HUMAN RESOURCES
Illinois State University

Leave of Absence Fact Sheet

When applying for a leave, please follow the steps below. Any questions may be directed to your Benefits Counselor in Human Resources at 309-438-8311 or hrbenefits@ilstu.edu.

Step 1: Review the papers in this packet. Submit all pages of the application materials to Human Resources at 101 Nelson Smith Building, via email at hrbenefits@ilstu.edu, or via fax at 309-438-7421. We request your application for leave at least 30 days prior to your leave begin date. If 30-days' notice is not feasible, then notification must be as soon as possible.

Step 2: Provide Human Resources with the required supporting documentation within 15 calendar days of your leave begin date or application submission date, whichever is later. If you anticipate a delay in providing this documentation, please contact your Benefits Counselor to discuss the situation. Documentation can be submitted to Human Resources at 101 Nelson Smith Building, via fax at 309-438-7421, or via email at hrbenefits@ilstu.edu. It is your responsibility to ensure Human Resources has received the required documentation.

Step 3: Advise your Benefits Counselor throughout your leave of any changes to your anticipated leave start or return to work date(s).

Step 4: Returning to Work

If you have been on a leave for your own serious health condition, you must provide a physician's release to Human Resources as soon as you receive it.

> If your physician returns you to work with restrictions or on a part-time basis, the University may need up to five working days to determine if you will be able to perform your duties according to your job description. During this five-day period, you will remain on leave. You cannot return to work until the University agrees to accept the limitations.

If you are an individual with a disability and need a reasonable accommodation under the Americans with Disabilities Act (ADA) or other state or federal law, you may request an accommodation by contacting the Office of Equal Opportunity and Access at 309-438-3383. More information is available at: https://policy.illinoisstate.edu/conduct/1-3-1.shtml

If you have been on a leave to care for a family member, you do not need to provide a physician's release to Human Resources. You do need to communicate your return to work date to your Benefits Counselor as soon as it is known.

Communication

Communication regarding your leave request will be sent via e-mail to your ilstu.edu account. It is your responsibility to ensure your email account remains active while on leave. Contact the Technology Support Center at 309-438-4357 for assistance.

Employee Rights and Responsibilities

Please refer to the reverse side of this notice to review the Employee Rights and Responsibilities related to FMLA protected leaves. More information may also be found on the Human Resources website. For any questions, please contact your Benefits Counselor by calling 309-438-8311. If you feel your rights have been denied, please forward your appeal to the AVP of Human Resources.

For full policy information, please see the University Policy website at policy.illinoisstate.edu and the Human Resources site at hr.illinoisstate.edu/benefits.

Notice of Rights and Responsibilities for FMLA Protected Leaves

FMLA Leave Entitlement

You have a right under the FMLA to take unpaid, job-protected FMLA leave in a 12-month period for certain family and medical reasons, including up to **12 weeks** of unpaid leave in a 12-month period for the birth of a child or placement of a child for adoption or foster care, for a leave related to your own or a family member's serious health condition, or for certain qualifying exigencies related to the deployment of a military member to covered active duty. You also have a right under the FMLA to take up to **26 weeks** of unpaid, job-protected FMLA leave in a single 12-month period to care for a covered servicemember with a serious injury or illness (*Military Caregiver Leave*).

The 12-month period for FMLA leave is calculated as a "rolling" 12-month period measured backward from the date of any FMLA leave usage. (*Each time an employee takes FMLA leave, the remaining leave is the balance of the 12 weeks not used during the 12 months immediately before the FMLA leave is to start*).

All FMLA leave must be used for the designated leave purpose.

Substitution of Paid Leave

You have a right under the FMLA to request that your accrued paid leave be substituted for your FMLA leave. This means that you can request that your accrued paid leave run concurrently with some or all of your unpaid FMLA leave, provided you meet any applicable requirements of our leave policy. Concurrent leave use means the absence will count against both the designated paid leave and unpaid FMLA leave at the same time. If you do not meet the requirements for taking paid leave, you remain entitled to take available unpaid FMLA leave in the applicable 12-month period. Even if you do not request it, the FMLA allows us to require you to use your available sick, vacation, or other paid leave during your FMLA absence.

*University policy requires you to use all of your available paid leave during your FMLA leave. Any paid leave taken for this reason will also be designated as FMLA leave and counted against the amount of FMLA leave you have available to use in the applicable 12-month period.

Maintain Health Benefits

Your health benefits must be maintained during any period of FMLA leave under the same conditions as if you continued to work. During any paid portion of FMLA leave, your share of any premiums will be paid by the method normally used during any paid leave. During any unpaid portion of FMLA leave, you must continue to make any normal contributions to the cost of the health insurance premiums by paying the State of Illinois directly. Failure to submit payment to the State of Illinois for premiums may result in cancellation of coverage.

You may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave if you do not return to work following unpaid FMLA leave for a reason other than: the continuation, recurrence, or onset of your or your family member's serious health condition which would entitle you to FMLA leave; or the continuation, recurrence, or onset of a covered servicemember' s serious injury or illness which would entitle you to FMLA leave; or other circumstances beyond your control.

Other Employee Benefits

Upon your return from FMLA leave, your other employee benefits, such as pensions or life insurance, must be resumed in the same manner and at the same levels as provided when your FMLA leave began.

Return-to-Work Requirements

You must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA-protected leave. An equivalent position is one that is virtually identical to your former position in terms of pay, benefits, and working conditions. At the end of your FMLA leave, all benefits must also be resumed in the same manner and at the same level provided when the leave began. You do not have return-to-work rights under the FMLA if you need leave beyond the amount of FMLA leave you have available to use.

