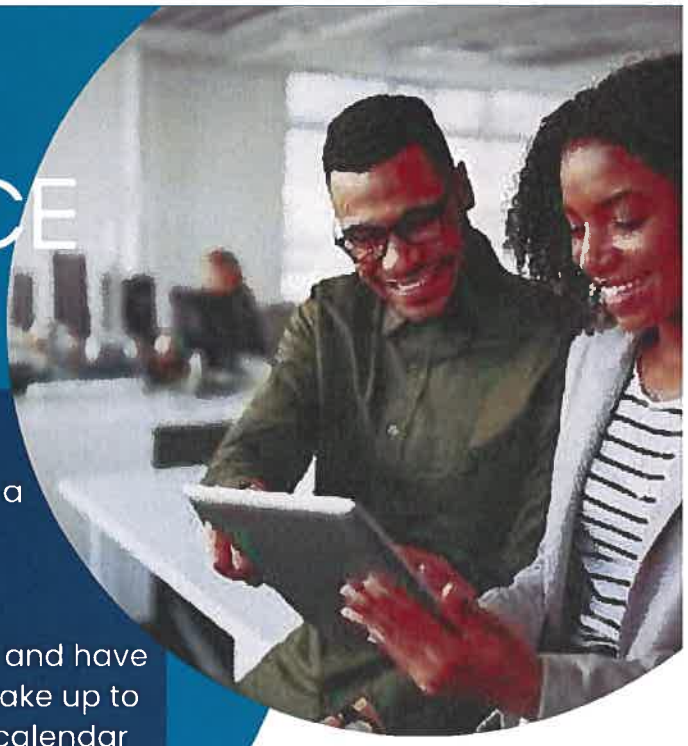
PREPARING FOR A LEAVE OF ABSENCE



PLEASE FOLLOW THE CHECKLIST

A full-time employee, who needs to be away from work for FIVE or more days due to illness, or that of a family member, should apply for FMLA.

Employees who have a cumulative 1 year of service and have worked for 1250 hours over the last 12 months may take up to 12 weeks of unpaid leave during a 12-month rolling calendar period under the Federal Family and Medical Leave Act (FMLA).

The employee should provide 30 days notice as soon as possible when the leave is forseeable. If the leave is not forseeable, the employee should notify HR when the need for leave becomes known to the employee.

The Benefits Specialist will require the certification to be completed by the doctor and submitted back to HR within 15 days of the request for FMLA.

- **Consult HR for guidance on procedures and requirements**
- **Find out about FMLA eligibility**
- **Talk to your manager**
- **Put in your notice 30 days priorto your absence**
- **Submit completed documents to HR**
- **Prepare to transition your work while on leave**
- **Set up an out of office email and voicemail**
- **Provide Return to work release forms to your manager and HR**
- **Prepare for your return to work**

CHICAGO STATE UNIVERSITY

Leave Request Form

Employee Name: _____ Employee ID: _____

Home Mailing Address: _____

Phone: _____ Title: _____

Type of Leave: ☐ Medical Leave ☐ Family Medical Leave ☐ Worker'sCompensation

Please Check the Reason For Leave: Own Serious Health Condition:_____ Care for newborn/placed child:_____

Pregnancy Disability:_____

Family Member Serious Health Condition:_____

Work-Incurred Injury:_____

Other:_____

Requested Start Date:_____

Anticipated Return to Work Date:_____

Intermittent or reduced work schedule (describe):_____

Please provide an anticipated schedule below. If this schedule requires adjustment, notify manager at least 1 week in advance.

Insert appropriate time below	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

A leave of absence may consist of leave without pay and/or paid leave (Vacation or sick leave). Paid leave will be used in accordance with applicable policy/contracts.

Supervisor Name:_____

Supervisor Email Address:_____

Employee Signature & Date:_____

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

U.S. Department of Labor
Wage and Hour Division

WAGE AND HOUR DIVISIO

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

OMB Control Number: 1235-00C
Expires: 8/31/202

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a nee for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. 29 U.S.C. §§ 261 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 employe fails to provide complete and sufficient medical certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Informatic 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 th information necessary for a complete and sufficient medical certification, which is set out at 29 C.F.R. § 825.306. **You may not ask th employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308.** Additionally, you **ma 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 medic histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files an 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 th Genetic Information Nondiscrimination Act applies.

