

**FAMILY AND MEDICAL LEAVE/OTHER MEDICAL LEAVE OF ABSENCE REQUEST
EASTERN ILLINOIS UNIVERSITY
Charleston, Illinois**

Employment Category:

- Civil Service
- Administrative & Professional
- Faculty
- Academic Support Professional

Type of Leave

- Family & Medical Leave of Absence (FMLA)
- Workers' Compensation Medical Leave (WC/FMLA)
(also considered as FMLA)
- Medical Leave – Not FMLA Eligible

Employee Name: _____
Address: _____

Employee ID# _____

I am requesting the medical leave of absence checked above for the period from _____
(Last Day Worked) through _____ from my position with the right to return to a position in this
classification.

I understand that Eastern Illinois University requires medical certification to support a request for a medical leave. If
applying for FMLA, I understand it is for a maximum of 12 weeks total per year. FMLA does not create or extend other
sick leave benefits. Employee may use sick and/or vacation benefits during FMLA

The reason for the FMLA leave is: (Please check appropriate box.)

- the birth of a child, or the placement of a child with you for adoption or foster care; or
- a serious health condition that makes you unable to perform the essential functions of your job; ** or
- a serious health condition affecting your spouse, child, parent, for which you are needed to provide care.

**This includes work related injuries.

If a medical leave is approved, Eastern Illinois University will require a signed statement from your treating physician
before you return to work. It must state the exact date that you can return to work along with any restrictions that you
may have. Bring or fax your return to work statement to Human Resources Employment, Room 2020 Old Main, Fax 217-
581-3614.

Please communicate with your supervisor to coordinate your return to work date. In all cases employees granted a
medical leave would return to their classification. Failure to return to duty on the approved date shall be deemed an
unauthorized and unexcused absence, which is cause for dismissal.

Employee's signature: _____ Date: _____

Office Use Only

- Approved Denied FMLA Other Medical WC/FMLA Medical
(WC approved/denied by CMS)
(FMLA approved/denied by EIU)

If denied give reason: _____

By _____ / _____
Authority or Designee Title Date

Date copy sent to employee: _____ By: _____

Employee: _____

Employee ID# _____

Effective Date: _____

Approximate return date: _____

Type of Leave Requested: FMLA WC/FMLA Medical Other Medical _____

CIVIL SERVICE EMPLOYEE – BENEFIT USAGE REQUEST

This will officially inform the Department of Human Resources as to your wishes regarding usage of your benefits while you are on leave. Please check the category(ies) that apply:

Family and Medical Leave of Absence (For a Disability Leave of Absence you MUST use sick leave per the State Universities Retirement System.)

- 1. Sick Leave and Accrued Leave _____
- 2. Sick Leave Only _____
- 3. Accrued Leave Only _____
- 4. Accrued Leave – save five days* _____
- 5. Compensatory Time _____
- 6. Pending Worker’s Compensation _____
- 7. No Benefits Used _____

(If you are requesting wage compensation through Workers’ Compensation (TTD), you must notify EIU’s Workers’ Compensation Coordinator *in writing*)

*Board of Trustee’s Policy states that the employee has the right to stop using Accrued Leave benefits after the total remaining reaches five days or less.

In order for your benefits to be paid according to your present work schedule, please answer the following two questions:

1. The number of hours I work per week is: (circle one →) 37.50 hrs 40.00 hrs

2. Number of **Regular** hours worked each day →

MON	TUES	WED	THU	FRI	SAT	SUN

For more information on the Family and Medical Leave Act of 1993, please select the following link, <http://www.dol.gov/whd/regs/compliance/posters/fmlaen.pdf> and print the US Department of Labor publication.

Employee Signature _____

Date _____

Benefits Officer _____

Date _____

Office use only:

Benefits exhaust date _____

Copy returned to Employment: _____

CERTIFICATION OF PHYSICIAN OR PRACTITIONER

(Family and Medical Leave Act of 1993)

Send or Fax to:

EASTERN ILLINOIS UNIVERSITY
Department of Human Resources/Employment
600 Lincoln Avenue, Charleston, IL 61920
Phone: (217) 581-3463 ~ Fax: (217) 581-3614

DATE _____

1. Employee Name: _____

2. Patient's name and Relationship to Employee (If other than employee): _____

3. The attached sheet describes a "serious health condition" under the Family and Medical Leave Act. Check the appropriate category under which the patient's condition qualifies:

(1) _____ (2) _____ (3) _____ (4) _____ (5) _____ (or) none of the attached _____

4. Describe the medical facts (diagnosis) that support your certification, including a brief statement as to how the medical facts meet the criteria checked above: _____

5. Date condition commenced: _____

6. Probable duration of condition (and probable duration of the patient's present incapacity, if different: _____

7. Regimen of treatment to be prescribed (indicate number of visits, general nature and duration of treatment, including referral to other provider of health services. Include schedule of visits or treatment if it is medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal schedule of hours per day or days per week):

(a) By Physician or Practitioner:

(b) By another provider of health services, if referred by Physician or Practitioner:

If this certification is for the **EMPLOYEE**, complete items 8 through 11. If this certification relates to care for the employee's seriously ill family member, then skip item 8, 9 and 10 and complete items 11 through 16.

