

# 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 servicemember during a single 12-month period. A covered servicemember 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 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; 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 supersede 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:  
1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627  
[WWW.WAGEHOUR.DOL.GOV](http://WWW.WAGEHOUR.DOL.GOV)

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



WHD Publication 1420 - Revised February 2013

# REQUEST FOR FAMILY AND MEDICAL LEAVE

## University of Arkansas Fayetteville

Employee Name (Last, First, MI)		Date (mm/dd/yy)
Employee I.D. Number	Department	Telephone Number
Supervisor Name		Employee Job Title
Requested FMLA Begin Date (mm/dd/yy)	Requested FMLA End Date (mm/dd/yy)	
<p>Please read and sign below:</p> <ul style="list-style-type: none"> <li>• I am requesting Family and Medical Leave (FMLA) for the dates shown above.</li> <li>• 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.</li> <li>• I understand that the University of Arkansas may require a written second opinion from a health care provider at the expense of the University.</li> <li>• 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.</li> </ul>		
Employee signature		Date (mm/dd/yy)

### AUTHORIZATION (to be completed by HR personnel only):

<input type="checkbox"/> Approved <input type="checkbox"/> Disapproved	
FMLA type: <input type="checkbox"/> Personal <input type="checkbox"/> Maternity/Paternity <input type="checkbox"/> Family	
Eligibility:    Employed 12 mo: _____            1,250 hrs worked _____	
Approving Authority: _____	
Date: _____	

**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 of 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 circumstances, 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 employer'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 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 not 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, 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 payments 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 care provide 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, benefits 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 for Serious Injury  
or Illness of a Veteran for  
Military Caregiver Leave  
(Family and Medical Leave Act)

U.S. Department of Labor  
Wage and Hour Division



OMB Control Number: 1235-0003  
Expires: 2/28/2015

**Notice to the EMPLOYER**

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking military caregiver leave under the FMLA leave due to a serious injury or illness of a covered veteran to submit a certification providing sufficient facts to support the request for leave. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 CFR 825.310. Employers must generally maintain records and documents relating to 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 CFR 1630.14(c)(1), if the Americans with Disabilities Act applies.

**SECTION I: For completion by the EMPLOYEE and/or the VETERAN for whom the employee is requesting leave**

**INSTRUCTIONS to the EMPLOYEE and/or VETERAN:** Please complete Section I before having Section II completed. The FMLA permits an employer to require that an employee submit a timely, complete, and sufficient certification to support a request for military caregiver leave under the FMLA leave due to a serious injury or illness of a covered veteran. If requested by the employer, your response is required to obtain or retain the benefit of FMLA-protected leave. 29 U.S.C. 2613, 2614(c)(3). Failure to do so may result in a denial of an employee's FMLA request. 29 CFR 825.310(f). The employer must give an employee at least 15 calendar days to return this form to the employer.

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

**Part A: EMPLOYEE INFORMATION**

Name and address of employer (this is the employer of the employee requesting leave to care for a veteran):

Name of employee requesting leave to care for a veteran:

First

Middle

Last

Name of veteran (for whom employee is requesting leave):

First

Middle

Last

Relationship of employee to veteran:

Spouse  Parent  Son  Daughter  Next of Kin  (please specify relationship):

**Part B: VETERAN INFORMATION**

(1) Date of the veteran's discharge:

\_\_\_\_\_

(2) Was the veteran **dishonorably** discharged or released from the Armed Forces (including the National Guard or Reserves)? Yes  No

(3) Please provide the veteran's military branch, rank and unit at the time of discharge:

\_\_\_\_\_

(4) Is the veteran receiving medical treatment, recuperation, or therapy for an injury or illness?  
Yes  No

**Part C: CARE TO BE PROVIDED TO THE VETERAN**

Describe the care to be provided to the veteran and an estimate of the leave needed to provide the care:

\_\_\_\_\_

\_\_\_\_\_

**SECTION II: For completion by: (1) a United States Department of Defense ("DOD") health care provider; (2) a United States Department of Veterans Affairs ("VA") health care provider; (3) a DOD TRICARE network authorized private health care provider; (4) a DOD non-network TRICARE authorized private health care provider; or (5) a health care provider as defined in 29 CFR 825.125.**

**INSTRUCTIONS to the HEALTH CARE PROVIDER:** The employee named in Section I has requested leave under the military caregiver leave provision of the FMLA to care for a family member who is a veteran. For purposes of FMLA military caregiver leave, a serious injury or illness means an injury or illness incurred by the servicemember in the line of duty on active duty in the Armed Forces (or that 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 manifested itself before or after the servicemember became a veteran, and is:

- (i) a continuation of a serious injury or illness that was incurred or aggravated when the covered veteran was a member of the Armed Forces and rendered the servicemember unable to perform the duties of the servicemember's office, grade, rank, or rating; or
- (ii) a physical or mental condition for which the covered veteran has received a U.S. Department of Veterans Affairs Service Related Disability Rating (VASRD) of 50 percent or greater, and such VASRD rating is based, in whole or in part, on the condition precipitating the need for military caregiver leave; or
- (iii) a physical or mental condition that substantially impairs the covered veteran's ability to secure or follow a substantially gainful occupation by reason of a disability or disabilities related to military service, or would do so absent treatment; or
- (iv) an injury, including a psychological injury, on the basis of which the covered veteran has been enrolled in the Department of Veterans' Affairs Program of Comprehensive Assistance for Family Caregivers.

A complete and sufficient certification to support a request for FMLA military caregiver leave due to a covered veteran's serious injury or illness includes written documentation confirming that the veteran's injury or illness was incurred in the line of duty on active duty or existed before the beginning of the veteran's active duty and was aggravated by service in the line of duty on active duty, and that the veteran is undergoing treatment, recuperation, or therapy 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 military caregiver leave coverage. Limit your responses to the veteran's condition for which the employee is seeking leave.

(Please ensure that Section I has been completed before completing this section. Please be sure to sign the form on the last page and return this form to the employee requesting leave (See Section I, Part A above). **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.**)

**Part A: HEALTH CARE PROVIDER INFORMATION**

Health care provider's name and business address:

\_\_\_\_\_

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

Type of Practice/Medical Specialty: \_\_\_\_\_

Please indicate if you are:

- a DOD health care provider
- a VA health care provider
- a DOD TRICARE network authorized private health care provider
- a DOD non-network TRICARE authorized private health care provider
- other health care provider

**PART B: MEDICAL STATUS**

Note: If you are unable to make certain of the military-related determinations contained in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as, DOD Recovery Care Coordinator) or an authorized VA representative.

(1) The Veteran's medical condition is:

- A continuation of a serious injury or illness that was incurred or aggravated when the covered veteran was a member of the Armed Forces and rendered the servicemember unable to perform the duties of the servicemember's office, grade, rank, or rating.
- A physical or mental condition for which the covered veteran has received a U.S. Department of Veterans Affairs Service Related Disability Rating (VASRD) of 50% or higher, and such VASRD rating is based, in whole or in part, on the condition precipitating the need for military caregiver leave.
- A physical or mental condition that substantially impairs the covered veteran's ability to secure or follow a substantially gainful occupation by reason of a disability or disabilities related to military service, or would do so absent treatment.
- An injury, including a psychological injury, on the basis of which the covered veteran is enrolled in the Department of Veterans' Affairs Program of Comprehensive Assistance for Family Caregivers.
- None of the above.

(2) Is the veteran being treated for a condition which was incurred or aggravated by service in the line of duty on active duty in the Armed Forces? Yes  No

(3) Approximate date condition commenced: \_\_\_\_\_

(4) Probable duration of condition and/or need for care: \_\_\_\_\_

(5) Is the veteran undergoing medical treatment, recuperation, or therapy for this condition? Yes  No

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

\_\_\_\_\_

**PART C: VETERAN'S NEED FOR CARE BY FAMILY MEMBER**

"Need for care" encompasses both physical and psychological care. It includes situations where, for example, due to his or her serious injury or illness, the veteran is unable to care for his or her own basic medical, hygienic, or nutritional needs or safety, or is unable to transport him or herself to the doctor. It also includes providing psychological comfort and reassurance which would be beneficial to the veteran who is receiving inpatient or home care.

(1) Will the veteran 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: \_\_\_\_\_

(2) Will the veteran require periodic follow-up treatment appointments? Yes  No

If yes, estimate the treatment schedule: \_\_\_\_\_



(3) Is there a medical necessity for the veteran to have periodic care for these follow-up treatment appointments?  
Yes  No

(4) Is there a medical necessity for the veteran to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)? Yes  No

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

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Signature of Health Care Provider: \_\_\_\_\_ Date: \_\_\_\_\_

**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 CFR 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 20 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 Ave., NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE EMPLOYEE REQUESTING LEAVE (As shown in Section I, Part "A" above).**