The Family and Medical Leave Act requires that an employee provide his/her employer (The University of Arkansas) with 30 calendar days advance notice prior to the expected start of the leave. If 30 days advance notice is not possible, the employee must provide the employer with as much advance notice as possible, ordinarily within one or two business days of when the need for leave becomes known to the employee.

The FMLA forms are required to be completed and returned to Human Resources. These forms are required to document whether your absence from work meets the criteria to establish an FMLA eligible situation. If the circumstances surrounding your absence meet the FMLA eligibility requirements, the University has an obligation to protect your job for a period of up to twelve workweeks per calendar year or twenty-six workweeks per 12-month period for care of a covered service member.

These forms should be returned to Wa'Nika Smith in Human Resources at ADMN 222 as soon as possible.

If you have any questions, please contact Wa'Nika Smith at Human Resources, phone 479-575-7618 or fax 479-575-6971.

Revised 02/2015
REQUEST FOR FAMILY AND MEDICAL LEAVE
University of Arkansas Fayetteville

<table>
<thead>
<tr>
<th>Employee Name (Last, First, MI)</th>
<th>Date (mm/dd/yy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee I.D. Number</td>
<td>Department</td>
</tr>
<tr>
<td>Supervisor Name</td>
<td>Employee Job Title</td>
</tr>
<tr>
<td>Requested FMLA Begin Date (mm/dd/yy)</td>
<td>Requested FMLA End Date (mm/dd/yy)</td>
</tr>
</tbody>
</table>

Please read and sign below:

- I am requesting Family and Medical Leave (FMLA) for the dates shown above.
- I understand that FMLA, as federally mandated, is unpaid leave. Current state policy, however, requires substitution of accrued paid leave for FMLA time request when such leave is available.
- I understand that the University of Arkansas may require a written second opinion from a health care provider at the expense of the University.
- I understand that, if approved for FMLA, the University will continue paying the Employer portion of my group health insurance, if I am a participant. I understand that I am responsible for paying the Employee’s portion for the Health Plan for each pay period. If I do not pay, my Health Plan may be cancelled after 30 days.

<table>
<thead>
<tr>
<th>Employee Signature</th>
<th>Date (mm/dd/yy)</th>
</tr>
</thead>
</table>

**AUTHORIZED (to be completed by HR personnel only):**

- [ ] Approved
- [ ] Disapproved

FMLA type:  
- [ ] Personal
- [ ] Maternity/Paternity
- [ ] Family

Eligibility: Employed 12 mo: ___________ 1,250 hrs worked: ___________

Approving Authority: ___________________________________________

Date: ________________________________________________________

Revised 02/2015
EMPLOYEE RIGHTS AND RESPONSIBILITIES
UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement
FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- for incapacity due to pregnancy, prenatal medical care or child birth;
- to care for the employee's child after birth, or placement for adoption or foster care;
- to care for the employee's spouse, son, daughter or parent, who has a serious health condition; or
- for a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements
Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness.*

*The FMLA definitions of "serious injury or illness" for current servicemembers and veterans are distinct from the FMLA definition of "serious health condition".

Benefits and Protections
During FMLA leave, the employer must maintain the employee’s health coverage under any “group health plan” on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee’s leave.

Eligibility Requirements
Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months*, and if at least 50 employees are employed by the employer within 75 miles.

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

Definition of Serious Health Condition
A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee’s job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave
An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer’s operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave
Employees may choose when or may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer’s normal paid leave policies.

Employee Responsibilities
Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer’s normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities
Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees’ rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee’s leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers
FMLA makes it unlawful for any employer to:

- interfere with, restrain, or deny the exercise of any right provided under FMLA; and
- discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement
An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supercede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulation 29 C.F.R. § 825.300(a) may require additional disclosures.

For additional information:
1-866-USWAGE (1-866-848-9243) TTY: 1-877-889-5627
WWW.WAGEHOUR.DOL.GOV

U.S. Department of Labor | Wage and Hour Division
FAMILY AND MEDICAL LEAVE ACT OF 1993 PROCEDURES
UNIVERSITY OF ARKANSAS, FAYETTEVILLE

1. Time granted under the Family and Medical Leave Act of 1993 will be counted against the annual
12-work week entitlement, which is based on a calendar year. An employee's Family and Medical
Leave designation must be approved by the University or Arkansas Human Resources
representative.

2. A Certification of Health Care Provider form must be completed and submitted to Human
Resources for each request for Family and Medical Leave. The certification must be submitted
within 15 days of each request for Family and Medical Leave or as soon as is reasonably possible
in the case of unforeseen need for leave. A certification is needed for each occasion where the
employee is requesting leave to assist a seriously ill family member. Under specified circumstance,
the University may request re-certification after 30 days. Failure to provide certification as
designated above may result in denial of Family and Medical Leave until such time as the
completed certification is received or discontinuation of leave currently in effect.

