

# 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** (see contact information below).

## 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.

Employee Information			
<b>Name:</b>		<b>Employee ID #:</b>	
<b>Contact info:</b> Work Phone: _____ Other Phone (if we need to reach you while on leave): _____ Email: _____			
<b>Department Name:</b>		<b>Date:</b>	
<b>Dept. Manager Name:</b>		<b>Supervisor Name (if different than Mgr.):</b>	
<b>Phone:</b>	<b>Email:</b>	<b>Phone:</b>	<b>Email:</b>
Leave Request Information			
<b>First Day of Leave (Required):</b> _____		<b>Last day of Leave (Required):</b> _____	
<b>I am requesting a:</b>			
<input type="checkbox"/> <b>Continuous Leave of Absence (off work entirely during dates above)</b>			
<input type="checkbox"/> <b>Intermittent Leave of Absence (smaller blocks of time ranging from a few hours to a few days at a time)</b> 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)			
<b>AND</b>			
_____ hours or _____ day(s) per episode			
<input type="checkbox"/> <b>Reduced/Modified Schedule</b> 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")			
Reason for Request			
<input type="checkbox"/> <b>Self:</b> leave for your own serious health condition, including pregnancy  Is leave due to an on-the-job injury? <input type="checkbox"/> Yes <input type="checkbox"/> No  For Pregnancy or Adoption - anticipated date of birth or placement: _____			
<input type="checkbox"/> <b>Family:</b> leave due to a family member's serious health condition, or parental leave  Relationship of family member to you: _____ If son or daughter, provide date of birth: _____  For Pregnancy or Adoption - anticipated date of birth or placement: _____  Is leave due to an injury/illness associated with a family member's military service? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<input type="checkbox"/> <b>Military:</b> family member called to active duty (Certification of Qualifying Exigency form must be completed to document the need for leave)			
Employee Signature		Dept. Manager Signature	
Date		Date	

**To Employee:** Complete the upper right corner of this page and arrange for your health care provider to complete the remainder of the form. **Return the completed form as soon as possible, but no later than 15 calendar days after the date you receive it.** Return it to the appropriate office indicated in the space to the right. Contact this office if you believe that you will not be able to return the completed form within the specified time period.

Employee email:

**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](mailto:UWMCFMLA@uw.edu)

**Our employee is requesting leave from work and/or a modified work schedule under the FMLA for a health condition. Please provide the information requested below so that we can process our employee's leave request. Only provide information regarding the condition(s) that relate to our employee's request to take leave or adopt a modified work schedule.**

*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.*

Describe the medical facts related to the condition(s) that require our employee to be off work and/or to work a reduced or intermittent work schedule (medical facts may include symptoms, diagnosis, or any plan for continuing treatment or therapy):

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

If yes, dates of admission: \_\_\_\_\_

Date(s) you treated patient for this condition: \_\_\_\_\_

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

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

Was your patient referred to other health care provider(s) for evaluation or treatment? Yes ☐ No ☐

If yes, describe the nature and expected duration of the treatments:

### For Pregnancy-Related Incapacity

Expected date of delivery:

Planned C-Section? Yes ☐ No ☐

Expected dates of your patient's physical incapacity due to pregnancy and delivery (not parental leave):

From (date): \_\_\_\_\_ to (date): \_\_\_\_\_

## Need for Leave or Work Schedule Adjustment

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 "indeterminate" may not be specific enough for us to determine leave eligibility for our employee under the Family and Medical Leave Act.

