

# Medical Leave Fact Sheet

## Family and Medical Leave Act

As a faculty or staff member employed at Illinois State University, you may take up to twelve (12) weeks of paid/unpaid, job-protected leave for certain family and medical reasons. Whether the leave is paid or unpaid is dependent on what benefits you have available. You are eligible for this leave if you have total cumulative service of at least one year and have worked at least 1250 hours during the previous 12 months. Your FMLA leave time will be calculated on a “rolling” 12-month period measured backward from the date of any FMLA leave usage. All approved requests for Extended Illness Leaves and Worker’s Comp Leaves will count toward the 12-week limit if you qualify for an FMLA leave.

Although most leaves will be continuous, some leaves may be intermittent. Approved FMLA leave is used concurrently with any payable time. Earned sick, vacation, and compensatory time must be used and will count toward the 12-week limit.

### Notification Requirements

If you are going to be absent for more than 3 consecutive days due to a serious health condition, please review the reverse side of this fact sheet for more information. You must notify your immediate supervisor and Human Resources Benefit Services (Nelson Smith Building, Room 101, 438-8311) at least 30 days before you want to go on leave under the FMLA. If 30-days notice is not possible, then notification must be as soon as possible. Written documentation to support the absence must be received no later than 15 calendar days following the FMLA request date. If proper documentation is not received within the 15 days, your request for FMLA could be denied.

### Your Responsibilities

**Employee:** It is your responsibility to inform your supervisor of any time missed due to your FMLA leave. Benefit time should be reported on the time card or benefit usage card and marked as sick leave for continuous FMLA leave or FM for intermittent FMLA leave. (See example below)

**Supervisor:** Time reporting is the responsibility of the supervisor during the employee’s absence. (See example below)

	FM	FM	FM
Day of Month	1	2	3
Regular Hrs.	7.5		4.0
Vacation Hrs.			
Sick Hrs.		7.5	3.5

**Insurance:** Should you find that your payable benefits do not cover the entire duration of your FMLA leave, Illinois State University will continue your insurance program as it existed just prior to your FMLA leave. You will be billed for your normal payroll deduction amounts. If you fail to pay your bill, your insurance coverage will be terminated.

### Returning to Work

- If you have been off work due to your own serious health condition and your physician returns you to work with no restrictions, you must submit a physician's release to Human Resources as soon as you receive it.
- If your physician returns you to work with restrictions or on a part-time basis, you must submit a physician's release to Human Resources as soon as you receive it. The University may need up to five working days to determine if you will be able to perform your duties according to your job description. During this five-day period, you will remain on leave. You CANNOT return to work with restrictions until the University agrees to accept the limitations.
- If you are returning to work from a continuous FMLA leave for caring for a family member, you must notify Human Resources of your impending return as soon as possible.
- If you are returning to work following a worker’s compensation leave, you must take a physician’s release to the Office of Human Resources (Nelson Smith Building Room 101, 438-8311) in order to return to work.

### Job Protection and Benefits

- When you return from FMLA leave, you will be restored to your original or equivalent position with equivalent pay, benefits, and other terms of employment.
- Your group health insurance and other existing benefits will be maintained for the duration of FMLA leave.
- You will accrue benefits while using earned sick and vacation time. You will not accrue benefits while on unpaid FMLA leave.
- Extended benefits (150 hours) will not be paid until proper medical documentation is received.

### Intermittent Leave

An initial interview is required with a leave coordinator to review your responsibilities while on an intermittent leave. When reporting an unscheduled FMLA absence, you must designate the absence as FMLA at that time. If your intermittent leave provides for scheduled absences, you are required to notify your supervisor of dates and times of your absences in advance. Supporting documentation may be requested.

### Your Rights

If you feel that your rights have been denied, please forward your appeal to the Director of Human Resources.

# Employee Rights and Responsibilities

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## 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 or 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 with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the service member medically unfit to perform his or her duties for which the service member is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

## 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 one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

## 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;
- 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.

**ILLINOIS STATE UNIVERSITY  
OFFICE OF HUMAN RESOURCES  
MEDICAL LEAVE APPLICATION**

**Section I: Applicant Section**

Name: \_\_\_\_\_ University ID: \_\_\_\_\_

Address: \_\_\_\_\_ Home Ph: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Work Ph: \_\_\_\_\_

Employee Type: \_\_\_ Administrative/Professional \_\_\_ Civil Service \_\_\_ Faculty Employment %: \_\_\_\_\_

Department: \_\_\_\_\_ Mail Code: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Beginning Date for Leave: \_\_\_\_\_ Estimated Length of Leave: \_\_\_\_\_

Last Day Worked: \_\_\_\_\_ Normal Work Schedule (Days & Times): \_\_\_\_\_

Type of Leave: (circle one)      Continuous      Intermittent      Reduced Schedule      Worker's Comp

**Basic Leave**

\_\_\_ The birth of a child, or placement of a child with you for adoption or foster care.

\_\_\_ Your own serious health condition.

\_\_\_ Because you are needed to care for your \_\_\_ spouse \_\_\_ parent due to his/her serious health condition.

Name of spouse or parent \_\_\_\_\_.

\_\_\_ Because you are needed to care for your child.

Name of child \_\_\_\_\_ Date of birth of child \_\_\_\_\_.

**Military Family Leave**

\_\_\_ Because of a qualifying exigency arising out of the fact that your \_\_\_ spouse; \_\_\_ son or daughter; \_\_\_ 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. Name of service member \_\_\_\_\_.

