EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT

EMPLOYEE ENTITLEMENT

An eligible employee may take up to twelve weeks (26 weeks to care for a covered servicemember with a serious injury or illness under (e) below) of Family and Medical Leave during each 12-month period for which eligibility criteria have been met. The initial 12-month period is measured back from the date the employee first takes FMLA leave. Family and Medical Leave shall be granted for (a) the birth or placement of a child for adoption or foster care; (b) for the care of an immediate family member (child, spouse, or parent) with a serious health condition; (c) when an employee is unable to perform the functions of his or her position due to a serious health condition; (d) because of a qualifying exigency arising out of the fact that a family member (child, spouse, or parent) is a member of the Reserves or the regular Armed Forces and is deployed to a foreign country on covered active duty; or (e) for the care of an immediate family member (child, spouse, parent, or next of kin) who is a covered service-member with a serious injury or illness. For leave taken for the birth or placement of a child for adoption or foster care, entitlement expires at the end of the twelve-month period following the date of the birth or adoption placement.

EMPLOYEE ELIGIBILITY

To be eligible for FMLA benefits, an Eastern Illinois University employee must:

(1) have worked for Eastern Illinois University for at least twelve months; and
(2) have worked at least 1,000 hours of service during the previous twelve months.

SERIOUS HEALTH CONDITION

Serious health condition means an illness, injury, impairment, or physical or mental condition that involves**:**

- any period of incapacity or treatment connected with inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical facility;
- any period of incapacity requiring absence of more than three full consecutive calendar days from work, school, or other regular daily activities that also involves continuing treatment (or under the supervision of) a health care provider;
- any continuing treatment by (or under the supervision of) a health care provider for a chronic or long-term health condition that is incurable or so serious that, if not treated, would likely result in a period of incapacity of more than three calendar days;
- prenatal care; or
- an injury or illness incurred by a covered service-member: (a) in the line of duty on covered active duty in the Armed Forces (or existed before the beginning of the member's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces); and (b) that may render the service-member medically unfit to perform the duties of the service-member's office, grade, rank, or rating. In the case of a veteran, this injury or illness could have "manifested itself before or after the member became a veteran".

MEDICAL CERTIFICATION

Certification issued by the employee's or the family member's health care provider is required to support a request for Family and Medical Leave due to a serious health condition (see Medical Certification forms). Requests for paid leaves shall be in accordance with the University's sick leave/vacation policies. Departments may require employees to provide the opinion of a second health care provider designated or approved by the University, but not employed by the University. The opinion of a third provider may be required when there are differing opinions. The opinion of the third provider shall be considered final and shall be binding on the University and employee. Any expenses associated with obtaining second and third opinions shall be the responsibility of the employing department.

CERTIFICATION OF QUALIFYING EXIGENCY FOR MILITARY FAMILY LEAVE

Certification issued by the employee is required for an employee seeking FMLA leave due to a qualifying exigency. A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes written documentation confirming a covered military member's covered active duty or call to covered active duty status.

RETURN FROM FAMILY AND MEDICAL LEAVE

The University requires an employee to obtain a statement from a health care provider that he/she is able to resume work. Employee is expected to contact supervisor as soon as posible to coordinate anticipated date of return. A staff employee who has been absent for Family and Medical Leave shall be restored to the position of employment held by the employee when the leave commenced; or an equivalent position with equivalent employment benefits, pay, and other terms and conditions of employment.

USE OF PAID AND UNPAID LEAVE

Birth or Placement of a Child for Adoption or Foster Care: The University will apply accumulated paid leave benefits concurrently with FMLA leave. For the birth or placement of a child for adoption or foster care, the university will apply sick leave or accrued leave, at the employee's discretion. Any portion of the FMLA period for which sick leave or accrued leave is not applied shall be without pay.

Serious Health Condition, Family Member or Employee: The University will apply accumulated paid leave benefits concurrently with FMLA leave. For care of a spouse, child, or parent with a serious health condition or because of an employee's own serious health condition, the leave is provided under the University Sick Leave and the campus Academic sick leave policies. If an employee's sick leave is exhausted, the university will apply vacation leave to ensure continuance in pay status during the FMLA period. Any portion of the FMLA period that extends past the exhaustion of compensable leave benefits will be without pay.

