



APPLICATION FOR LEAVE OF ABSENCE EMPLOYEE APPLICATION

This pkt. must be completed in its entirety as far in advance as possible; at least 30 days for a foreseeable leave, or **as soon as practicable** for an unforeseeable leave. For more info on FMLA see Policy # 3364-25-30.

Name: _____ Department: _____

Immediate Supervisor: _____ Your Work Phone extension: _____

START OF LEAVE: I would like to begin the leave on _____

END OF LEAVE: I anticipate the leave needs to continue through _____

Main Campus Only - I wish to keep _____ hours of vacation (maximum 40 hrs) and _____ hours of sick time (maximum 40 hrs)

I understand that if any dates change, I need to give the Human Resources Department as much notice as possible. I also understand that if I qualify for FMLA, recertification may be required. I understand that I must follow any and all departmental and organizational call in procedures for each day I am scheduled to work until I receive official written documentation of my leave approval, if applicable.

The shaded section should only be completed if applying for an FMLA.

FAMILY AND MEDICAL LEAVE OF ABSENCE (ONLY):

I need a [Complete all that apply]:

Full-time leave **from:** _____ **through:** _____ Intermittent leave **from:** _____ **through:** _____

OR reduced schedule leave

If request is for an intermittent or reduced schedule leave the reason is [Check one]:

chronic serious health condition permanent/long-term serious health condition planned medical treatments other

If reason is "other", please describe. For planned medical treatments or reduced leave schedule, indicate the schedule you most prefer.

NON-FMLA LEAVES:

I wish to apply for the following type of leave for myself [CHECK ONE]:

SICK LEAVE

UNPAID LEAVE

PATERNITY/MATERNITY LEAVE

MILITARY LEAVE *PLEASE ATTACH COPY OF YOUR OFFICIAL ORDERS

*Issued by the President of the United States, Congress, or the Governor AND an official copy of monthly military pay and allowances pursuant to section 5919.29 of the Ohio Revised Code.

REQUIREMENTS OF Non-FMLA LEAVES: Please provide the non-FMLA Leave of Absence Request Form.

I understand that I must continue to pay for the same portion of my health care coverage (if any) that I normally pay during active employment in order for my coverage to continue throughout the leave. I understand that I must return to work the first business day after my leave ends. If I do not, my employment may be discontinued. Depending on my reason for not returning, I may have to reimburse the University of Toledo for the cost of health care premiums during the leave. If the need, as stated above, changes significantly, it is my responsibility to notify my employer. I understand that I cannot work for any other employer while on a leave from the University of Toledo.

EMPLOYEE'S Signature _____ Date _____

Human Resource Department ONLY:

Rocket Number: _____

Job Title: _____

Vacation: _____

HSC or MC

FTE: _____

Sick: _____

Date of Hire: _____

Hrs Worked: _____

Comp: _____

FMLA Form 1- 9/06

FMLA HR Usage: _____

Total: _____

Hand Deliver or Mail to HR – Do Not Fax or Deliver faxed copies

CERTIFICATION BY HEALTH CARE PROVIDER FAMILY MEDICAL LEAVE ACT 1993 Employee Certification



Human Resources
Mail Stop 205
2801 W. Bancroft St., Toledo, Ohio 43606-3390
419-530-4747

ATTN Employee: Please be sure that all applicable fields are completed to avoid delays or denial of request.

EMPLOYEE INFORMATION – MUST BE COMPLETED BY EMPLOYEE

1. Name: _____ Home Phone: _____

UT email address _____ Rocket Number: _____
(You will receive an EMAIL NOTIFICATION when a determination is made.) (Can be found on your pay stub)

I give my permission for this information concerning the medical condition for which this leave is being requested to be provided to The University of Toledo from whom family or medical leave is being requested. I hereby authorize a health care provider representing the University to contact my physician to verify my requested family & medical leave.

Employee Signature: _____ Date: _____

BELOW INFO TO BE COMPLETED & SIGNED BY HEALTH CARE PROVIDER as defined by the FMLA.

2. Does the patient's condition qualify as a serious health condition under FMLA? Yes No

If so, please check the applicable category [MUST CHECK ONE]:

- (1) Inpatient Hospital Care
- (2) Absence Plus Treatment
- (3) Pregnancy
- (4) Chronic Condition
- (5) Permanent/Long-term Condition Requiring Supervision
- (6) Multiple treatments (Non-Chronic Conditions)

3. **COMPLETE ALL THAT APPLIES (Must have specific start and estimated end dates):**

Full Time Leave from: _____ through: _____ AND/OR

Intermittent Leave OR Reduced Schedule from: _____ through: _____
(Not more than 1 year)

Return to Work Date

4. Please provide the **medical facts/diagnosis** which support your certification (Only One Condition per Certification): _____

5. a. State the approximate date the condition commenced (mm/dd/yy) _____

b. State the probable duration of the condition (mm/dd/yy) _____

c. Will it be necessary for the employee to work only on an **intermittent** or **reduced schedule** as a result of the condition (including for treatment as described in # 7 below)? Yes No

