

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, 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 Environmental Health and Safety (Nelson Smith Building Room 202, 438-8325) 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

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
FMLA/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**

REQUIREMENTS WHILE ON INTERMITTENT FMLA LEAVE

Please initial each of the following statements indicating that you have read, understand, and will comply with each of these requirements. If you have any questions about this form, it is your responsibility to contact your Benefits Counselor for clarification prior to signing and submitting this form. You may reach your Benefits Counselor at the Office of Human Resources by calling 309-438-8311 (TDD/TTY 309-438-2269).

- Intermittent Leave starts with the date the application is completed or requested.
- Doctor's certification needs to be completed and returned within 15 days of the signed application or the leave could be denied.
- If additional information is needed from the doctor, it will be your responsibility to provide the information within the designated time period.
- If the Intermittent Leave is for scheduled absences, you must provide the dates and times of your scheduled absences to your department (and to Human Resources, if requested).
- When calling in/reporting an unscheduled absence covered by your Intermittent FMLA Leave, you must clearly designate the absence as FMLA time to whomever you are required to report your absences.
- Approved Intermittent FMLA Leave **can only** be used for the medical condition identified on the doctor's certification form.
- When the Intermittent FMLA medical condition prevents you from working more than 3 consecutive days, an application for Continuous FMLA Leave must be completed.
- Partial day absences will count toward the total Intermittent FMLA absence allowance.
- Intermittent Leave does expire. If the need for leave still exists after the expiration date, it is your responsibility to request an updated leave.
- FMLA time reported on your benefit usage or time card should be marked with the designation "FM" above it.
- Extended benefits (150 hours) are not payable while on an Intermittent Leave. Only sick, vacation, or comp time can be used for these absences.

Applicant signature: _____ Date: _____

Certification for Serious Injury or Illness of Covered Service Member for Military Family Leave

SECTION I: For Completion by the EMPLOYEE and/or the COVERED SERVICE MEMBER for whom the Employee Is Requesting Leave.

This section must be completed first before Section II can be completed by a health care provider.

Name of Employee Requesting Leave to Care for Covered Service Member:

Name of Covered Service Member (for whom employee is requesting leave to care):

Relationship of Employee to Covered Service Member Requesting Leave to Care:

Spouse Parent Son Daughter Next of Kin

Is the Covered Service Member a Current Member of the Regular Armed Forces, the National Guard or Reserves? Yes No

If yes, please provide the covered service member's military branch, rank and unit currently assigned to:

Is the covered service member 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)? Yes No

If yes, please provide the name of the medical treatment facility or unit: _____

Is the Covered Service Member on the Temporary Disability Retired List (TDRL)? Yes No

Describe the Care to Be Provided to the Covered Service Member and an Estimate of the Leave Needed to Provide the Care:

SECTION II: For Completion by a UNITED STATES DEPARTMENT OF DEFENSE (“DOD”) HEALTH CARE PROVIDER or a HEALTH CARE PROVIDER who is either: (1) a United States Department of Veterans Affairs (“VA”) health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider. INSTRUCTIONS to the HEALTH CARE PROVIDER:

The employee listed on Section I has requested leave under the FMLA to care for a family member who is a 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. For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty that may render the service member medically unfit to perform the duties of his or her office, grade, rank, or rating.

A complete and sufficient certification to support a request for FMLA leave due to a covered service member’s serious injury or illness includes written documentation confirming that the covered service member’s injury or illness was incurred in the line of duty on active duty and that the covered service member is undergoing treatment for such injury or illness by a health care provider listed above. 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.

Health Care Provider’s Name and Business Address:

Telephone: () _____ Fax: () _____ Email: _____

Type of Practice/Medical Specialty: _____

Please check the appropriate box as to whether you are either: ___ a DOD health care provider; ___ a VA health care provider; ___ a DOD TRICARE network authorized private health care provider; or ___ a DOD non-network TRICARE authorized private health care provider.

Covered Service Member’s medical condition is classified as (Check One of the Appropriate Boxes):

___ **(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 service member medically unfit to perform the duties of the member’s office, grade, rank, or rating.

___ **NONE OF THE ABOVE**

Was the condition for which the Covered Service member is being treated incurred in line of duty on active duty in the armed forces? ___ Yes ___ No

Approximate date condition commenced: _____

Probable duration of condition and/or need for care: _____

Is the covered service member undergoing medical treatment, recuperation, or therapy? Yes No

If yes, please describe medical treatment, recuperation or therapy:

Will the covered service member need care for a single continuous period of time, including any time for treatment and recovery? Yes No

If yes, estimate the beginning and ending dates for this period of time: _____

Will the covered service member require periodic follow-up treatment appointments? Yes No

If yes, estimate the treatment schedule: _____

Is there a medical necessity for the covered service member to have periodic care for these follow-up treatment appointments? Yes No

If yes, please estimate the frequency and duration of the periodic care:

Signature of Health Care Provider: _____ **Date:** _____