

# Family and Medical Leave Act (FMLA) Personal Health Condition/Pregnancy Employee Checklist

## ALL TASKS ARE REQUIRED:

**Request time off work.** Follow your department's normal request procedures to request 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 because of an emergency, **you must provide notification as required by your department. You 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 all leave requests** (If dates unknown, please provide estimates. "Indefinite" dates or "leave as needed" are not acceptable dates and cannot be approved).
- Identify type of leave being requested** (LOA - full or intermittent or a reduced or modified work schedule)
- 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)
- Distribute copies of your signed and completed Request for LOA or Modified Work Schedule form to:**
  - Manager
  - Human Resources (original copy)
  - Department Payroll Coordinator
  - Self

## **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 FMLA requests, an estimate of the intermittent frequency, duration, and start/end dates must be provided by the Health Care Provider. We are unable to evaluate requests for intermittent FMLA without this information).
- Return the completed form directly to HR (the confidential health care information on this form should not be shared with your manager)

## **Make Additional Arrangements for Your Leave of Absence (if applicable)**

- Contact** your department time keeper/manager to discuss use of benefit time during your leave (i.e., vacation, holiday, sick leave, compensatory time, and 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 discontinue parking deductions while on leave: 206-744-3254 (HMC) or 206-221-3701 (UWMC)

## **Return, scan or fax forms directly to your HR Office:**

**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

***We cannot grant final approval of your leave request without these completed forms.  
Incomplete forms may delay approval process.***



University of Washington Medical Centers Human Resources <b>Family &amp; Medical Leave</b> <b>Certification of Health Care Provider</b> <b>Personal Health Condition/Pregnancy</b>	<b>To Employee - Please Print &amp; Complete on Each Page</b>	
	Employee Name:	
	Employee EID #:	
	Department:	
	Employee Phone:	Employee Email:

<b>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.</b>	<b>Return to:</b> <input type="checkbox"/> <b>Harborview Medical Center</b> Human Resources Operations Office 325 Ninth Avenue Box: 359715 Seattle, WA 98104-2499 Phone: (206) 744-9220 Fax: (206) 744-9955 Or, send scan to: HMCFMLA@uw.edu	<input type="checkbox"/> <b>UW Medical Center</b> 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: UWCMFMLA@uw.edu
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PART 1 – To Be Completed by Employee			
Manager's Name (please print):	Manager's Title:	Manager's Phone:	Manager's Email:
Employee Signature: _____ Date: _____			

PART 2 – To Be Completed by Health Care Provider
<p><b>Our employee is requesting leave from work and/or an intermittent, reduced or modified work schedule under the FMLA. Please provide the information requested below so that we can process our employee's leave request. Only provide information relating to the condition(s) that require our employee to take leave or adopt an intermittent, reduced or modified work schedule.</b> 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.</p>

For Pregnancy-Related Time off Work	
Expected date of delivery: _____ Scheduled C-Section Date: (If Applicable) _____	Expected dates of time off work required due to pregnancy and delivery (6 weeks for normal delivery – 8 weeks for C-Section): From: _____ To: _____

Part A: Medical Facts
<b>Patient Health Condition</b> Is patient's condition a "Serious Health Condition?" <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please check the applicable categories below: <input type="checkbox"/> Permanent or Long-Term Incapacity <input type="checkbox"/> Absence, plus treatment <input type="checkbox"/> Pregnancy Complication <input type="checkbox"/> A Chronic Condition <input type="checkbox"/> Multiple Treatments <input type="checkbox"/> Hospital/Inpatient Care - <b>Date Admitted:</b> _____ <b>Date Discharged/Released:</b> _____
Was medication, other than over-the-counter medication, prescribed? <input type="checkbox"/> Yes <input type="checkbox"/> No
Was your patient referred to other health care provider(s) for evaluation or treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe the nature and expected duration of the treatments:
Is this a work-related injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of injury: _____ (Employee must also contact the Risk Management Department at 206-616-3329)

University of Washington Medical Centers Human Resources <b>Family &amp; Medical Leave          Certification of Health Care Provider          Personal Health Condition/Pregnancy</b>	<b>To Employee - Please Print &amp; Complete on Each Page</b>	
	Employee Name: _____	
	Employee EID #: _____	
	Department: _____	
Employee Phone: _____		Employee Email: _____


**Part A: Medical Facts (Cont.)**

Several of the following questions ask about the frequency or duration of a condition or treatment. We know that health conditions can vary or change over time, so please provide your best estimate in response to these questions, being as specific as you can. Using terms such as "lifetime," "unknown," or "indefinite" is not specific enough for us to determine leave eligibility for our employee covered by the Family and Medical Leave Act.

Describe the medical facts related to the condition(s) that require your patient to be off work (full leave or intermittent leave) or adopt a reduced or modified work schedule (medical facts may include symptoms, diagnosis, or any plan for continuing treatment or therapy):

**Part B: Leave of Absence Requirements for Care**

**Need for Continuous Leave of Absence**

Will your patient be incapacitated for a single, continuous period of time, including time for treatment and recovery?  Yes  No  
 If yes, estimate the beginning and ending dates for the period of incapacity:  
 From (Date required): \_\_\_\_\_ To (Date required): \_\_\_\_\_  
 If YES  Go to Part C. If No, complete the section below.

