FAMILY AND MEDICAL LEAVE Information Sheet
University of Arkansas Fayetteville

Employee Name (Last, First)		Date (mm/dd/yy)
Employee I.D. Number	Department	Faculty/Staff (Choose One)
Supervisor Name Timekeeper Name		Employee Job Title
Requested FMLA Begin Date (mm/dd/yy)	Requested FMLA End Date (mm/dd/yy)	

AUTHORIZATION (to be completed by HR personnel only):

Eligibility:

Employed 12 mo? ☐ Yes ☐ No 1,250 hrs worked? ☐ Yes ☐ No

Date of Hire: _____ Hours worked: _____

☐ Approved ☐ Disapproved

FMLA type: ☐ Personal ☐ Maternity/Paternity ☐ Family

Family Member:

FMLA category: ☐ Intermittent

Parameters: _____

☐ Continuous

Dates: _____

Fitness for Duty? ☐ Yes ☐ No

Approving Authority: _____

Date: _____

For office use only: (check box once completed)

- ☐ Rights & Responsibilities Notice
- ☐ Designation Notice
- ☐ Approval Letter
- ☐ Fitness for Duty Form (if applicable)
- ☐ Exhaustion Letter
- ☐ Email to department

Revised 12/2019

FAMILY AND MEDICAL LEAVE ACT

Information Sheet

The Family and Medical Leave Act (FMLA) provides certain employees with up to 12 weeks of unpaid, job-protected leave per year. It also requires that their group health benefits be maintained during the leave.

FMLA is designed to help employees balance their work and family responsibilities by allowing them to take reasonable unpaid leave for certain family and medical reasons. It also seeks to accommodate the legitimate interests of employers and promote equal employment opportunity for men and women.

FMLA applies to all public agencies, all public and private elementary and secondary schools, and companies with 50 or more employees. These employers must provide an eligible employee with up to 12 weeks of unpaid leave each year for any of the following reasons:

- **For the birth and care of the newborn child of an employee;**
- **For placement with the employee of a child for adoption or foster care;**
- **To care for an immediate family member (i.e., spouse, child, or parent) with a serious health condition; or**
- **To take medical leave when the employee is unable to work because of a serious health condition.**

Employees are eligible for leave if they have worked for their employer at least 12 months, at least 1,250 hours over the past 12 months, and work at a location where the company employs 50 or more employees within 75 miles. Whether an employee has worked the minimum 1,250 hours of service is determined according to FLSA principles for determining compensable hours or work.

Time taken off work due to pregnancy complications can be counted against the 12 weeks of family and medical leave.

Military family leave provisions, first added to the FMLA in 2008, afford FMLA protections specific to the needs of military families.

Special rules apply to employees of local education agencies. The U.S. Department of Labor administers FMLA; however, the Office of Personnel Management administers FMLA for most federal employees.

Certification of Health Care Provider for Family Member's Serious Health Condition under the Family and Medical Leave Act

U.S. Department of Labor
Wage Hour Division

WAGE AND HOUR DIVISION

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

OMB Control Number: 1235-0003
Expires: 6/30/2023

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave to care for a family member with a serious health condition to submit a medical certification issued by the family member's health care provider. 29 U.S.C. §§ 2613, 2614(c)(3); 29 C.F.R. § 825.305. The employer must give the employee **at least 15 calendar days** to provide the certification. If the employee fails to provide complete and sufficient medical certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

SECTION I - EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, this form asks the health care provider for the information necessary for a complete and sufficient medical certification, which is set out at 29 C.F.R. § 825.306. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308**. Additionally, you **may not** request a certification for FMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care.

Employers must generally maintain records and documents relating to medical information, 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 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.

(1) Employee name: _____
First *Middle* *Last*

(2) Employer name: University of Arkansas Date: _____ *(mm/dd/yyyy)*
(List date certification requested)

(3) The medical certification must be returned by _____ *(mm/dd/yyyy)*
(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee's diligent, good faith efforts.)

