Department of Human Resources

RU
RADFORD UNIVERSITY

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www.radford.edu

An Equal Opportunity/ Affirmative Action Institution

MEMO

TO: Employee

FROM: Personnel Services

SUBJECT: Family and Medical Leave

Enclosed is an application form to request leave under the provisions of the Family and Medical Leave Act (FMLA) of 1993. Also enclosed, is a sheet outlining your rights under FMLA and a medical certification form to be completed by the health care provider when the leave is needed due to a serious health condition.

If you are applying for leave because of the birth of a child, you will need to supply evidence of the date of birth. If the leave is needed because of the adoption or foster care placement of a child, you will need to provide evidence of the date the child was placed under your care.

Employees who experience *leave without pay* while qualified to use Family and Medical Leave due to a family member's illness or injury may request to participate in the Commonwealth's Leave Sharing Program. You may contact Personnel Services at 831-6110 or access the Human Resources web site at http://www.radford.edu/~pers-web/forms-word.htm for additional information and/or forms to apply.

If you have questions or need additional information, please phone the Department of Human Resources at ext. 6110.

Enclosures

Your Rights
under the
Family and Medical Leave Act of 1993

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to "eligible" employees for certain family and medical reasons. Employees are eligible if they have worked for their employer for at least one year, and for 1,250 hours over the previous 12 months, and if there are at least 50 employees within 75 miles. The FMLA permits employees to take leave on an intermittent basis or to work a reduced schedule under certain circumstances.

Reasons for Taking Leave:

Unpaid leave must be granted for any of the following reasons:
• to care for the employee's child after birth, or placement for adoption or foster care;
• to care for the employee's spouse, son or 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.

At the employee's or employer's option, certain kinds of paid leave may be substituted for unpaid leave.

Advance Notice and Medical Certification:

The employee may be required to provide advance leave notice and medical certification. Taking of leave may be denied if requirements are not met.
• The employee ordinarily must provide 30 days advance notice when the leave is "foreseeable."
• An employer may require medical certification to support a request for leave because of a serious health condition, and may require second or third opinions (at the employer's expense) and a fitness for duty report to return to work.

Job Benefits and Protection:

• For the duration of FMLA leave, the employer must maintain the employee's health coverage under any "group health plan."
• Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.
• The use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

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:
• 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:

• The U.S. Department of Labor is authorized to investigate and resolve complaints of violations.
• An eligible employee may bring a civil action against an employer for violations.

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.

For Additional Information:

If you have access to the Internet visit our FMLA website: http://www.dol.gov/esa/whd/fmla. To locate your nearest Wage-Hour Office, telephone our Wage-Hour toll-free information and help line at 1-866-4USWAGE (1-866-487-9243): a customer service representative is available to assist you with referral information from 8am to 5pm in your time zone; or log onto our Home Page at http://www.wagehour.dol.gov.

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division
Washington, D.C. 20210

WH Publication 1420
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Certification of Health Care Provider Form
Family and Medical Leave Act of 1993

Employee's Name:	Patient's Name (if different from employee)
Employee's Department:	Patient's Relationship to Employee:

Do you believe the physical presence of the employee named above is necessary or beneficial in the care of the patient?

☐ Yes ☐No If Yes, for how long? ____________________

The Following is to be Completed by the Attending Physician or Practitioner:
The information requested on this form relates only to the *serious health condition* for which the employee is requesting leave under the Family and Medical Leave Act. ***Please check the applicable category of the patient's qualifying condition.***

☐ **Hospital Care** Admission to Hospital Date: __________ Discharge Date: __________

☐ **Acute Condition (Absence Plus Treatment)**

☐ **Birth of a Child** Estimated Date of Delivery ____________________

☐ Request for Mother ☐ Request for Father

☐ **Chronic/Permanent** Expected frequency of absence: __________ days per month
Lasting __________ hours per absence

1. Length of time your patient has had/will have this condition: From: __________ Through: __________
(keeping the employee from performing the essential functions of his/her job.)

2. Describe the *regimen of treatment* to be prescribed indicating the number of visits, general nature and duration of treatment, including referral to other provider(s) of health services.

Include schedule of visits or treatment, if medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal schedule of hours per day or days per week.

____
Print or Type Name of Healthcare Provider

____
Signature of Healthcare Provider

____
Type of Practice

____
Street and Mailing Address

____________________ ____________________
Telephone Number **FAX Number**

____________________ ____________________
Physician Signature **Date**

Please Return the Completed Form to:
Human Resources, Department of Human Resources, Radford University
704 Clement Street, P.O. Box 6889, Radford, VA 24142 or fax to 540-831-6278

Radford University Family and Medical Leave (FMLA) Request Form

Name:			**Date:**
Employee ID Number:	**Department:**		
Mailing Address (home):		**Home Phone Number:**	
Supervisor's Name:		**Phone Number:**	
☐ **Staff** **Salaried Appointment** ☐ **Wage Appointment** ☐ **Faculty** **Salaried Appointment**		**Normal Work Hours Per Week:**	
Anticipated Begin Date of Leave:	**Expected Return to Work Date:**		
Has the Employee Taken Other *FMLA* leave During this Calendar Year?			
The leave option you chose is to: ☐ **Retain leave balances during leave and take LWOP** ☐ **Use applicable leave balances**			
Explain Reason for Request:			
Schedule of Leave Request: ☐ For entire period requested above ☐ Intermittent (a few hours a day, for a few days a week or on an as needed basis) * * **Intermittent time off must be approved and coordinated by employees supervisor.** *** Supervisors Signature: ____**			

*When both husband and wife work full-time for Radford University, the amount of FML is limited to a combined total of 12 work weeks in a 12-month period when the leave is for the birth, adoption, or foster care placement of a child, or for care of a parent or child who has a serious health condition.

NOTE: A FML request based on an employee's serious health condition or the serious health condition of an employee's spouse, child or parent requires medical certification from a health care provider.

I UNDERSTAND AND AGREE TO THE FOLLOWING PROVISIONS:

I have worked for state government (agency, if wage employee) for at least 12 months and for at least 1,250 hours in the previous 12 months.

If I chose to take LWOP or go into a LWOP status, it is my responsibility to pay my portion of the health care premium to my agency by the due date. If I am in a LWOP status I will not earn leave during that pay period.

At the end of FML, I will be reinstated to my original position or a comparable position.

A failure to return to work at the end of FML may be treated as a resignation unless an extension has been agreed upon and approved by Radford University.

Employees Signature: ____ **Date:** ______________