Family and Medical Leave
Employee Checklist

Request time off work
Follow your department’s normal procedure for requesting leave. Provide as much advance notice of the need for leave as possible. If at least 30 days advance notice is not possible, you are required to request leave as soon as you know you will need to be away from work. If the need for leave is due to an emergency, you must provide notification as required by your department and are required to notify your manager before leaving the workplace.

Request for Leave of Absence (LOA) or Modified Work Schedule Form
The following items MUST be included on the form in order for HR to process your request for leave:

- Indicate a start date and end date for the leave (If dates unknown, provide estimates. “Indefinite” dates or “leave as needed” are not acceptable and cannot be approved).
- Identify type of leave being requested (LOA - continuous or intermittent, or a reduced or modified work schedule). For intermittent leave, identify frequency and duration of leave needed.
- Identify reason for request (i.e., personal health condition, pregnancy or parental leave)
- Obtain manager’s signature (this acknowledges his/her receipt of your request for LOA or intermittent, reduced or modified work schedule)
- Send a copy of the signed and completed form to the appropriate Human Resources Office

Certification of Health Care Provider Form
- Complete employee information on Part 1 of the form and upper right corner of each page of the form
- Give entire form to your Health Care Provider for completion of Part 2 (NOTE: For intermittent leave requests, an estimate of the intermittent frequency, duration, and start/end dates must be provided by the Health Care Provider. Intermittent leave requests cannot be evaluated without this information.)
- Return the completed form directly to HR (the confidential health information on this form should not be shared with your manager)

Make Additional Arrangements for your Leave of Absence (if applicable)
- Contact your department timekeeper/manager to discuss use of benefit time during your leave (i.e., vacation, holiday, sick leave, compensatory time, leave without pay)
- Contact UW Benefits Office to discuss your health care coverage and/or new dependent information at 206-543-2800
- Contact Commuter Services to find out about discontinuing parking deductions while on leave: 206-744-3254 (Harborview) or 206-221-3701 (UWMC)

Return, scan or fax forms directly to your HR Office (copies are acceptable; however, HR reserves the right to request the originals for clarification):

Harborview Medical Center
Human Resources Operations Office
325 Ninth Avenue
Box 359715
Seattle, WA 98104
Phone: (206) 744-9220 Fax: (206) 744-9955
Or, send scan to: HMCFMLA@uw.edu

UW Medical Center
Human Resources Operations Office
1959 NE Pacific
Room BB150, Box 356054
Seattle, WA 98195
Phone: (206) 598-6116 Fax: (206) 598-4610
Or, send scan to: UWMCFMLA@uw.edu

Your leave request cannot be approved without these completed forms.
Incomplete forms may delay the approval process.
Request for Leave of Absence or Modified Work Schedule
Family and Medical Leave

Complete the relevant sections of this form, have your manager sign it, and submit it to HR with the Health Care Provider certification form. The manager’s signature is required and is only an acknowledgement of the request, not an approval.

<table>
<thead>
<tr>
<th>Employee Information</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Employee ID #:</td>
</tr>
<tr>
<td>Contact info:</td>
<td></td>
</tr>
<tr>
<td>Work Phone:</td>
<td>Other Phone (if we need to reach you while on leave):</td>
</tr>
<tr>
<td>Email:</td>
<td>Email:</td>
</tr>
<tr>
<td>Dept. Name:</td>
<td>Date:</td>
</tr>
<tr>
<td>Dept. Manager Name:</td>
<td>Supervisor Name (if different than Mgr.):</td>
</tr>
<tr>
<td>Phone:</td>
<td>Email:</td>
</tr>
<tr>
<td></td>
<td>Phone:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Leave Request Information</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>First Day of Leave (Required):</td>
<td>Last day of Leave (Required):</td>
</tr>
<tr>
<td>I am requesting a:</td>
<td></td>
</tr>
<tr>
<td>Continuous Leave of Absence (off work entirely during dates above)</td>
<td></td>
</tr>
</tbody>
</table>
| Intermittent Leave of Absence (smaller blocks of time ranging from a few hours to a few days at a time) | Please provide an estimate of your leave and/or treatment schedule for the dates above, by completing the following information:  
| ___ times per ___ week(s) or ___ month(s) |  
| AND | |
| ___ hours or ___ day(s) per episode | |
| Reduced/Modified Schedule | Please describe the schedule you are requesting for the dates above (e.g., “work 8 hrs per day, 4 days per week”–or “work M, T, W, & Th, 4 hrs per day”) |