SECTION II - EMPLOYEE

Please complete and sign Section II before providing this form to your family member or your family member's health care provider. The FMLA allows an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of your family member. If requested by your employer, your response is required to obtain or retain the benefit of the FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). **You are responsible for making sure the medical certification is provided to your employer within the time frame requested, which must be at least 15 calendar days.** 29 C.F.R. §§ 825.305-825.306. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA leave request. 29 C.F.R. § 825.313.

(1) Name of the family member for whom you will provide care: _____

(2) Select the relationship of the family member to you. The family member is your:

☐ Spouse ☐ Parent ☐ Child, under age 18
☐ Child, age 18 or older and incapable of self-care because of a mental or physical disability

Spouse means a husband or wife as defined or recognized in the state where the individual was married, including in a common law marriage or same-sex marriage. The terms "child" and "parent" include *in loco parentis* relationships in which a person assumes the obligations of a parent to a child. An employee may take FMLA leave to care for an individual who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave to care for a child for whom the employee has assumed the obligations of a parent. No legal or biological relationship is necessary.

Employee Name: _____

(3) Briefly describe the care you will provide to your family member: (*Check all that apply)*

☐ Assistance with basic medical, hygienic, nutritional, or safety needs ☐ Transportation

☐ Physical Care ☐ Psychological Comfort ☐ Other: _____

(4) Give your **best estimate** of the amount of leave needed to provide the care described: _____

_____

(5) If a **reduced work schedule** is necessary to provide the care described, give your **best estimate** of the reduced schedule you are able to work. From _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy),* I am able to work _____ (*hours per day*) _____ (*days per week).*

Employee Signature _____ **Date** _____ *(mm/dd/yyyy)*

SECTION III - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form below. A family member of your patient has requested leave under the FMLA to care for your patient. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a family member with a serious health condition. For FMLA purposes, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that *involves inpatient care* or *continuing treatment by a health care provider*. For more information about the definitions of a serious health condition under the FMLA, see the chart at the end of the form.

You also may, but are **not required** to, provide other appropriate medical facts including symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment. Please note that some state or local laws may not allow disclosure of private medical information about the patient's serious health condition, such as providing the diagnosis and/or course of treatment.

Health Care Provider's name: *(Print)* _____

Health Care Provider's business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____) _____ Fax: (____) _____ E-mail: _____

PART A: Medical Information

Limit your response to the medical condition for which the employee is seeking FMLA leave. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. **After completing Part A, complete Part B to provide information about the amount of leave needed.** Note: For FMLA purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

(1) Patient's Name: _____

(2) State the approximate date the condition started or will start: _____ *(mm/dd/yyyy)*

(3) Provide your **best estimate** of how long the condition lasted or will last: _____

(4) For FMLA to apply, care of the patient must be medically necessary. Briefly describe the type of care needed by the patient (*e.g., assistance with basic medical, hygienic, nutritional, safety, transportation needs, physical care, or psychological comfort).*

_____

_____

Employee Name: _____

(5) Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

- ☐ **Inpatient Care**: The patient (☐ has been / ☐ is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): _____

- ☐ **Incapacity plus Treatment**: *(e.g. outpatient surgery, strep throat)*
  Due to the condition, the patient (☐ has been / ☐ is expected to be) incapacitated for *more than* three consecutive, full calendar days from _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*.

  The patient (☐ was / ☐ will be) seen on the following date(s): _____

  _____

  The condition (☐ has / ☐ has not) also resulted in a course of continuing treatment under the supervision of a health care provider *(e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment)*

- ☐ **Pregnancy**: The condition is pregnancy. List the expected delivery date: _____ *(mm/dd/yyyy)*.

- ☐ **Chronic Conditions**: *(e.g. asthma, migraine headaches)* Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

- ☐ **Permanent or Long Term Conditions**: *(e.g. Alzheimer's, terminal stages of cancer)* Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

- ☐ **Conditions requiring Multiple Treatments**: (*e.g. chemotherapy treatments, restorative surgery)* Due to the condition, it is medically necessary for the patient to receive multiple treatments.

- ☐ **None of the above**: If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed. Go to page 4 to sign and date the form.