In addition, employees with a serious health condition, who exhaust their accrued sick leave balances, may be eligible t o receive disability benefits through SURS. Employees ma y request an APPLICATION FOR DISABILITY BENEFITS from the campus Benefits office when their leave is anticipated to be greater than 60 days. Any portion of the FMLA period for which accrued vacation, sick leave, or disability benefits are not applied shall be without pay.

INSURANCE COVERAGE AND RETIREMENT CONTRIBUTIONS DURING UNPAID LEAVE

Coverage of group health and dental insurance shall be continued by the University at the same level that coverage would have been provided if the employee had remained in continuous employment. Employees are responsible for paying the employee-paid portion of any insurance premiums presently paid by payroll deduction. **If the employee does not make required payments** during the leave period, the CMS-Group Insurance Division (GID) will terminate the member's coverage the first day of the current month. These members are ineligible to continue coverage under COBRA and will not receive a COBRA notification letter (eligible or ineligible). CMS will take action to collect all outstanding premium(s), which may include involuntary withholding. Employees are encouraged to contact the Benefits Service Center for information on changes in status and to arrange for billing prior to their last day of work.

Employees pay the entire premium plus a 2% administrative fee for COBRA coverage. Central Management Services (CMS) mails monthly billing statements to the employee's home address on or about the tenth of each month. Bills for the current month are due by the twenty-fifth of that month and are paid to CMS. Individuals electing COBRA coverage have 45 days from the date coverage is elected to pay currently due premiums. Failure to submit payment by the due date terminates COBRA rights.

The University may recover any premiums paid for maintaining coverage for the employee if the employee fails to return from Family and Medical Leave for a reason other than continuation, recurrence, onset of a serious health condition (employee or family), or other circumstances beyond the control of the employee. Certification of such conditions may be required by the University.

To determine the effect of Family and Medical Leave on the accumulation of service time for retirement and to assure continuation of contributions, the employee should contact SURS at 1-800-ASK-SURS (1-800-275-7877).

Eastern Illinois University
FAMILY AND MEDICAL LEAVE FORM

Effective August 5, 1993, Eastern Illinois University implemented the Family and Medical Leave Policy in compliance with the federal Family and Medical Leave Act (FMLA) of 1993 and amended the policy in 2009 due to regulation revisions effective January 16, 2009. Such leaves shall be granted to eligible employees (a) for the birth or adoption of a child; (b) for the care of a child, spouse, or parent who has a serious health condition; (c) when an employee is unable to perform the function of his or her position due to a serious health condition; (d) because of a qualifying exigency arising out of the fact that a family member (child, spouse, or parent) is on covered active duty or call to covered active duty status as a member of the Reserves or the regular Armed Forces; or (e) for the care of an immediate family member (child, spouse, parent, or next of kin) who is a covered service-member with a serious injury or illness. FMLA leaves are granted by the Human Resource Department. Eligible employees are entitled to up to twelve workweeks (26 weeks to care for a covered service-member with a serious injury or illness) of unpaid family and medical leave during each consecutive twelve-month period for which eligibility criteria have been met. The University will apply accumulated paid leave benefits concurrently with FMLA leave, in accordance with the University Sick Leave and the campus Academic sick leave policies. If an employee's sick leave is exhausted, the university will apply vacation leave to ensure continuance in pay status during the FMLA period. Any portion of the FMLA period that extends past the exhaustion of compensable leave benefits will be without pay.

If foreseeable, requests for Family and Medical Leave should be made at least thirty days in advance of the leave or as soon as practicable. If the need for leave is not foreseeable, requests should be made within two business days of learning of the need for leave.