### Continuous Leave:

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): \_\_\_\_\_ to (date): \_\_\_\_\_

### Intermittent Leave:

Will the condition(s) cause episodic flare-ups that prevent your patient from performing his/her job functions? Yes ☐ No ☐

If yes, please explain:

Based upon your 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 time per 3 months, 2 days per episode)

**Frequency:** \_\_\_\_\_ time(s) per \_\_\_\_\_ week(s) -or- \_\_\_\_\_ month(s)

AND

**Duration:** \_\_\_\_\_ hours or \_\_\_\_\_ day(s) per episode

**From (date):** \_\_\_\_\_ **to (date):** \_\_\_\_\_

### Appointments:

Are follow-up and/or periodic treatment appointments medically-necessary for your patient? Yes ☐ No ☐

If yes, describe the anticipated treatment schedule and any treatment recovery period(s):

Will there be a need for planned medical appointments and/or absences? Yes ☐ No ☐

**Frequency:** \_\_\_\_\_ time(s) per \_\_\_\_\_ week(s) -or- \_\_\_\_\_ month(s)

AND

**Duration:** \_\_\_\_\_ hours or \_\_\_\_\_ day(s) per episode

**From (date):** \_\_\_\_\_ **to (date):** \_\_\_\_\_

### Reduced/Modified Work Schedule:

Will your patient require a reduction in or modification of the amount of time worked per week due to his/her medical condition, including any time for treatment and recovery? Yes ☐ No ☐

If yes, describe the reduced or modified work schedule that you believe is medically necessary:

This work schedule needs to be in place **from (date):** \_\_\_\_\_ **to (date):** \_\_\_\_\_

### Health Care Provider Information (please complete or attach business card)

Name (please print) \_\_\_\_\_ Specialty \_\_\_\_\_

Business Address \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Health Care Provider Signature (required) \_\_\_\_\_ 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 rolling 12 month period. 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	
Cause of absence defined as:	Example:
<b><u>Inpatient Care</u></b> <ul style="list-style-type: none"> <li>• Inpatient care; or</li> <li>• Any subsequent treatment related to inpatient care; or</li> <li>• Any period of incapacity* from a condition requiring inpatient care or recovery from such a condition.</li> </ul>	<ul style="list-style-type: none"> <li>• Overnight hospital stay</li> <li>• Post-surgery exam</li> <li>• Post-surgery recovery</li> </ul>
<b><u>Absence Plus Treatment</u></b> <ul style="list-style-type: none"> <li>• Incapacitated* for more than 3 days (work and non-work days).</li> <li>• 2 or more treatments by a health care provider; or</li> <li>• 1 or more treatment(s) followed by regimen of continuing treatment supervised by a health care provider.</li> </ul>	<ul style="list-style-type: none"> <li>• Health care provider exams to determine &amp; evaluate condition</li> <li>• Health care provider exam plus antibiotics or course of treatment such as physical therapy</li> </ul>
<b><u>Prenatal/Pregnancy</u></b> <ul style="list-style-type: none"> <li>• Any period of incapacity* due to pregnancy or for prenatal care.</li> </ul>	<ul style="list-style-type: none"> <li>• Prenatal visits, morning sickness</li> </ul>
<b><u>Chronic or Long-Term or Multiple Treatment Conditions/Appts.</u></b> <ul style="list-style-type: none"> <li>• Incapacitated* for more or less than 3 days (work and non-work days).</li> <li>• Periodic treatments over a period of time for a condition that may cause episodic incapacity.*</li> <li>• Incapacity* due to a condition for which treatment may not be effective that requires continued supervision by a health care provider.</li> <li>• 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.</li> </ul>	<ul style="list-style-type: none"> <li>• Health care provider appt. for asthma, diabetes, epilepsy</li> <li>• Absence due to Alzheimer's, severe stroke, terminal illness</li> <li>• Cancer treatments, kidney dialysis</li> </ul>
<p>* <b>Incapacity:</b> 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.</p>	

## 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>
- Leave planning and usage: UWHR Life Events web pages - <http://tinyurl.com/UWHR-LifeEvents>

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

Office Listings	Office Phone Numbers
UWMC Human Resources	206-598-6116
Harborview Human Resources	206-744-9220
Risk Management ( <i>for on-the-job illness or injury</i> )	206-543-0183
Benefits Office	206-543-2800
Disability Services Office	206-543-6450
Disability Services Office TTY	206-543-6452

# **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.

Leave 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 servicemember 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:**

1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627

**[WWW.WAGEHOUR.DOL.GOV](http://WWW.WAGEHOUR.DOL.GOV)**

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