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

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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 Military Family Leave for Qualifying Exigency under the Family and Medical Leave Act

U.S. Department of Labor
Wage and Hour Division

WAGE AND HOUR DIVISION

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

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

The Family and Medical Leave Act (FMLA) provides that eligible employees may take FMLA leave for a qualifying exigency while the employee's spouse, child, or parent (the military member) is on covered active duty or has been notified of an impending call or order to covered active duty. The FMLA allows an employer to require an employee seeking FMLA leave due to a qualifying exigency to submit a certification. 29 U.S.C. §§ 2613, 2614(c)(3). The employer must give the employee **at least 15 calendar days** to provide the certification. 29 C.F.R. § 825.305(b). If the employee fails to provide complete and sufficient certification, the employee's FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at http://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 employee for the information necessary for a complete and sufficient qualifying exigency certification, which is set out at 29 C.F.R. § 825.309. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. § 825.309.**

(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

Please complete all Parts of Section II and sign the form before returning it to your employer. The FMLA allows an employer to require that you submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a qualifying exigency. If requested by your employer, your response is required to obtain the benefits and protections of the FMLA. 29 C.F.R. § 825.309. Failure to provide a complete and sufficient certification may result in a denial of your FMLA leave request. A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes written documentation confirming a military member's covered active duty or call to covered active duty status. **You are responsible for making sure the certification is provided to your employer within the time frame requested, which must be at least 15 calendar days.** 29 C.F.R. § 825.313.

(1) Provide the name of the military member on covered active duty or call to covered active duty status:

_____
First *Middle* *Last*

(2) Select your relationship of the military member. The military member is your:

☐ Spouse ☐ Parent ☐ Child, of any age

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 for a qualifying exigency related a military member who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave for a qualifying exigency related a military member for whom the employee has assumed the obligations of a parent. No legal or biological relationship is necessary.

Employee Name: _____

PART A: COVERED ACTIVE DUTY STATUS

Covered active duty or call to covered active duty in the case of a member of the Regular Armed Forces means duty during the deployment of the member with the Armed Forces to a foreign country. Covered active duty or call to covered active duty in the case of a member of the Reserve components means duty during the deployment of the member with the Armed Forces to a foreign country under a Federal call or order to active duty in support of a contingency operation pursuant to: Section 688 of Title 10 of the United States Code; Section 12301(a) of Title 10 of the United States Code; Section 12302 of Title 10 of the United States Code; Section 12304 of Title 10 of the United States Code; Section 12305 of Title 10 of the United States Code; Section 12406 of Title 10 of the United States Code; chapter 15 of Title 10 of the United States Code; or, any other provision of law during a war or during a national emergency declared by the President or Congress so long as it is in support of a contingency operation. 10 U.S.C. § 101(a)(13)(B).

An employer may require the employee to provide a copy of the military member's active duty orders or other documentation issued by the military which indicates that the military member is on covered active duty or call to covered active duty status, and the dates of the military member's covered active duty service. **This information need only be provided to the employer once, unless additional leave is needed for a different military member or different deployment.**

(3) Provide the dates of the military member's covered active duty service: _____

(4) Please check one of the following and attach the indicated written document to support that the military member is on covered active duty or call to covered active duty status:

- ☐ A copy of the military member's covered active duty orders
- ☐ Other documentation from the military indicating that the military member is on covered active duty or has been notified of an impending call to covered active duty, such as official military correspondence from the military member's chain of command
- ☐ I have previously provided my employer with sufficient written documentation confirming the military member's covered active duty or call to covered active duty status

PART B: APPROPRIATE FACTS

Under the FMLA, leave can be taken for a number of qualifying exigencies. 29 C.F.R. § 825.126(b). Complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes available written documentation which supports the need for leave such as a copy of a meeting announcement for informational briefings sponsored by the military, a document confirming the military member's Rest and Recuperation leave, or other documentation issued by the military which indicates that the military member has been granted Rest and Recuperation leave, or a document confirming an appointment with a third party (*e.g.*, a counselor or school official, or staff at a care facility, a copy of a bill for services for the handling of legal or financial affairs). Please provide appropriate facts related to the particular qualifying exigency to support the FMLA leave request, including information on the type of qualifying exigency and any available written documentation of the exigency event.

