Family Medical Leave Act (FMLA)

Self-Certification Forms

Please return completed forms to:
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Benefit Analyst
NKU Human Resources
859-572-7556 (phone)
859-572-6998 (fax)
Tiptonj1@nku.edu

Rev. 6/2013
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 childbirth;
- 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;
- For a serious health condition that makes the employee unable to perform the employee’s job.

Military Family Leave Entitlements
Eligible employees who are spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation 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 unpaid leave to care for a covered service member during a single 12-month period. A covered service member is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the service member medically unfit to perform his or her duties for which the service member is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retirement list.

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 one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

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.

Use of Leave
An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on an extended 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.

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 employee’s 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;
- 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 186 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.

For additional information:
WWW.WAGEHOUR.DOL.GOV

U.S. Department of Labor | Employment Standards Administration | Wage and Hour Division

WHD Publication 1409 Revised January 208
Leaves of Absence Request

Name: ______________________________ Date of Hire: ______________________________

Address: ________________________________________________________________

Employee ID#: __________________________ Department: ____________________________

Supervisor: ____________________________ Date of Request: _________________________

REASON for LEAVE REQUEST
☐ Self – Serious health condition
☐ Birth or first year care of a child
☐ Placement of a child for adoption/foster care
☐ Care of a spouse, child, parent,
☐ Military Orders
☐ Personal
☐ Other (Please Specify) ______________________________________________________________________

Time Requested is for (Circle One): Intermittent Use Reduced Schedule Single Block

LEAVE DATES:
Last Day Worked: ___________ Leave Begins: ___________ (Estimated/Actual) Return to Work: ___________

Employee Signature: ____________________________

Supervisor Signature: ____________________________

Do not write/complete any section below this line

LEAVE DESIGNATION: (Eligible for FMLA Yes No)

<table>
<thead>
<tr>
<th>FMLA-Single Block</th>
<th>Personal</th>
<th>FMLA Hours Available</th>
<th>Accruals as of</th>
</tr>
</thead>
<tbody>
<tr>
<td>FMLA-Intermittent</td>
<td>Faculty</td>
<td></td>
<td>Sick Hours</td>
</tr>
<tr>
<td>Temporary Disability</td>
<td>Military</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workers Compensation</td>
<td>Other</td>
<td></td>
<td>Vacation Hours</td>
</tr>
</tbody>
</table>

IMPORTANT:
If your leave (for a portion) is unpaid, you will be responsible for your share of benefit costs. You have a maximum of 30-day grace period in which to make premium payments. Listed below are the amounts you must pay in order to continue your benefit coverage if your leave (or a portion) is unpaid. Checks should be made payable to NKU.

BIWEEKLY/MONTHLY Contributions Due: ____________________________
Medical: _______ Dental: _______ Vision: _______ Life: _______ ST Disability: _______ Other: _______

Supporting Documentation Received: ____________________________

Note: If you are out due to your own condition, you will be required to submit a release note from your doctor to return to work.

Approved by: ____________________________ on ____________

Rev. 1-2012
Fill-in, print, and sign. Send to Human Resources - Benefits at AC 708

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**LOA – Release for Information**

**NAME:**

**DEPT:**

**DATE:**

**INFORMATION RELEASE**

This is authorization for the Benefits Manager/Representative, at Northern Kentucky University to discuss my diagnosis and/or treatment of for purposes of verifying my condition, treatment dates, regimen of treatment and/or therapy, and my return to work ability/status with (if any) limitations/restrictions.

This information is necessary for:

- Granting/Verifying a leave of absence that I have requested
- Processing a request for sick time, from the sick bank administered by the NKU Benevolent Association
- Verifying my return to work

In compliance with the Health Insurance Portability and Accountability Act (HIPAA), it is my understanding that any information obtained is CONFIDENTIAL and will be used solely for the purposes indicated above. Any information/documentation will be kept in a separate medical file at NKU to protect my privacy and will not be released (or discussed) without my consent.

Requested by: ____________________________ Social Security Number: XXX-XX-

I agree to all of the conditions herein. Signed: ____________________________

NKU-HRLOAREL 09/03

http://access.nku.edu/hr/HR%20Index/Benefits/Forms/Forms/loa.htm

7/2/2009
SECTION I: For Completion by the EMPLOYER
INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee’s health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

Employer name and contact:

Employee’s job title: __________________________ Regular work schedule: __________________________

Employee’s essential job functions:

Check if job description is attached: ______

SECTION II: For Completion by the EMPLOYEE
INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: __________________________
First __________________________ Middle __________________________ Last __________________________

SECTION III: For Completion by the HEALTH CARE PROVIDER
INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as “lifetime,” “unknown,” or “indeterminable” may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Provider’s name and business address: __________________________

Type of practice / Medical specialty: __________________________

Telephone: (_______) _______ Fax: (_______) _______
PART A: MEDICAL FACTS

1. Approximate date condition commenced: ________________________________

Probable duration of condition: _________________________________________

Mark below as applicable:
Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?  
____ No  ____ Yes. If so, dates of admission: ______________________________

Date(s) you treated the patient for condition: ______________________________

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

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

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?  
____ No  ____ Yes. If so, state the nature of such treatments and expected duration of treatment:

2. Is the medical condition pregnancy?  ____ No  ____ Yes. If so, expected delivery date: ________________

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to 
provide a list of the employee’s essential functions or a job description, answer these questions based upon 
the employee’s own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition?  ____ No  ____ Yes.

If so, identify the job functions the employee is unable to perform:

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave 
(such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use 
of specialized equipment):

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___No ___Yes.

If so, estimate the beginning and ending dates for the period of incapacity: ____________________________

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee’s medical condition? ___No ___Yes.

If so, are the treatments or the reduced number of hours of work medically necessary? ___No ___Yes.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

__________________________________________________________________________________________

Estimate the part-time or reduced work schedule the employee needs, if any:

_________ hour(s) per day; _________ days per week from ____________ through ________________

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ___No ___Yes.

Is it medically necessary for the employee to be absent from work during the flare-ups? ___ No ___Yes. If so, explain:

__________________________________________________________________________________________

__________________________________________________________________________________________

Based upon the 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 episode every 3 months lasting 1-2 days):

Frequency : ______ times per ______ week(s) ______ month(s)

Duration: ______ hours or ___ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER:

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

Page 3
Signature of Health Care Provider

Date

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 OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.