<table>
<thead>
<tr>
<th>Reason for Request</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Self: leave for your own serious health condition, including pregnancy</td>
<td></td>
</tr>
<tr>
<td>Is leave due to an on-the-job injury? ☐ Yes ☐ No</td>
<td></td>
</tr>
<tr>
<td>For Pregnancy or Adoption - anticipated date of birth or placement: ______________________.</td>
<td></td>
</tr>
<tr>
<td>Family: leave due to a family member’s serious health condition, or parental leave</td>
<td></td>
</tr>
<tr>
<td>Relationship of family member to you: ______________________. If son or daughter, provide date of birth: ______________________.</td>
<td></td>
</tr>
<tr>
<td>For Pregnancy or Adoption - anticipated date of birth or placement: ______________________.</td>
<td></td>
</tr>
<tr>
<td>Is leave due to an injury/illness associated with a family member’s military service? ☐ Yes ☐ No</td>
<td></td>
</tr>
<tr>
<td>Military: family member called to active duty (Certification of Qualifying Exigency form must be completed to document the need for leave)</td>
<td></td>
</tr>
</tbody>
</table>

Employee Signature

Dept. Manager Signature

Rev. 1/2015
**University of Washington**

**Certification of Serious Injury or Illness of Covered Servicemember for Military Family Leave**

**Human Resources**

<table>
<thead>
<tr>
<th>To Employee - Please Print &amp; Complete on Every Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Name:</td>
</tr>
<tr>
<td>Department:</td>
</tr>
<tr>
<td>Employee Phone:</td>
</tr>
<tr>
<td>Employee Email:</td>
</tr>
</tbody>
</table>

Please complete Part 1, and arrange for your health care provider to complete Part 2. Return the completed form as soon as possible, but no later than 15 calendar days from the date you receive it. Return as indicated in the “Return to” space to the right.

**PART 1 – To Be Completed by Employee – (Please Print)**

<table>
<thead>
<tr>
<th>Supervisor’s name</th>
<th>Supervisor’s title</th>
<th>Supervisor’s phone</th>
<th>Supervisor’s email</th>
</tr>
</thead>
</table>

Name of covered servicemember you will care for: ________________________________________________________________________________________________

Servicemember’s relationship to you:  
- [ ] Parent  
- [ ] Child  
- [ ] Spouse  
- [ ] Domestic Partner  
- [ ] Brother/Sister  
- [ ] Grandchild  
- [ ] Grandparent  
- [ ] Next of Kin  

Is this a “step” relationship (i.e., step parent, step brother, etc.)?  
- [ ] No  
- [ ] Yes

Is the covered servicemember a current member of the regular Armed Forces, the National Guard or Reserves?  
- [ ] Yes  
- [ ] No

If yes, please provide the following information for covered servicemember. military branch, rank and unit currently assigned to:

<table>
<thead>
<tr>
<th>Military branch</th>
<th>Rank</th>
<th>Current unit assignment</th>
</tr>
</thead>
</table>

Is the covered servicemember assigned to a military medical treatment facility as an outpatient or to a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients (such as a medical hold or warrior transition unit)?  
- [ ] Yes  
- [ ] No

If yes, please provide the name of the medical treatment facility or unit: ____________________________________________

Is the covered servicemember on the temporary disability retired list (TDRL)?  
- [ ] No  
- [ ] Yes

