade, rank, or rating. "Need for care" includes both physical and psychological care. It includes situations where, for example, due to his or her serious injury or illness, the servicemember is not able to care for his or her own basic medical, hygienic, or nutritional needs or safety, or needs transportation to the doctor. It also includes providing psychological comfort and reassurance which would be beneficial to the servicemember who is receiving inpatient or home

Employee Name: _____

care. A complete and sufficient certification to support a request for FMLA leave due to a current servicemember's serious injury or illness includes written documentation confirming that the servicemember's injury or illness was incurred in the line of duty on active duty or if not, that the current servicemember's injury or illness existed before the beginning of the servicemember's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces, and that the current servicemember is undergoing treatment for such injury or illness by a health care provider listed above.

PART A: HEALTH CARE PROVIDER INFORMATION

Health Care Provider's Name: *(Print)* _____

Health Care Provider's business address: _____

Type of practice/Medical specialty: _____

Telephone: (___) _____ Fax: (___) _____ E-mail: _____

Please select the type of FMLA health care provider you are:

- ☐ DOD health care provider
- ☐ VA health care provider
- ☐ DOD TRICARE network authorized private health care provider
- ☐ DOD non-network TRICARE authorized private health care provider
- ☐ Health care provider as defined in 29 C.F.R. § 825.125

PART B: MEDICAL INFORMATION

Please provide appropriate medical information of the patient as requested below. Limit your responses to the servicemember's condition for which the employee is seeking leave. If you are unable to make some of the military-related determinations contained below, you are permitted to rely upon determinations from an authorized DOD representative, such as a DOD recovery care coordinator. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. §1635.3(e).

(1) Patient's Name: _____

(2) List the approximate date condition started or will start: _____ *(mm/dd/yyyy)*

(3) Provide your **best estimate** of how long the condition will last: _____

(4) The servicemember's injury or illness: *(Select as appropriate)*

- ☐ Was incurred in the line of duty on active duty.
- ☐ Existed before the beginning of the servicemember's active duty and was aggravated by service in the line of duty on active duty.
- ☐ None of the above.

(5) The servicemember (☐ is / ☐ is not) undergoing medical treatment, recuperation, or therapy for this condition.
If yes, briefly describe the medical treatment, recuperation or therapy: _____

Employee Name: _____

(6) The current servicemember's medical condition is classified as: *(Select as appropriate)*

- ☐ **(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 29 C.F.R. § 825.113 of the FMLA. If such leave is requested, you may be required to complete DOL FORM WH-380-F or an employer-provided form seeking the same information.*

PART C: AMOUNT OF LEAVE NEEDED

For the medical condition checked in Part B, complete all that apply. Some 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.

(7) Due to the condition, the servicemember will need care for a **continuous period of time**, including any time for treatment and recovery. Provide your **best estimate** of the beginning date _____ *(mm/dd/yyyy)* and end date _____ *(mm/dd/yyyy)* for this period of time.

(8) Due to the condition, it is medically necessary for the servicemember to attend **planned medical treatment** appointments (scheduled medical visits). Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery _____ *(e.g. 3 days/week)*

(9) Due to the condition, it is medically necessary for the servicemember to receive care on an **intermittent basis** (periodically), such as the care needed because of episodic flare-ups of the condition or assisting with the servicemember's recovery. Provide your **best estimate** of how often (frequency) and how long (the duration) the intermittent episodes will likely last.

Over the next 6 months, intermittent care is estimated to occur _____ times per (☐ day / ☐ week / ☐ month) and are likely to last approximately _____ (☐ hours / ☐ days) per episode.

Signature of Health Care Provider _____ **Date** _____ *(mm/dd/yyyy)*

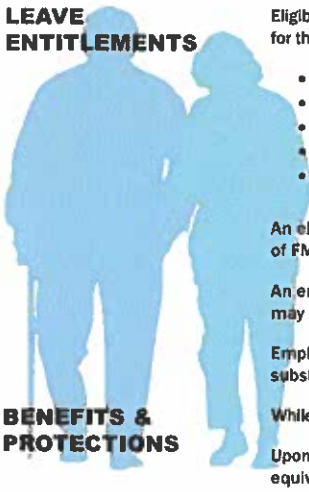
PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

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 15 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 Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THE DEPARTMENT OF LABOR. RETURN IT TO THE PATIENT.

EMPLOYEE RIGHTS
UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION



LEAVE ENTITLEMENTS

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within one year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

BENEFITS & PROTECTIONS

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

ELIGIBILITY REQUIREMENTS

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

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

REQUESTING LEAVE

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

EMPLOYER RESPONSIBILITIES

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

ENFORCEMENT

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

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

WAGE AND HOUR DIVISION