Check **Yes** or **No** in the boxes below, as appropriate.

- | | Yes | No | |
|----|--------------------------|--------------------------|---|
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | Is inpatient hospitalization of the employee required? |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | Is employee able to perform work of any kind? (If "NO", skip Item 9.) |

(OVER)

- Yes No
10. Is employee able to perform the functions of employee's position? (Answer after reviewing statement from employer of essential functions of employee's position, or, if none provided, after discussing with employee.)

I authorize my physician/practitioner below to release my medical information about me to my employer, Eastern Illinois University, for the purpose of this medical leave and/or return from leave.

Employee Signature	Date
11. Signature of Physician or Practitioner: _____	
Name of Physician or Practitioner (Please type or print): _____	
Addresses of Physician or Practitioner: _____	
Type of Practice (Field of Specialization, if any): _____	

For certification relating to care for the employee's seriously ill **FAMILY MEMBER**, complete items 11 through 15 as they apply to the **FAMILY MEMBER**.

- Yes No
12. Is inpatient hospitalization of the family member (patient) required?
13. Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety, or transportation?
14. After review of the employee's signed statement (See Item 16 below), is the employee's presence necessary or would it be beneficial for the care of the patient? (This may include psychological comfort.)

15. Estimate the period of time care is needed or the employee's presence would be beneficial:

ITEM 16 IS TO BE COMPLETED BY THE EMPLOYEE NEEDING FAMILY LEAVE.

16. When Family Leave is needed to care for a seriously ill family member, the employee shall state the care s/he will provide and an estimate of the time period during which this care will be provided, including a schedule if leave is to be taken intermittently or on a reduced leave schedule:

Employee Signature	Date
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SERIOUS HEALTH CONDITION

Pursuant to the Family and Medical Leave Act Regulations (29 CFR 825.800), a serious health condition entitling an employee to FMLA leave means:

1. An illness, injury, impairment, or physical or mental condition that involves:

a. INPATIENT CARE (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity (for purposes of this section, defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom), or any subsequent treatment in connection with such inpatient care; or

b. CONTINUING TREATMENT BY A HEALTH CARE PROVIDER. A serious health condition involving continuing treatment by a health care provider includes:

(1) A period of incapacity (i.e., inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom) of more than three consecutive calendar days, including any subsequent treatment or period of incapacity relating to the same condition, that also involves:

(a) Treatment two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or

(b) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider.

(2) Any period of incapacity due to pregnancy, or for prenatal care.

(3) Any period of incapacity or treatment for such incapacity due to a chronic serious health condition. A chronic serious health condition is one which:

(a) Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;

(b) Continues over an extended period of time (including recurring episodes of a single underlying condition); and

(c) May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

(4) A period of incapacity, which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

(5) Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).

2. Treatment for an illness, injury, impairment, or physical or mental condition includes (but is not limited to) examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations. A regimen of continuing treatment under the supervision of a health care provider includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition (e.g., oxygen). A regimen of continuing treatment that includes the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider, is not, by itself, sufficient to constitute a regimen of continuing treatment for purposes of FMLA leave.

3. Conditions for which cosmetic treatments are administered (such as most treatments for acne or plastic surgery) are not "serious health conditions" unless inpatient hospital care is required or unless complications develop. Ordinarily, unless complications arise, the common cold, the flu, ear aches, upset stomach, minor ulcers, headaches other than migraine, routine dental or orthodontia problems, periodontal disease, etc., are examples of conditions that do not meet the definition of a serious health condition and do not qualify for FMLA leave. Restorative dental or plastic surgery after an injury or removal of cancerous growths are serious health conditions provided all the other FMLA conditions are met. Mental illness resulting from stress or allergies may be serious health conditions, but only if all FMLA conditions are met.

4. Substance abuse may be a serious health condition if FMLA conditions are met. However, FMLA leave may only be taken for treatment for substance abuse by a health care provider or by a provider of health care services on referral by a health care provider. On the other hand, absence because of the employee's use of the substance, rather than for treatment, does not qualify for FMLA leave.

5. Absences attributable to incapacity due to pregnancy, prenatal care, or a chronic serious health condition qualify for FMLA leave even though the employee or the immediate family member does not receive treatment from a health care provider during the absence, and even if the absence does not last more than three days. For example, an employee with asthma may be unable to report for work due to the onset of an asthma attack or because the employee's health care provider has advised the employee to stay home when the pollen count exceeds a certain level. An employee who is pregnant may be unable to report to work because of severe morning sickness.