**Care You Will Provide to the Covered Servicemember**

Describe care you will provide to your family member

I am requesting time off work:  
- [ ] No  
- [ ] Yes

If Yes: From (date) ____________ to (date) ____________

I am requesting a reduced work schedule as follows:  
- [ ] No  
- [ ] Yes

If Yes: _____ hours/day for ________ days/week until (date) ____________

I am requesting an intermittent work schedule:  
- [ ] No  
- [ ] Yes

If yes, describe requested schedule:

Employee Signature__________________________________________________ Date____________________
PART 2 – To Be Completed by United States Department of Defense (DOD) Health Care Provider

For completion by a United States Department of Defense ("DOD") Health Care Provider or a Health Care Provider who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider.

Our employee has requested leave covered by the FMLA to care for a family member who is a member of the Regular Armed Forces, the National Guard, or the Reserves and who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list because of a serious injury or illness. For purposes of FMLA covered leave, a serious injury or illness is one that was incurred in the line of duty on active duty that may render the servicemember medically unfit to perform the duties of his or her office, grade, rank, or rating. Certification to support a request for FMLA covered leave due to a servicemember's serious injury or illness includes written confirmation that the servicemember's injury or illness was incurred in the line of duty on active duty, and that the servicemember is undergoing treatment for such injury or illness by a health care provider as listed above.

The Genetic Information 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.

If you are unable to provide some of the military-related determinations referenced below, you may rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator).

### Health Care Provider Information

<table>
<thead>
<tr>
<th>Health care provider’s name</th>
<th>Type of practice/medical specialty</th>
<th>Telephone</th>
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<tbody>
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<tr>
<th>Business address</th>
<th>Fax</th>
<th>Email</th>
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</table>

Check the appropriate box - I am a:  
- DOD health care provider  
- VA health care provider  
- DOD TRICARE network authorized private health care provider  
- DOD non-network TRICARE authorized private health care provider  

Other – Please explain:

### Covered Servicemember’s Medical Status

The covered servicemember’s medical condition is classified as:

- (VSI) Very Seriously Ill/Injured – Illness/Injury is of such severity that life is imminently endangered. Family members are requested at bedside immediately. (This is an internal DOD casualty assistance designation used by DOD healthcare providers.)

- (SI) Seriously Ill/Injured – Illness/injury is of such severity that there is cause for immediate concern, but there is no imminent danger to life. Family members are requested at bedside. (This is an internal DOD casualty assistance designation used by DOD healthcare providers.)

- OTHER Ill/Injured – A serious injury or illness that may render the servicemember medically unfit to perform the duties of the member's office, grade, rank, or rating.

- NONE OF THE ABOVE – (Note to Employee: If this box is checked, you may still be eligible to take leave to care for a covered family member with a “serious health condition” under the FMLA, in which case you may need to complete a Certification of Health Care Provider for Family Member's Serious Health Condition form.)

Was the condition for which you are treating the covered servicemember incurred in line of duty while on active duty in the armed forces?  
- Yes  
- No

Approximate duration of condition: From (date) to (date)

Is the covered servicemember undergoing medical treatment, recuperation, or therapy?  
- Yes  
- No

If yes, please describe medical treatment, recuperation or therapy:
## Certification of Serious Injury or Illness of Covered Servicemember for Military Family Leave

**Human Resources**

**To Employee - Please Print & Complete on Every Page**

<table>
<thead>
<tr>
<th>Employee Name:</th>
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<tbody>
<tr>
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<td>Employee Phone:</td>
<td></td>
</tr>
<tr>
<td>Employee Email:</td>
<td></td>
</tr>
</tbody>
</table>

### Covered Servicemember’s Need for Care by Family Member

Will the covered servicemember need care for a single continuous period of time, including any time for treatment and recovery?  
[ ] No  [ ] Yes

If yes, please estimate the approximate duration of condition: From (date)____________ to (date)______________

Will the covered servicemember require periodic, scheduled follow-up treatment appointments?  
[ ] No  [ ] Yes