(5) Select the appropriate **Qualifying Exigency Category** and, if needed, provide additional information related to the event:

- ☐ Short notice deployment (*i.e.,* deployment within seven or fewer days of notice)
- ☐ Military events and related activities *(e.g., official ceremonies or events, or family support and assistance programs):*

  _____
- ☐ Childcare related activities for the child of the military member *(e.g., arranging for alternative childcare):*

  _____

Employee Name: _____

- ☐ Care for the military member's parent *(e.g., admitting or transferring the parent to a new care facility):*

  _____

- ☐ Financial and legal arrangements related to the deployment *(e.g., obtaining military identification cards)*
- ☐ Counseling related to the deployment (*i.e.*, counseling provided by someone other than a health care provider)
- ☐ Military member's short-term, temporary Rest and Recuperation leave (R&R) (leave for this reason is limited to 15 calendar days for each instance of R&R)
- ☐ Post deployment activities *(e.g., arrival ceremonies, or reintegration briefings and events):* _____

  _____

- ☐ Any other event that the employee and employer agree is a qualifying exigency: _____

  _____

(6) **Available written documentation** supporting this request for leave is (☐ attached / ☐ not attached / ☐ not available).

PART C: AMOUNT OF LEAVE NEEDED

Provide information concerning the amount of leave that will be needed. Several questions in this section seek a response as to the frequency or duration of the qualifying exigency leave needed. Be as specific as you can; terms such as "*unknown*" or "*indeterminate*" may not be sufficient to determine FMLA coverage.

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

(8) Provide your best estimate of how long the exigency lasted or will last:

From _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*

(9) Due to a qualifying exigency, I need to work a **reduced schedule**. Provide your **best estimate** of the reduced schedule you are able to work:

From _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*

I am able to work _____

(e.g., 5 hours/day, up to 25 hours a week)

(10) Due to a qualifying exigency, I will need to be absent from work for a **continuous period of time**. Provide your **best estimate** of the beginning and ending dates for the period of absence:

From _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*

Employee Name: _____

(11) Due to a qualifying exigency, I will need to be absent from work on an **intermittent basis** (periodically).

Provide your **best estimate** of the frequency (how often) and duration (how long) of each appointment, meeting, or leave event, including any travel time.

Over the next 6 months, absences on an **intermittent basis** are estimated to occur: _____ times per (☐ day / ☐ week / ☐ month) and are likely to last approximately _____ (☐ hours / ☐ days) per episode.

(12) My leave is due to a qualifying exigency that involves **Rest and Recuperation leave** (R & R) of the military member (leave for this reason is limited to 15 calendar days for each instance of R & R leave).

List the dates of the military member's R &R leave:

From _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*

PART D: THIRD PARTY INFORMATION

If applicable, please provide information below that may be used by your employer to verify meetings or appointments with a third party related to the qualifying exigency. Examples of meetings with third parties include: arranging for childcare or parental care, to attend non-medical counseling, to attend meetings with school, childcare or parental care providers, to make financial or legal arrangements, to act as the military member's representative before a federal, state, or local agency for purposes of obtaining, arranging or appealing military service benefits, or to attend any event sponsored by the military or military service organizations. This information may be used by your employer to verify that the information contained on this form is accurate.

Individual *(e.g., name and title)* or Entity / Organization: _____

Address: _____

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

Describe purpose of meeting: _____

Employee Signature _____ **Date** _____ *(mm/dd/yyyy)*

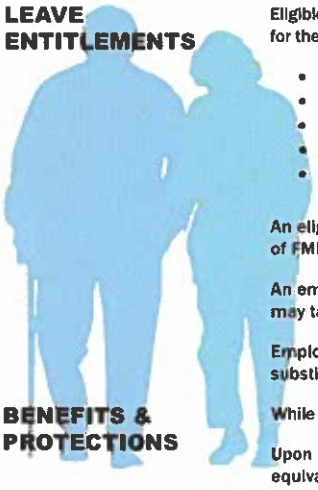
PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 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 DEPARTMENT OF LABOR. RETURN FORM TO THE EMPLOYER.

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

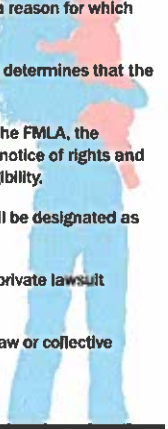
Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is 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