Family and Medical Leave: Required Paperwork for Family Member

Your anticipated absence for your family member's serious health issue may qualify for benefits under the Family and Medical Leave Act (FMLA) of 1993. This letter is to advise you of your rights and the steps necessary for you to take in order to begin the FMLA request process.

FMLA is a federal law that protects your job and benefits while you are on leave; it provides 480 hours/12 weeks of job and benefit protection; it does not guarantee pay and it does not provide additional leave hours. You are required to use your accrued leave before going into an unpaid status, if applicable, and these hours run concurrently with FML. The paperwork is required to determine if the circumstances qualify for FML and to accurately determine if the circumstances qualify for the use of sick leave, vacation leave and/or unpaid leave. Please be assured this paperwork is kept separately from your personnel file and all medical information is confidential.

To request leave under FMLA there are certain documents required. Attached are two forms: (1) the *UHV Family and Medical Leave Request* and (2) the *Certification of Health Care Provider for Family Member's Serious Health Condition.* Please complete the UHV Family and Medical Leave Request form and have the health care provider complete the Certification of Health Care Provider form. Both forms should be returned to the Office of Human Resources within 15 days or 30 days prior to the commencement of your leave. If you are unable to meet this deadline, please contact me.

After the documents have been reviewed, you will receive written notification regarding the outcome of your FMLA request. If you fail to return the forms as required, your absence may be ineligible for job and benefit protection under FMLA.

You are required to coordinate your absences and maintain regular communication with your immediate supervisor during the period of time you are on FML. Failure to maintain this communication could result in the cancellation of your remaining FMLA benefits.

Employee Rights & Responsibilities provides additional FMLA information and is attached for your review.

Best regards,

Devon Dueser
Payroll/Records Manager
DueserDV@uhv.edu
Phone: (361) 570-4803
Fax: (361) 580-5509

Lauree Tomas
Benefits/HRMS Manager
tomasl@uhv.edu
Phone: (361) 570-4802
Fax: (361) 580-5509

FMLA: Required Paperwork Instructions- Family Member

You will complete:

1. FMLA UHV Request Form

Give your doctor:

1. Certification of Health Care Provider for Employee Form
2. FMLA GINA Notice to Health Care Provider

Your doctor will complete:

1. Certification of Health Care Provider for Employee Form

You will return to me:

1. FMLA UHV Request Form
2. Certification of Health Care Provider for Employee Form

The two forms must be returned to the Office of Human Resources within 15 days from the date provided or 30 days prior to the commencement of your leave. If you are unable to meet this deadline, please contact us. Forms can be returned to us via fax or scan/email. If you prefer, the forms can be dropped of in hard copy in the HR Office or mail the forms. Below is the contact information:

Devon Dueser
Payroll/Records Manager
DueserDV@uhv.edu
Phone: (361) 570-4803
Fax: (361) 580-5509

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University of Houston-Victoria
Attn: Office of Human Resources
3007 N. Ben Wilson St.
UHV West Building – Room 117
Victoria, TX 77901

UHV University of Houston - Victoria

Family and Medical Leave/Parental Leave Request Form

To Be Completed by the Office of Human Resources

Parental Leave ☐ Yes ☐ No   Family and Medical Leave ☐ Yes ☐ No

To Be Completed By The Employee

Employee Information

Name______________________________EMPLID____________________

Home Address________________________City__________State_____Zip_____

Phone (Home) _______________ (Cell) _____________ (Work) ____________

Personal Email (if you will not check work email while out)____________________________

Department: _________Supervisor's Name: _________________Work Ext.: _________

Work Schedule____

Leave Request Summary

1) Is the qualifying condition due to the serious health condition of the employee? ☐ Yes ☐ No

2) Is the qualifying condition due to birth or placement of a child with you for adoption or foster care? ☐ Yes ☐ No

   Please indicate: ☐ Birth ☐ Adoption ☐ Foster Care   Anticipated birth or placement date: _________

3) Is the qualifying event due to Military Leave: ___Active Duty Leave___Military Caregiver Leave? ☐ Yes ☐ No

   Active Duty: Qualifying Exigency________________Relationship_____________

   Military Caregiver: Certification of health care provider: ☐ Yes ☐ No   Certification for next of kin: ☐ Yes ☐ No

4) Is the qualifying condition due to a serious health condition of child, parent, or spouse of employee? ☐ Yes ☐ No

   If leave requested is for the serious health condition of a dependent, please give the following information:

   Name__________________Relationship__________DOB(if child)_______

5) Is this a joint application with a spouse who is also a UHV employee? ☐ Yes ☐ No

UNIVERSITY OF HOUSTON - VICTORIA

Family and Medical Leave/Parental Leave Request Form

***To Be Completed By The Employee**

Dates of Leave

☐ Continuous full-time leave, beginning ____/____/____ and ending ____/____/____.