If yes, please estimate the treatment schedule:

Is there a medical necessity for the covered servicemember to have periodic care from a family member for these follow-up appointments?  
[ ] No  [ ] Yes

Is there a medical necessity for the covered servicemember to have periodic care from a family member or a health care provider for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of a medical condition)?  
[ ] No  [ ] Yes

If yes, please estimate the frequency and duration of the periodic care:

---

Signature of Health Care Provider  
________________________________________________________________________

Date_____________________________________________
Information about the
Family and Medical Leave Act (FMLA)

The Family and Medical Leave Act, a federal law, is designed to give you time away from work for your own serious health condition, the serious health condition of an eligible family member, or for new children in the household. In addition, the FMLA provides for leave due to serious injury or illness of a covered service member or a qualifying exigency. The leave time taken under the FMLA is unpaid; however, in accordance with your collective bargaining agreement or University policy, you may choose to utilize your accrued vacation, sick leave, personal holiday and/or compensatory time during your unpaid FMLA time off. The University of Washington has incorporated the protection of this law into its policy for job-protected family and medical leaves. In some instances, University policy and State law may provide additional leave rights.

Eligibility
You are eligible for FMLA leave if you:
- have worked for the State for a total of 12 months; AND,
- have been actively at work for the State for at least 1,250 hours during the 12 months immediately before the effective date of the leave.

Reasons for Family and Medical Leave (FMLA)
The FMLA provides job-protected leave of absence up to 12 weeks per calendar year. You may take leave for:
- Your own serious health condition
- The serious health condition of an eligible family member
- Birth or adoption/placement of your new child, if taken within 12 months of the birth or adoption/placement
- The serious injury or illness of a covered service member
- A qualifying exigency, when a family member is notified of an impending call to order for military duty

Requesting a Family and Medical Leave
- When possible, you should request time off from your manager at least 30 days in advance of the date you will start the leave.
- When advance notice is not possible, as in an emergency situation, you are required to notify your manager and follow your departmental guidelines for requesting time away from work, as soon as you are aware of your need for a leave of absence.
- Review the Family and Medical Leave Act Checklist
- Complete the following forms:
  1. Request for Leave of Absence or Modified Work Schedule
  2. Certification of Health Care Provider (return directly to HR within 15 days of request for leave)
- Human Resources may request periodic recertification of your leave.
- To determine any potential impact on your bargaining unit seniority, review your collective bargaining agreement, if applicable.
- Failure to submit requested information may result in a denial of your leave request.

Pay for Time Off
Please work directly with the person responsible for completing your timesheets to apply the appropriate accrued leave and/or leave without pay during your leave. FMLA time off is unpaid; however, available accrued sick leave, vacation, personal holiday, and/or compensatory time may be used in accordance with your collective bargaining agreement.

Intermittent, Reduced or Modified Work Schedule
If you take a FMLA leave, you may take the leave all at once, on an intermittent basis (taking leave periodically as is medically necessary), or on a reduced or modified work schedule (working less than your usual number of hours in a week).

Benefits during Family and Medical Leave
During the portion of a leave that is covered by FMLA, your medical benefits will continue the same as during your active employment status. You will still be responsible for the employee portion of the premiums. Please contact the Benefits Office at 543-2800 to discuss your health care coverage during your leave.
Returning to Work

If on leave for your own health condition and you return to work prior to your expected return date, you must provide Human Resources with a certification from your health care provider that you are released to return to work. On a job-protected leave you are guaranteed an equivalent job, but not necessarily the same job, if you return within the maximum 12 work weeks of leave. Equivalent means the same status, grade and benefits as the job you held at the beginning of your leave. If your position was eliminated during your leave, you may be separated from the University in accordance with the guidelines in effect for such situations at the time of your return to work.