If YES, **give an estimate of the likely duration and frequency of episodes of incapacity we might expect due to this condition: REQUIRED**

d. Is the condition a **chronic condition** (#4) or **pregnancy** (#3)? Yes No

EMPLOYEE NAME: _____

6. a. Are additional **treatments** required for the condition? Yes No

If **YES**, provide an estimate of the probable number of such treatments: _____

If the patient will be absent from work or other daily activities because of **treatment** on an **intermittent** or **part-time** basis, also provide an estimate of the probable number of and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any:

Estimate or Number of Treatments Required: _____

Interval of Treatments Required: _____

Actual or Estimated Dates of Treatment: _____

Period of Time Requested for Recovery: _____

b. Will any of these treatments be provided by **another provider of health services** (e.g. physical therapist)? Yes No

If **YES**, please state the nature of the treatments:

c. **Is a regimen of continuing treatment** by the patient required under your supervision? Yes No

If **YES**, provide a general description of such regimen (e.g. **prescription drugs**, physical therapy requiring special equipment, etc.):

7. a. If medical leave is required for the **employee's absence from work** because of the **employee's own condition** (including absences due to pregnancy or a chronic condition) on a fulltime or intermittent basis, is the employee **able to perform** their current job assignment when at work (the employee should supply you with information about the essential job functions)?

Yes No

If **NO**, is the employee able to perform work of any kind? Yes No

b. If able to perform some work, what **essential functions of the employee's job** are they unable to perform?

ATTENTION: In signing this certification you are verifying that the above information is true to the best of your knowledge. Please be sure to include all medical facts completely and accurately that apply to the patient's condition. You may be contacted by a University of Toledo authorized Health Care Provider, Leave Administrator or other as allowed under the D.O.L. FMLA Regulations 29 C.F.R. § 825.307(a), to clarify and/or authenticate the certification.

Signature of Health Care Provider _____ Date _____

(****Stamps will not be accepted*)

Printed Name of Health Care Provider _____

Address: _____ Type of Practice _____

_____ Telephone Number _____

GIVE THIS ORIGINAL COMPLETED FORM TO THE EMPLOYEE. FAXES OR COPIES NOT ACCEPTED.

Certification of Health Care Provider (Family and Medical Leave Act of 1993)
U.S. Department of Labor Employment Standards Administration Wage and Hour Division

A “**Serious Health Condition**” means an illness, injury impairment, or physical or mental condition that involves one of the following:

1. Hospital Care **Inpatient care** (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity^{View footnote 2} or subsequent treatment in connection with or consequent to such inpatient care.
2. Absence Plus Treatment (a) A period of incapacity^{View footnote 2} of **more than three consecutive calendar days** (including any subsequent treatment or period of incapacity^{View footnote 2} relating to the same condition), that also involves: (1) **Treatment**^{View footnote 3} **two or more times** by a health care provider, by a nurse or physician’s assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or (2) **Treatment** by a health care provider on **at least one occasion** which results in a **regimen of continuing treatment**^{View footnote 4} under the supervision of the health care provider.
3. Pregnancy Any period of incapacity due to **pregnancy**, or for **prenatal care**.
4. Chronic Conditions Requiring Treatments

A **chronic condition** which:

- (1) Requires **periodic visits** for treatment by a health care provider, or by a nurse or physician’s assistant under direct supervision of a health care provider;
 - (2) Continues over an **extended period of time** (including recurring episodes of a single underlying condition); and
 - (3) May cause **episodic** rather than a continuing period of incapacity^{View footnote 2} (e.g., asthma, diabetes, epilepsy, etc.).
5. Permanent/Long-term Conditions Requiring Supervision

A period of **Incapacity**^{View footnote 2} which is **permanent or long-term** due to a condition for which treatment may not be effective. The employee or family member must be **under the continuing supervision of, but need not be receiving active treatment by, a health care provider**. Examples include Alzheimer’s, a severe stroke, or the terminal stages of a disease.

6. Multiple Treatments (Non-Chronic Conditions)

Any period of absence to receive **multiple treatments** (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider^{View footnote 2}, either for **restorative surgery** after an accident or other injury, **or for a condition that would likely result in a period of incapacity**^{View footnote 2} **of more than three consecutive calendar days in the absence of medical intervention or treatment**, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), and kidney disease (dialysis).

Note: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

^{Footnote 1} Here and elsewhere on this form, the information sought relates **only** to the condition for which the employee is taking FMLA leave.

^{Footnote 2} “Incapacity,” for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery there from.^{Footnote 3}

Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.^{Footnote 4}

A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

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 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.

Military Family Leave Entitlements

Eligible employees with a 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 leave to care for a covered servicemember during a single 12-month period. A covered servicemember 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 servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired 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 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.

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;
- 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. Regulations 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