☐ Dates to be determined and as approved by supervisor.

☐ Intermittent leave:

1st period beginning ____/____/____ and ending ____/____/____.

2nd period beginning ____/____/____ and ending ____/____/____.

☐ Dates to be determined as needed and as approved by supervisor.

☐ Combination of continuous and intermittent leave needed.

☐ Reduced schedule leave, beginning ____/____/____ and ending ____/____/____.

FTE reduced to: ____________

Employee Agreement

I understand and agree to the following provisions as applicable:

- I have at least 12 calendar months of service with the State of Texas prior to the date of leave; and I have worked at least 1,250 hours for the State of Texas immediately preceding my leave. If less that amount, I am eligible for Parental Leave for the birth or placement of a child.
- I must exhaust all sick and vacation accrued leave while taking FML/Parental Leave. Once my paid leave is exhausted, I will be placed on leave without pay.
- After 12 weeks or the amount of approved leave, if I do not return to work or contact my supervisor or manager on or before the date intended, it will be considered that I abandoned my job.
- I will report periodically during the leave (at least once per week) to my supervisor on my leave status and intention to return to work.
- I will receive the state credit for health insurance during Family and Medical or Parental Leave and will be billed for any additional insurance premiums due. Should I fail to pay the additional premiums, my health insurance coverage will be changed to employee only level and optional coverage will be canceled. Continuation of group insurance is subject to the conditions and policies of ERS relating to coverage while on leave without pay.
- I must provide a release to return to work from my physician following my leave. Should I fail to do so, my department may deny restoration of my employment.

Employee Signature____Date______________

Certification of Health Care Provider for Family Member's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.

OMB Control Number: 1235-0003
Expires: 8/31/2021

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 to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. 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' family members, 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, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: ____

____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your family member or his/her 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 to care for a covered family member with a 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. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Your name: ____
First Middle Last

Name of family member for whom you will provide care:____________________________________
First Middle Last

Relationship of family member to you: ____

If family member is your son or daughter, date of birth:_______________________________________

Describe care you will provide to your family member and estimate leave needed to provide care:

____

____

____

____ ____ _______________________________
Employee Signature Date

CONTINUED ON NEXT PAGE

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. 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 "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the patient needs leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e). Page 3 provides space for additional information, should you need it. 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: ____

   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: ____

   Was medication, other than over-the-counter medication, prescribed? ___No ___Yes.

   Will the patient need to have treatment visits at least twice per year due to the condition? ___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. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

____

____

____

____

 CONTINUED ON NEXT PAGE

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ___No ___Yes.

   Estimate the beginning and ending dates for the period of incapacity: ___________________________________

   During this time, will the patient need care? __ No __ Yes.

   Explain the care needed by the patient and why such care is medically necessary:

   ____

   ____

   ____

   ____

   ____

5. Will the patient require follow-up treatments, including any time for recovery? ___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:

   ____

   Explain the care needed by the patient, and why such care is medically necessary: ________________________

   ____

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? __ No __ Yes.

   Estimate the hours the patient needs care on an intermittent basis, if any:

   ________ hour(s) per day; ________ days per week from _________________ through __________________

   Explain the care needed by the patient, and why such care is medically necessary:

   ____

   ____

   ____

   ____

 CONTINUED ON NEXT PAGE

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ____No ____Yes.

   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

   Does the patient need care during these flare-ups? ____ No ____ Yes.

   Explain the care needed by the patient, and why such care is medically necessary: ________________________

   ____

   ____

   ____

   ____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

____

____

____

____

____

____

______________________________________ ______________________________________

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.

Notice to Health Care Provider

Genetic Information Nondiscrimination Act of 2008 (GINA)

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.

University of Houston-Victoria
Attn: Office of Human Resources
3007 N. Ben Wilson St.
UHV West Building – Room 117
Victoria, TX 77901

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.

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 servicemember 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.

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; 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

U.S. Department of Labor | Wage and Hour Division

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