Pregnancy Disability, Parental Leave and FMLA

- **Birth Mother:** You are entitled to pregnancy disability leave with a job guarantee for the period of time that you are sick or temporarily disabled in connection with pregnancy or childbirth. FMLA leave starts on the same day that disability leave begins, and runs concurrently for up to 12 weeks. Parental leave is in addition to any pregnancy disability leave taken. You are eligible for pregnancy disability leave and parental leave regardless of your eligibility under FMLA.
- **Non-Birth Parent and Adoptive Parent:** FMLA leave and parental leave run concurrently. Typically this leave must be taken in one consecutive time period and it must be taken within 12 months of the birth or adoption/placement of a child. You are eligible for parental leave regardless of your eligibility under FMLA.

## Definition of a Serious Health Condition

<table>
<thead>
<tr>
<th>Cause of absence defined as:</th>
<th>Example:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Care</strong></td>
<td>• Overnight hospital stay</td>
</tr>
<tr>
<td>• Inpatient care; or</td>
<td>• Post-surgery exam</td>
</tr>
<tr>
<td>• Any subsequent treatment related to inpatient care; or</td>
<td>• Post-surgery recovery</td>
</tr>
<tr>
<td>• Any period of incapacity* from a condition requiring inpatient care or recovery from such a condition.</td>
<td></td>
</tr>
<tr>
<td><strong>Absence Plus Treatment</strong></td>
<td>• Health care provider exams to determine &amp; evaluate condition</td>
</tr>
<tr>
<td>• Incapacitated* for more than 3 days (work and non-work days).</td>
<td>• Health care provider exam plus antibiotics or course of treatment such as physical therapy</td>
</tr>
<tr>
<td>• 2 or more treatments by a health care provider; or</td>
<td></td>
</tr>
<tr>
<td>• 1 or more treatment(s) followed by regimen of continuing treatment supervised by a health care provider.</td>
<td></td>
</tr>
<tr>
<td><strong>Prenatal/Pregnancy</strong></td>
<td>• Prenatal visits, morning sickness</td>
</tr>
<tr>
<td>• Any period of incapacity* due to pregnancy or for prenatal care.</td>
<td></td>
</tr>
<tr>
<td><strong>Chronic or Long-Term or Multiple Treatment Conditions/Appnts.</strong></td>
<td>• Health care provider appt. for asthma, diabetes, epilepsy</td>
</tr>
<tr>
<td>• Incapacitated* for more or less than 3 days (work and non-work days).</td>
<td>• Absence due to Alzheimer’s, severe stroke, terminal illness</td>
</tr>
<tr>
<td>• Periodic treatments over a period of time for a condition that may cause episodic incapacity.*</td>
<td>• Cancer treatments, kidney dialysis</td>
</tr>
<tr>
<td>• Incapacity* due to a condition for which treatment may not be effective that requires continued supervision by a health care provider.</td>
<td></td>
</tr>
<tr>
<td>• Absences to receive treatments for post-injury restorative surgery or any condition that, if left untreated, could lead to incapacity* of more than 3 days.</td>
<td></td>
</tr>
</tbody>
</table>

* **Incapacity:** Inability to work, attend school or perform other regular daily activities. Minor illnesses and injuries are not considered a serious health condition unless serious complications develop, even if the absence is beyond three days; particularly if there is not a requirement for ongoing medical treatment.

Where Can I Get Additional Information?

If you have questions, please consult the following resources:
- HR Office - Harborview .................................................. (206) 744-9220
- HR Office - UWMC ......................................................... (206) 598-6116
- Benefits Office – for questions regarding your benefits while on leave.................. (206) 543-2800
http://www.washington.edu/admin/hr/roles/mgr/leaveholiday/fmla/index.html
University of Washington
Family and Medical Leave Act Information Summary
(For Non-Academic Employees)

The UW provides this information for employees who have requested or are taking leave that could be covered by the federal Family and Medical Leave Act (FMLA) and provides additional information that is unique to Washington State, UW employment, or that you should otherwise know about. The federal poster “Employee Rights and Responsibilities Under the Family and Medical Leave Act” summarizes employee and employer rights and responsibilities under the FMLA and is attached at the end of this document. You can also download the poster at: http://tinyurl.com/FMLA-notice.