**Need for Intermittent, Reduced or Modified Work Schedule**

Will your patient be incapacitated in a way that requires intermittent leaves of absence from work or a reduction in the amount of time worked per week due to his/her medical condition, including any time for treatment and recovery?  Yes  No  
 If yes, please provide an estimate of the **intermittent leave** and/or the **anticipated treatment schedule** (e.g., 1 episode every 3 months lasting 1-2 days and/or 1 one-hour appointment per week). **NOTE: We are unable to evaluate requests for intermittent FMLA without an estimate of intermittent frequency, duration, and start/end dates:**  
 Intermittent Leave Frequency: \_\_\_\_\_ times per \_\_\_\_\_ week(s) -or- \_\_\_\_\_ month(s)  
 Intermittent Leave Duration: \_\_\_\_\_ hours or \_\_\_\_\_ day(s) per episode  
 From (Date required): \_\_\_\_\_ To (Date required): \_\_\_\_\_

**AND/OR**  
 Please describe the **reduced/modified work schedule** needed (e.g., work 3 days a week, 8 hours a day):  
 Reduced/Modified: \_\_\_\_\_ days a week, \_\_\_\_\_ hours a day--or--Other: \_\_\_\_\_  
 From (Date required): \_\_\_\_\_ To (Date required): \_\_\_\_\_

**Part C: Health Care Provider Information** (please complete or attach business card with information)

Name (please print): \_\_\_\_\_ Specialty: \_\_\_\_\_  
 Business Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

To the best of my knowledge, the information provided throughout this form is true and correct.  
 Health Care Provider Signature: \_\_\_\_\_ 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 illness, the serious illness of an eligible family member, or for new children in the household. In addition, the Family and Medical Leave Act provides for leave due to serious injury or illness of a covered service member or a qualifying exigency. The leave time taken under the Family and Medical Leave Act is unpaid; however, in accordance with your collective bargaining agreement or University Policy, you may choose to utilize your accrued vacation, sick leave, 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 family and medical 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)

Family and medical leave provides job-protected leave of absence up to 12 weeks per calendar year. You may take family and medical leave for:

- Your own serious health condition.
- The serious health condition of an eligible family member
- Birth, adoption/placement of your new child, if taken within 12 months of the birth, 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.
- Complete the following forms:
  1. *Family and Medical Leave Act Checklist*
  2. *Request for Leave of Absence or Modified Work Schedule*
  3. *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.

### Pay for Time Off

Please work directly with the person responsible for completing your timesheets to determine your leave use during your family and medical leave. Family and medical leave time off is unpaid; however, in accordance with your collective bargaining agreement, accrued sick leave hours, if available, may be used when on leave. You may also use any other paid time off, such as accrued vacation, personal holiday, or compensatory time during the unpaid family and medical leave.

### Intermittent, Reduced or Modified Work Schedule

If you take a family and medical 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

While on family and medical leave, 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 family and medical leave.

## *Family and Medical Leave Act (FMLA) Information (Continued)*

### Returning to Work

If 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. Family and Medical Leave starts on the same day that disability leave begins, and runs 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-Birthing Parent and Adoptive Parent:** Family and Medical Leave and parental leave run concurrently. This leave must be taken in one consecutive time period within 12 months of the birth, adoption/placement of a child. You are eligible for parental leave regardless of your eligibility under FMLA.

<b>Definition of a Serious Health Condition</b>	
<b>Cause of absence defined as:</b>	<b>Example:</b>
<b><u>Inpatient Care</u></b> • Inpatient care; or • Any subsequent treatment related to inpatient care; or • Any period of incapacity* from a condition requiring inpatient care or recovery from such a condition.	• Overnight hospital stay • Post-surgery exam • Post-surgery recovery
<b><u>Absence Plus Treatment</u></b> • Incapacitated* for more than 3 days (including weekends). • 2 or more treatments by a health care provider; or • 1 or more treatment(s) followed by regimen of continuing treatment supervised by a health care provider.	• Health care provider exams to determine & evaluate condition • Health care provider exam plus antibiotics
<b><u>Prenatal/Pregnancy</u></b> • Any period of incapacity* due to pregnancy or for prenatal care.	• Prenatal visits, morning sickness
<b><u>Chronic or Long-Term or Multiple Treatment Conditions</u></b> • Incapacitated* for more or less than 3 days. • Periodic treatments over a period of time for a condition that may cause episodic incapacity.* • Incapacity* due to a condition for which treatment may not be effective that requires continued supervision by a health care provider. • 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.	• Health care provider appt. for asthma, diabetes, epilepsy • Absence due to Alzheimer's, severe stroke, terminal illness • Cancer treatments, kidney dialysis
* <b>Incapacity:</b> Inability to work, attend school or perform other regular daily activities.	

### **Where Can I Get Additional Information?**

If you have questions, please consult the following resources:

- HR Operations - HMC ..... (206) 744-9220
- HR Operations - UWMC ..... (206) 598-6116
- Benefits Office..... (206) 543-2800