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TO BE COMPLETED BY EMPLOYEE

Employee Name:_____ E-Number: _____

Address/City/State/Zip:_____

Home Phone:_____ Office Phone:_____ E-mail:_____

Department/Unit:_____ Title:_____ Supervisor Name: _____

REASON FOR LEAVE

_____ **Serious illness of employee** (Medical Certification is required)

☐ **Serious illness of spouse, child or parent** (Medical Certification is required)

Name of individual:_____ Relationship: _____

_____ **Birth of a child**

☐ **Placement of a child with employee for adoption or foster care** (attach legal confirmation)

Anticipated date of delivery, adoption or placement: _____

☐ **Qualifying exigency for spouse, child, or parent on covered active duty or call to covered active duty**. *(Certification of Qualifying Exigency for Military Family Leave is required)*

Name of individual:_____ Relationship: _____

☐ **Serious illness or injury of a covered service-member (spouse, child, parent, or next of kin)** *(Medical Certification is Required)*

Name of individual:_____ Relationship: _____

Please specify current work schedule: ☐ 37.5 hours or ☐ 40 hours

Day	MON	TUES	WED	THUR	FRI	SAT	SUN
Hours							

The University will apply accumulated paid leave benefits concurrently with FMLA leave, in accordance with the University Sick Leave and the campus Academic sick leave policies. If an employee's sick leave is exhausted, the university will apply vacation leave to ensure continuance in pay status during the FMLA period. Any portion of the FMLA period that extends past the exhaustion of compensable leave benefits will be without pay.

EXPECTED DURATION

LEAVE WILL BE TAKEN AS (check one):

☐ a block of time from_____ to _____
(month/day/year) *(month/day/year)*

☐ intermittently (e.g., separate blocks of time due to single illness) (please describe on separate sheet)

_____ temporarily reduced work schedule (please describe on separate sheet)

I have read the "Employee Rights and Obligations Under FMLA" attached and understand all my rights and obligations under this policy. I also understand that any leave taken as designated FMLA leave (paid and/or unpaid) counts toward my FMLA leave entitlement.

Employee Signature_____ Date _____

Clear

TO BE COMPLETED BY HUMAN REOURCE DEPARTMENT

(*SEE EMPLOYEE RIGHTS AND RESPONSIBILITIES***)**

Employee Name_____ E-Number:_____

1. Has the employee worked for the employer for at least 12 months? Yes No
   (If no, the employee is not eligible for FMLA.)

2. Has the employee worked 1000 hours during the previous 12 months? Yes No
   (If no, the employee is not eligible for FMLA.)
   _____hours worked _____% of employment

3. a. Is the reason for the leave because of the employee's serious health condition? Yes No
   OR
   b. Is the reason for the leave because of the employee's parent, child, or spouse's serious health condition? Yes No
   OR
   c. Is the reason for the leave because of the birth, adoption, or placement of foster care of a child by the employee? Yes No
   OR
   d. Is the reason for the leave because of a qualifying exigency arising out of the fact that a family member (child, spouse, or parent) is on covered active duty or call to covered active duty as a member of the Reserves or the regular Armed Forces? Yes No
   OR
   e. Is the reason for the leave because of the serious injury or illness of a covered Service-member? Yes No

4. Does the employee's medical certification (which is required for employee's own or family member's serious health condition, including the serious injury or illness of a covered service-member) support the request for leave? Yes No

5. If requesting qualifying exigency leave for spouse, child, or parent on covered active duty or call to covered active duty, has the appropriate documentation been provided to support the request for leave? Yes No

6. The employee has_____number of hours of FMLA leave entitlement remaining at the time of this leave request.

Based on the answers above, is the employee eligible for FMLA? Yes No

If no, state reason.

_____

NOTE: FMLA Approval is contingent upon receipt of proper medical-certifying documentation

_____

☐ Pending Worker's Compensation

_____ _____

Authorized HR Representative Date

☐ copy provided to employee in office ☐ mailed to employee on _____

Comments:_____

Family and Medical Leave Act CERTIFICATION OF HEALTH CARE PROVIDER FOR FAMILY MEMBER'S SERIOUS HEALTH CONDITION

SECTION I: For Completion by the EMPLOYEE

Please complete this section before giving this form to your family member or his/her medical provider.