(6) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. *(e.g., use of nebulizer, dialysis)* _____

_____

PART B: Amount of Leave Needed

For the medical condition(s) checked in Part A, complete all that apply. 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 if the benefits and protections of the FMLA apply.

(7) Due to the condition, the patient (☐ had / ☐ will have) **planned medical treatment(s)** (scheduled medical visits) *(e.g. psychotherapy, prenatal appointments)* on the following date(s): _____

_____

(8) Due to the condition, the patient (☐ was / ☐ will be) **referred to other health care provider(s)** for evaluation or treatment(s).

State the nature of such treatments: *(e.g. cardiologist, physical therapy)* _____

Provide your **best estimate** of the beginning date _____ *(mm/dd/yyyy)* and end date _____ *(mm/dd/yyyy)* for the treatment(s).

Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery

_____ *(e.g. 3 days/week)*

Employee Name: _____

(9) Due to the condition, the patient (☐ was / ☐ will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.

Provide your **best estimate** of the beginning date: _____ *(mm/dd/yyyy)* and end date _____ *(mm/dd/yyyy)* for the period of incapacity.

(10) Due to the condition it, (☐ was / ☐ is / ☐ will be) medically necessary for the employee to be absent from work to provide care for the patient on an **intermittent basis** (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, episodes of incapacity are estimated to occur _____ times per (☐ day / ☐ week / ☐ month) and are likely to last approximately _____ (☐ hours / ☐ days) per episode.

Signature of
Health Care Provider _____ **Date** _____ *(mm/dd/yyyy)*

Definitions of a Serious Health Condition *(See 29 C.F.R. §§ 825.113-.115)*
Inpatient Care
• An overnight stay in a hospital, hospice, or residential medical care facility. • Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.
Continuing Treatment by a Health Care Provider (any one or more of the following)
Incapacity Plus Treatment: A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either: o Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or, o At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.
Pregnancy: Any period of incapacity due to pregnancy or for prenatal care.
Chronic Conditions: Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.
Permanent or Long-term Conditions: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.
Conditions Requiring Multiple Treatments: Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.

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 15 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 Avenue, N.W., Washington, D.C. 20210.

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

FAMILY AND MEDICAL LEAVE

Introduction

The Family and Medical Leave Act (FMLA)[1] is a federal law that provides eligible employees with unpaid, job-protected leave for specified family and medical reasons. Each campus, division or unit ("campus") of the University of Arkansas System ("University") complies with the Act and shall provide FMLA leave to its eligible employees. The FMLA includes a lengthy set of rules; this policy covers only the highlights of the FMLA.[2] Additional questions should be directed to the human resources specialist for the employee's campus.

Eligibility

To be eligible for FMLA leave an employee must have been employed by a campus of the University for at least 12 months and must have worked at least 1,250 hours during the 12 months immediately before the FMLA leave begins. Only time actually worked is counted for the purposes of the FMLA. Sick leave, annual leave, catastrophic leave (if applicable), holiday time, and any other time not actually worked does not count toward FMLA eligibility.

Reasons for Leave

An eligible employee may take FMLA leave for one or more of the following reasons:

- The birth of the employee's son or daughter or placement of a child with the employee for adoption or foster care, and to bond with the newborn or newly placed child;
- To care for the employee's spouse, son, daughter, or parent who has a serious health condition;
- When a serious health condition renders the employee unable to perform the essential functions of his or her job;
- For certain events, called "qualifying exigencies," related to covered active duty, or a call to covered active duty, of the employee's spouse, son, daughter, or parent[3]; or

[1] On March 18, 2020, the Families First Coronavirus Response Act (FFCRA) was enacted to provide relief to American workers in response to the coronavirus pandemic. Pursuant to that Act, certain employers are required to provide emergency paid sick leave and expanded family and medical leave under the FMLA and Emergency Paid Sick Leave Act during the period from the effective date of April 2, 2020, through the expiration date of December 31, 2020. This policy does not address the particulars of those temporary leave requirements, which were communicated to the campuses, divisions and units upon enactment. Any employee seeking information concerning coronavirus specific leave should contact the campus, division and unit human resources department.