The FMLA allows eligible employees to take job protected leave from work for the reasons and the amount of time described on the FMLA poster. While the FMLA provides for unpaid time off, depending on the reason you need to take leave, your employment program, and your leave balances, you may have paid time off that you can use during your FMLA leave including: annual leave, sick leave, compensatory time, discretionary leave, personal holiday, and/or shared leave that has been donated by other employees. If you are eligible, you may also receive long-term disability insurance payments during the unpaid portion of FMLA leave.

In Washington State leave to care for a new born child is in addition to any leave the birth mother may need for sickness or temporary disability because of pregnancy or childbirth.

Certification of Leave
You may be required to provide certification from a health care provider to support the need for leave due to your own serious health condition or to care for a family member with a serious health condition. If certification is requested, you will need to arrange for completion of a Family and Medical Leave Certification of Health Care Provider Statement, and return it to the Human Resources Office serving your unit within 15 days. Failure to do this may delay approval of your leave request. The University may ask you to provide periodic updates regarding your ability to return to work, and the University may require a second medical opinion at its expense.

For leave related to a family member’s active duty in the armed services, certification of the family member’s military orders or status, or the reason for the leave may be required.

Return to Work Certification
Upon returning to work from FMLA-covered leave, you may be required to provide certification from a health care provider that you are fit to return to work. Contact your manager as soon as you know your expected return to work date.

Additional Resources
- Definitions of terms used in the Family Medical Leave Act: http://tinyurl.com/FMLA-definitions

If you have questions about this information, please consult the following resources:

<table>
<thead>
<tr>
<th>Office Listings</th>
<th>Office Phone Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>UWMC Human Resources</td>
<td>206-598-6116</td>
</tr>
<tr>
<td>Harborview Human Resources</td>
<td>206-744-9220</td>
</tr>
<tr>
<td>Risk Management (for on-the-job illness or injury)</td>
<td>206-543-0183</td>
</tr>
<tr>
<td>Benefits Office</td>
<td>206-543-2800</td>
</tr>
<tr>
<td>Disability Services Office</td>
<td>206-543-6450</td>
</tr>
<tr>
<td>Disability Services Office TTY</td>
<td>206-543-6452</td>
</tr>
</tbody>
</table>
EMPLOYEE RIGHTS AND RESPONSIBILITIES
UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement
FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- for incapacity due to pregnancy, prenatal medical care or child birth;
- to care for the employee’s child after birth, or placement for adoption or foster care;
- to care for the employee’s spouse, son, daughter or parent, who has a serious health condition; or
- for a serious health condition that makes the employee unable to perform the employee’s job.

Use of Leave
An employee does not need to use this leave entitlement in one block.

Leaves can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer’s operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Military Family Leave Entitlements
Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service-member during a single 12-month period. A covered service-member is:

(1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness*; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness.*

*The FMLA definitions of “serious injury or illness” for current servicemembers and veterans are distinct from the FMLA definition of “serious health condition”.

Benefits and Protections
During FMLA leave, the employer must maintain the employee’s health coverage under any “group health plan” on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee’s leave.

Eligibility Requirements
Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months*, and if at least 50 employees are employed by the employer within 75 miles.

*Special hours of service eligibility requirements apply to airline flight crew employees.

Definition of Serious Health Condition
A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee’s job, or prevents the qualified family member from participating in school or other daily activities.
Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Substitution of Paid Leave for Unpaid Leave
Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer’s normal paid leave policies.

Employee Responsibilities
Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer’s normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities
Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees’ rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee’s leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers
FMLA makes it unlawful for any employer to:
- interfere with, restrain, or deny the exercise of any right provided under FMLA; and
- discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement
An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulation 29 C.F.R. § 825.300(a) may require additional disclosures.

For additional information:
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