Employee's name:
Name of family member for whom employee will provide care:
Relationship of family member to employee: If family member is employee's son or daughter, date of birth: Is son/daughter over the age of 18? ☐ No ☐ Yes (If yes, health care provider also completes Part C: Medical Facts – Disability – For Son or Daughter Over the Age of 18 in addition to Parts A and B.)
Describe care that will be provided to family member by employee and estimate leave needed to provide care:
Employee Signature Date

SECTION II: For Completion by the HEALTH CARE PROVIDER

The Genetic 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.

PART A: MEDICAL FACTS – FMLA CONDITION

1. a. Approximate date condition commenced:

   b. Probable duration of condition:

   c. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
   ☐ No ☐ Yes

   If so, date(s) of admission: date(s) of discharge:

   d. Date(s) you treated the patient for condition:

e. Will the patient need to have treatment visits at least twice per year due to the condition? ☐ No ☐ Yes

f. Was medication, other than over-the-counter medication, prescribed? ☐ No ☐ Yes

g. 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. What is the patient's condition/diagnosis?

3. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, 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 or care by the employee seeking leave may include assistance with basic medical, hygiene, nutritional, safety or transportation needs, or the provision of physical or psychological care.

4. a. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ☐ No ☐ Yes

If so, estimate the beginning and ending dates for the period of incapacity:

b. 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. a. 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:

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

6. a. 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 _____

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

7. a. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ☐ No ☐ Yes

b. 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_____days(s) per episode

c. 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:

PART C: MEDICAL FACTS – DISABILITY – FOR SON OR DAUGHTER OVER THE AGE OF 18
To be completed ONLY for employees requesting Family Medical Leave to care for a child over the age of 18.

1. Please indicate which of the following "activities of daily living" or "instrumental activities of daily living" that the adult son/daughter requires active assistance or supervision to perform:

☐ Caring for own grooming and hygiene	☐ Cooking	☐ Maintaining a residence
☐ Bathing	☐ Cleaning	☐ Using telephones/directories
☐ Dressing	☐ Eating	☐ Using a post office
☐ Paying Bills	☐ Shopping	☐ Taking Public Transportation
☐ Other		

2. To address the following, please note that "major life activities" include, but are not limited to, functions such as "caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.* The following questions address if the physical or mental disability "substantially limits" one or more of the major life activities of the adult son or daughter:

a. Does the adult son/daughter have a medically recognized physical or mental disability, defined as "a physical or mental impairment that substantially limits one or more of the major life activities"? ☐ No ☐ Yes

b. Is the adult son or daughter unable to perform a major life activity that the average person in the general population can perform? ☐ No ☐ Yes

c. Is he/she significantly restricted as to the condition, manner, or duration under which he/she can perform a particular major life activity as compared to the condition, manner, or duration under which the average person in the general population can perform that same major life activity? ☐ No ☐ Yes

3. What is the nature and severity of the impairment?

4.	What is the duration or expected duration of the impairment?
5.	What is the permanent or long-term impact, or the expected permanent or long-term impact of or resulting from the impairment?

ADDITIONAL INFORMATION. IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

Signature of Health Care Provider	Type of Practice
Printed Name	Telephone Number
Address	Date
City, State, Zip Code	

*The term "substantially limits working" means significantly restricted in the ability to perform either a class of jobs or a broad range of jobs in various classes as compared to the average person having comparable training, skills and abilities. The inability to perform a single, particular job does not constitute a substantial limitation in the major life activity of working. In addition to these factors, the following may be considered in determining whether an individual is substantially limited in the major life activity of "working": The geographical area to which the individual has reasonable access; the job from which the individual has been disqualified because of an impairment, and the number and types of jobs utilizing similar training, knowledge, skills or abilities, within that geographical area, from which the individual is also disqualified because of the impairment (class of jobs); and/or; the job from which the individual has been disqualified because of an impairment, and the number and types of other jobs not utilizing similar training, knowledge, skills or abilities, within that geographical area, from which he individual is also disqualified because of the impairment (broad range of jobs in various classes).

Return completed certification form to Eastern Illinois University, Human Resources Fax: 217-581-3614