[2] In the event of a conflict between this policy and the provisions of the FMLA or its implementing regulations, the statute and regulations shall take precedence.

[3] "Qualifying exigency" includes, among other things, certain short-notice deployments, attendance at certain military events and related activities, and for certain school and childcare related activities. A covered service member is a current member of the Armed Forces (including the National Guard and Reserves) who is receiving medical treatment or therapy, is recuperating, in outpatient status, or on the temporary disability list for a serious injury or illness.

- To care for a covered service member with a service-related serious injury or illness and who is the employee's spouse, son, daughter, parent, or next of kin.

The terms "serious health condition," "qualifying exigency" and "covered service member" are defined at length in the FMLA. Generally speaking, a serious health condition is an illness, injury or chronic condition that involves treatment or supervision by a medical professional. It also includes incapacity or treatment related to pregnancy.

Duration of Leave

An eligible employee is entitled to up to 12 work weeks of FMLA leave during a 12-month period. Effective July 1, 2020, the 12-month period for calculating FMLA leave use for all employees will be measured forward from the date that the employee's first FMLA leave for any of the above reasons begins. The next 12-month period would begin the first time the employee takes FMLA leave after the completion of the prior 12-month period.

A total of 26 weeks in a 12-month period is available to care for a covered service member with a serious service-related injury or illness. Regardless of the method applied for other FMLA leave, the 12-month period for calculating use of leave to care for a covered service member begins on the first day the employee takes leave for this reason.

When an employee and spouse are both employed by the University, leave for the serious health condition of a parent, or for the birth or adoption of a child, is limited to a combined total of 12 weeks for both employees.

Leave may be taken as continuous leave, intermittent leave or through a reduced work schedule based on medical necessity.

Type of Leave

FMLA leave is unpaid leave and runs concurrently with paid leave provided by the University including sick leave, annual leave, compensatory time and, where applicable, any available catastrophic leave. Accordingly, an employee will receive pay pursuant to the University's applicable paid leave policies during the period of otherwise unpaid FMLA leave. In addition, catastrophic leave for parental purposes (if applicable) shall run concurrently with FMLA leave. However, an employee taking maternity-related leave or leave for an illness or injury for which the employee is receiving worker's compensation benefits may elect to take this FMLA leave as unpaid leave.

Requesting FMLA Leave; Employee Obligation to Provide Notice for Foreseeable Absence

Each campus, division, and unit shall establish procedures for requesting FMLA leave. An employee shall provide at least 30 days advance notice before FMLA leave is to begin if the need for the leave is foreseeable based on an expected birth, placement for adoption or foster care, planned medical treatment for a serious health condition of the employee or of a family member, or the planned medical treatment for a serious injury or illness of a covered service member. If 30 days' notice is not practicable for reasons such as a lack of knowledge of approximately when

leave will be required to begin, a change in circumstances, or a medical emergency, notice must be given as soon as practicable.

When information provided by an employee informs the campus of an FMLA qualifying event, the campus may designate the leave taken as FMLA leave, whether or not the employee requests FMLA leave.

An employee taking FMLA leave for the serious health condition of the employee or of a child, spouse or parent may be required to submit a healthcare provider's certification addressing the serious health condition. An employee taking leave because of a "qualifying exigency" or to care for a covered service member may also be required to provide a certification. The campus human resources office will provide the employee with certification forms after receiving notice of a request for FMLA leave.

When an employee's FMLA leave is the result of a serious health condition that caused the employee to be unable to perform the employee's job, the campus may, as a condition of returning to work, require the employee to present a certification from the employee's health care provider that the employee is able to resume work.

Benefits during FMLA Leave

The University will continue health benefits for an employee on FMLA designated leave, but the employee must continue to pay the employee's share of the health benefit premium. An employee on unpaid FMLA leave must make arrangements to pay the employee's share of the premium. The University does not pay for voluntary employee benefits while an employee is on leave without pay, regardless of whether the leave qualifies as FMLA leave. Employees should consult their campus human resources specialist to arrange for continuation of any voluntary benefits.

June 4, 2020