(1) Employee name: _____
First Middle Last

(2) Employer name: _____ Date: _____ (mm/dd/yyy
(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.)

(4) Employee's job title: _____ Job description ☐ is / ☐ is not attachec

Employee's regular work schedule: _____

Statement of the employee's essential job functions:

_____

(The essential functions of the employee's position are determined with reference to the position the employee held at the time the employee notified the employer of the need for leave or the leave started, whichever is earlier.)

SECTION II - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form. Your patient has requested leave und the FMLA. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to suppo a request for FMLA leave due to the serious health condition of the employee. For FMLA purposes, a "serious health condition" means a illness, injury, impairment, or physical or mental condition that involves **inpatient care** or **continuing treatment by a health care provider**. F more information about the definitions of a serious health condition under the FMLA, see the chart on page 4.

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

Employee Name: _____

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(s) for which the employee is seeking FMLA leave. Your answers should be your **best estimat** based upon your medical knowledge, experience, and examination of the patient. **After completing Part A, complete Part B to provid information about the amount of leave needed.** Note: For FMLA purposes, "incapacity" means the inability to work, attend school, or perfor regular daily activities due to the condition, treatment of the condition, or recovery from the condition. Do not provide information about genet 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 i the employee's family members, 29 C.F.R. § 1635.3(b).

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

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

(3) 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.

Employee Name: _____

(4) 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 condition, treatment, etc. Your answer should be your **best estimate** based upon your medical knowledge, experience, and examination of th patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage.

(5) 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): _____

_____

(6) 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)

_____

(7) Due to the condition, it is medically necessary for the employee to work a **reduced schedule**.

Provide your **best estimate** of the reduced schedule the employee is able to work. From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy) the employee is able to work: (e.g., 5 hours/day, up to 25 hours a week)

_____

(8) 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.

(9) Due to the condition, it (☐ was / ☐ is / ☐ will be) medically necessary for the employee to be absent from work 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

Employee Name: _____

PART C: Essential Job Functions

If provided, the information in Section I question #4 may be used to answer this question. If the employer fails to provide a statement of th employee's essential functions or a job description, answer these questions based upon the employee's own description of the essential jo functions. An employee who must be absent from work to receive medical treatment(s), such as scheduled medical visits, for a serious heal condition is considered to be **not able** to perform the essential job functions of the position during the absence for treatment(s).

(10) Due to the condition, the employee (☐ was not able / ☐ is not able / ☐ will not be able) to perform **one or more** of the essential job function(s). Identify at least one essential job function the employee is not able to perform:

_____

Signature of Health Care Provider _____ Date: _____ (mm/dd/yyy

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 OM control number. The Department of Labor estimates that it will take an average of 15 minutes for respondents to complete thi collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintainin the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burde estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to th 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.

CHICAGO STATE UNIVERSITY

Release to Return to Work

Date:_____

Employee Name:_____ Employee ID:_____

Please check one of the following:

- ☐ The employee is able to work a full, regular schedule with no restrictions, as of_____(date).
- ☐ The employee is unable to return to work until _____(date).
- ☐ The employee is able to return to work on a reduced schedule for ___ hours a day from _____(date) through_____ (date).
- ☐ The employee is able to return to work with restrictions from_____ (date) through_____ (date).

Please indicate restrictions, if any, below:

Standing (number of hours): _____ Walking (number of hours): _____

Sitting (number of hours): _____ Lifting (number of pounds): _____

Carrying (number of pounds): _____ Use of hands (repetitive motions):_____

Other restrictions: _____

_____

Provider Name(Printed):_____

Provider Signature:_____

CHICAGO STATE UNIVERSITY

Confirmation of Return to Work

Please sign below indicating that _____ has returned to work from their leave. Please return this form to the Office of Human Resources/Benefits no later than 2 days after the employee has returned to work.

By my signature below, I am verifying that employee _____ has returned to work from their leave on the date of _____. If we do not receive this form as completed by the supervisor, the employee **WILL NOT** be placed back on payroll.

_____ _____

Supervisor **Date**