

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.

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"> • 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. 		
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: _____		

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

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



WHD Publication 1420 · Revised February 2013

**FAMILY AND MEDICAL LEAVE ACT OF 1993 PROCEDUIES
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 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 (C0BRA), 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 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, FA YETTEVILLE
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)

U.S. Department of Labor
Wage and Hour Division



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

OMB Control Number: 1235-0003
Expires: 6/30/2018

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Please complete Section I before giving this form to your employee. 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 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of 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 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your family member or his/her medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a covered family member with a serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Your name: _____
First Middle Last

Name of family member for whom you will provide care: _____
First Middle Last

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 _____

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.

Provider’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: _____

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: _____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

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. 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 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 COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.