\_\_\_ Because you are the \_\_\_ spouse; \_\_\_ son or daughter; \_\_\_ parent; \_\_\_ next of kin of a covered service member with a serious injury or illness. Name of service member \_\_\_\_\_.

**Please sign your initials to certify that you have read and understand each section below.**

\_\_\_ In order to determine whether your absence qualifies as FMLA leave, requested documentation must be provided within 15 calendar days following the FMLA request date. If documentation is not received within the allowed time period, your leave could be denied.

\_\_\_ You will be required to use your available payable benefits during your FMLA absence. This means that you will receive your paid leave and the leave will also be considered protected FMLA leave and counted against your FMLA leave entitlement.

\_\_\_ While on leave you will be required to furnish us with periodic reports of your status and intent to return to work when requested.

I certify that I have received and read the Medical Leave Fact Sheet and Employee's Rights and Responsibilities. I have read and initialed each section above. I understand that I am required to provide appropriate documentation to substantiate my need for the above leave.

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Section II: Human Resource's Response to Medical Leave Application**

- The medical certification for completion by physician must be received within 15 calendar days following the FMLA request date.
- Other documentation \_\_\_\_\_ due on \_\_\_\_\_  
**If requested documentation is not received within allowed time, your leave application could be denied.**
- Provided employee a copy of their job description

**Tentative FMLA Response Pending Medical Certification**

- Tentatively Approved
- Formally Denied/Denial Reason Code \_\_\_\_\_
- Initials/Date \_\_\_\_\_

**Formal Response to FMLA/Medical Leave Application**

- Medical Leave application  Approved  Denied/Denial Reason Code \_\_\_\_\_  Not Applicable
- FMLA Application  Approved  Denied/Denial Reason Code \_\_\_\_\_

FMLA Intermittent Leave Expiration Date\* \_\_\_\_\_

\* *If the need for this leave still exists after the expiration date, it is your responsibility to contact Human Resources to continue the leave.*

**Reason For Denial**

- 1) Has not worked 1250 hours within the past 12 month
- 2) Did not return a completed physician certification
- 3) Has no available FMLA hours remaining
- 4) No documented serious health condition
- 5) Extended benefits have been exhausted
- 6) Has not met the FMLA's 12-month length of service requirement

- Extended Sick Leave  Approved/Sick leave hours that must be used prior to extended \_\_\_\_\_
- (Civil Service Employees Only)  Denied/Denial Reason Code \_\_\_\_\_
- Not Applicable

**Comments:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
*Authorized Signature* *Date*

**Formal Notice Distribution : Employee, Supervisor, Human Resources** **Revised 4/09**

**FMLA Certification of Health Provider for Family Member**

**For Completion by the EMPLOYEE**

Your name: \_\_\_\_\_

Name of family member for whom you will provide care: \_\_\_\_\_

Relationship of family member to you: \_\_\_\_\_

If family member is your son or daughter, date of birth: \_\_\_\_\_

Describe care you will provide to your family member and estimate leave needed to provide care:  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

**For Completion by the HEALTH CARE PROVIDER**

The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. 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 patient needs leave. **Please be sure to sign the form on the last page.**

**MEDICAL FACTS: Part A**

Approximate date condition commenced: \_\_\_\_\_

Probable duration of condition: \_\_\_\_\_

1. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?  
\_\_\_ No \_\_\_ Yes      If yes, dates of admission: \_\_\_\_\_
2. Date(s) you treated the patient for condition: \_\_\_\_\_
3. Will the patient need to have treatment visits at least twice per year due to the condition? \_\_\_ No \_\_\_ Yes
4. Was medication, other than over-the-counter medication, prescribed? \_\_\_ No \_\_\_ Yes
5. Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?  
\_\_\_ No \_\_\_ Yes      If yes, state the nature of such treatments and expected duration of treatment:  
\_\_\_\_\_  
\_\_\_\_\_
6. Is the medical condition pregnancy? \_\_\_ No \_\_\_ Yes      If yes, expected delivery date: \_\_\_\_\_
7. 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): \_\_\_\_\_  
\_\_\_\_\_

**--See Reverse--**

**AMOUNT OF CARE NEEDED: Part B** *When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care.*

1. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery?  No  Yes  
If yes, estimate the beginning and ending dates for the period of incapacity: \_\_\_\_\_
2. During this time, will the patient need care?  No  Yes  
Explain the care needed by the patient and why such care is medically necessary in Comments Section below.
3. Will the patient require follow-up treatments, including any time for recovery?  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:  
\_\_\_\_\_
4. Explain the care needed by the patient, and why such care is medically necessary in Comments Section below.
5. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery?  
 No  Yes  
Estimate the hours the patient needs care on an intermittent basis, if any:  
\_\_\_\_\_ hour(s) per day from \_\_\_\_\_ through \_\_\_\_\_  
\_\_\_\_\_ days per week from \_\_\_\_\_ through \_\_\_\_\_  
Explain the care needed by the patient and why such care is medically necessary in Comments Section below.
6. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities?  No  Yes  
If yes, does the patient need care during these flare-ups?  No  Yes  
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
7. **Comments:** Explain the care needed by the patient, and why such care is medically necessary:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Signature of Health Care Provider**

\_\_\_\_\_  
**Date**

Provider's name and business address: \_\_\_\_\_  
\_\_\_\_\_

Type of practice / Medical specialty: \_\_\_\_\_

Telephone: (\_\_\_\_\_) \_\_\_\_\_ Fax:(\_\_\_\_\_) \_\_\_\_\_