

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 1,250 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 possible 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 to receive disability benefits through SURS. Employees may 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 _____

TO BE COMPLETED BY HUMAN RESOURCE DEPARTMENT
 (SEE EMPLOYEE RIGHTS AND RESPONSIBILITIES)

Employee Name _____ **E-Number:** _____

- | | | |
|---|-----|----|
| 1. Has the employee worked for the employer for at least 12 months?
(If no, the employee is not eligible for FMLA.) | Yes | No |
| 2. Has the employee worked 1250 hours during the previous 12 months?
(If no, the employee is not eligible for FMLA.)
_____ hours worked _____ % of employment | Yes | No |
| 3. a. Is the reason for the leave because of the employee's serious health condition?
<i>OR</i>
b. Is the reason for the leave because of the employee's parent, child, or spouse's serious health condition?
<i>OR</i>
c. Is the reason for the leave because of the birth, adoption, or placement of foster care of a child by the employee?
<i>OR</i>
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?
<i>OR</i>
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 EMPLOYEE'S
SERIOUS HEALTH CONDITION**

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.

Employee's name: _____

PART A: MEDICAL FACTS

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 LEAVE NEEDED

4. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? No Yes

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

5. a. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? No Yes

If so, are the treatments or the reduced number of hours of work medically necessary? No Yes

b. Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

c. Estimate the part-time or reduced work schedule the employee needs, if any:

_____ hour(s) per day; _____ days per week from _____ through _____

6. a. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? No Yes

b. Is it medically necessary for the employee to be absent from work during the flare-ups? No Yes

If so, explain: _____

c. 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

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