3. It is Board Policy that all applicable accumulated paid leave must be exhausted before Family and
Medical Leave without pay (LWOP) will be granted except for maternity leave requests. Leave
requested for maternity purposes (birth or adoption of a child) will be counted toward the annual
12-work week Family and Medical Leave allotment.

4. In accordance with the Family and Medical Leave Act of 1993, the University will continue to
pay the employee's matching portion of Group Health, Basic Life and Basic Long Term Disability
Insurance Coverage for employees on Family and Medical Leave. The employee is responsible for
paying his/her portion of the premium, if his/her monthly paycheck is not sufficient to cover the
premium deduction or if the employee is on full LWOP. If the employee does not continue to pay
the employee portion of the premium, the insurance may be canceled.

5. Premiums should be paid to the University's insurance representative. Checks should be made
payable to the "University of Arkansas".

6. At the time of each premium payment, the employee must report his/her status and intention to
return to work.

7. The employee may choose no: to retain health coverage during Family and Medical Leave.
However, the employee is entitled to be reinstated on the same terms as prior to taking the leave,
without a qualifying period, physical examination, exclusion of pre-existing condition, etc., upon
returning to work.

8. Except as required by the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), the
University's obligation to maintain health benefits under the Family and Medical Leave Act
ceases if and when an employee informs the employer of his/her intent not to return from leave, or
the employee fails to return from leave, or the employee exhausts his/her Family and Medical
Leave entitlement.

9. The University will recover any premium payment missed by the employee and may recover the
University's share of premiums if the employee fails to return to work or leave expires, except in
certain stipulated circumstances.

10. If Family and Medical Leave is granted for the employee's own serious health condition, before the
employee may return to work, she/he must provide a statement from the health provider
stipulating that the employee is able to return to work. Any restrictions must be identified on the
statement.

11. The employee generally has a right to return to the same position or an equivalent position with
equivalent pay, benefit and working conditions at the conclusion of the leave.

I confirm that I have read the information contained herein on

(Date)_________________ (Employee's signature)_________________
UNIVERSITY OF ARKANSAS, FAYETTEVILLE
Genetic Information Nondiscrimination Act of 2008
(GINA) Disclosure Statement for Family Member

Note to employee: Please provide this notice to the health care provider with the appropriate certification form.

Pursuant to GINA's "safe harbor" provision in 29 CFR §1635.8(b)(1)(i) and 29 CFR §1635.8(b)(3) (providing for an exception for FMLA requests regarding the medical condition of a family member), the following language must be included with requests under the FMLA concerning a spouse, parent, or child's medical condition.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.
Certification of Health Care Provider for Family Member's Serious Health Condition (Family and Medical Leave Act)
SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to 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. 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). Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provide’s name and business address:__________________________________________________________

Type of practice / Medical specialty: ____________________________________________________________

Telephone: (_____)________________ Fax: (_____)__________________________________________

PART A: MEDICAL FACTS

1. Approximate date condition commenced: ______________________________________________________

   Probable duration of condition: ______________________________________________________________________

   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?  
   ____No  ____Yes. If so, dates of admission: __________________________________________________________

   Date(s) you treated the patient for condition: __________________________________________________________

   Was medication, other than over-the-counter medication, prescribed?  ____No  ____Yes.

   Will the patient need to have treatment visits at least twice per year due to the condition?  ____No  ____Yes

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?  
   ____No  ____Yes. If so, state the nature of such treatments and expected duration of treatment:

                                                                                                           __________________________________________________________________________

                                                  2. Is the medical condition pregnancy?  ____No  ____Yes. If so, expected delivery date: ________________________

2. Is the medical condition pregnancy?  ____No  ____Yes. If so, expected delivery date: ________________________

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

                                                                                                           __________________________________________________________________________

                                                                                                           __________________________________________________________________________

                                                                                                           __________________________________________________________________________
PART B: AMOUNT OF CARE NEEDED: 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:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery?  ____No  ____Yes.

   Estimate the beginning and ending dates for the period of incapacity: ________________________________

   During this time, will the patient need care?  ____No  ____Yes.

   Explain the care needed by the patient and why such care is medically necessary:

   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________

5. 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:

   ______________________________________________________

   Explain the care needed by the patient, and why such care is medically necessary:

   ______________________________________________________
   ______________________________________________________
   ______________________________________________________

6. 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; ________ days per week  from ____________ through ____________

   Explain the care needed by the patient, and why such care is medically necessary:

   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities?  ____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

Does the patient need care during these flare-ups?  ____No  ____Yes.

Explain the care needed by the patient, and why such care is medically necessary: ______________________________

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