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FMLA APPLICATION

Name: ______________________________________ University ID: _________________________

Address: ____________________________________ Contact Ph.: __________________________

City, State, Zip: ____Work Ph.: __________________

Employee Type: ___ Administrative/Professional __ Civil Service __ Faculty Employment %: _________

Department: ____________________ Mail Code: ___________ Supervisor: _____________________

Beginning Date for Leave: ___________ Estimated Length of Leave: ___________________________

Last Day Worked: _________________ Normal Work Schedule (Days & Times): _________________

Type of Leave: Continuous Intermittent Reduced Schedule Workers' Comp

Please initial the statement below.

____ Should my request for FMLA be denied due to ineligibility, I understand that I must complete the Request for Non FMLA Approved Medical Leave application in order for Human Resources to review my situation for a Non FMLA approved medical leave.

Basic Leave:

Please indicate the reason you are requesting leave:

___ Your own serious health condition.

**** Refer to the Parental Leave application packet for the birth of a child or placement of a child with you for adoption or foster care.

___ Required to care for your __ spouse __ parent due to his/her serious health condition.

Name of spouse or parent: ______________________________

___ Required to care for your child.

Name of child: _______________________ Date of birth of child: ______________________

___ An absence consistent with the terms of the Victim Economic Security and Safety Act (VESSA).

(* Medical Certification is NOT required. Please see your Benefits Counselor for assistance).

Military Family Leave:

Please indicate the reason you are requesting leave:

___I have a qualifying exigency arising out of the fact that my ____ spouse ____ son or daughter ____ parent is on active duty or call to active duty status in support of a contingency operation to a foreign country as a member of the National Guard or Reserves **OR** is active duty or has been notified of an impending call to active duty as a member of the Regular Armed Forces and is deployed to a foreign country. Name of service member: ________________________

___ I am the ___ spouse ___ son or daughter ___ parent ___ next of kin of a covered service member with a serious injury or illness. Name of service member: ________________________

Please see reverse side (page 2)

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Rev. 10/21

Please sign your initials to certify that you have read and understand each section below.

___ In order to determine whether your absence qualifies as FMLA leave, requested documentation must be provided within 15 calendar days following the FMLA request date. If documentation is not received within the allowed time period, your leave could be denied.

___ I understand that I will be required to use my available payable benefits during my FMLA absence. This means that I will receive my paid leave and the leave will also be considered protected FMLA leave and counted against my FMLA leave entitlement.

___ I understand that while on leave I will be required to furnish Human Resources with periodic reports of my status and intent to return to work when requested.

___ I understand that when applying for a FMLA-protected leave, I am responsible for following my normal departmental call-in procedural requirements until notification of approval has been received. When an employee does not comply with the departmental call-in procedural requirements, FMLA-protected leave may be delayed or denied.

___ I understand that based on my leave status, I should not complete any University-related work during my leave of absence either on a voluntary basis or by request from my supervisor and/or department. University personnel, including my supervisor/chair, may correspond, communicate, and request information needed to complete work in my absence. If you have any concerns about any requests or communication, please contact your Benefits Counselor to discuss.

___ I understand that if I have been off work due to my own serious health condition and my physician returns me to work with no restrictions, I must submit a physician's release to Human Resources as soon as you receive it. I understand that I CANNOT return to work without a release from Human Resources.

___ I understand that if my physician returns me to work with restrictions or on a part-time basis, I must submit a physician's release to Human Resources as soon as I receive it. The University may need up to five working days to determine if you will be able to perform your duties according to your job description. During this five-day period, you will remain on leave. You CANNOT return to work with restrictions until the University agrees to accept the limitations and provides you with a release to return.

___ I understand that if I am returning to work from a continuous FMLA leave for caring for a family member, I must notify Human Resources of my impending return as soon as possible.

____ I understand that the University may need to call my doctor on my behalf for clarification of medical documentation.

___ Information and updates regarding my leave will be provided through your Illinois State University email account (xxxxxx@ilstu.edu). It is your responsibility to ensure that your email is active and remains active while on leave. If you require any assistance with your email notifications, please contact the Technology Support Center at 309-438-HELP (4357).

I certify that I have received and read the Leave Fact Sheet and Employee's Rights and Responsibilities. I have read and initialed each section above. I understand that I am required to provide appropriate documentation to substantiate my need for the above leave.

Applicant's Signature: ____ Date: ________________

REQUIREMENTS WHILE ON INTERMITTENT FMLA LEAVE

Please initial each of the following statements indicating that you have read, understand, and will comply with each of these requirements. If you have any questions about this form, it is your responsibility to contact your Benefits Counselor for clarification prior to signing and submitting this form. You may reach your Benefits Counselor at Human Resources by calling (309) 438-8311 (TDD/TTY 309-438-2269).

___Intermittent Leave starts with the date the application is completed or requested.

___Doctor's certification needs to be completed and returned within 15 days of the signed application or the leave could be denied.

___If additional information is needed from the doctor, it will be your responsibility to provide the information within the designated time period.

___If the Intermittent Leave is for scheduled absences, you must provide the dates and times of your scheduled absences to your department (and to Human Resources, if requested).

___Calling in consistent with your department call-in procedures is required. When calling in/reporting an unscheduled absence covered by your Intermittent FMLA Leave, you must clearly designate the absence as FMLA time to whomever you are required to report your absences.

___It is the responsibility of the employee to track and know their FMLA usage.

___Approved Intermittent FMLA Leave can only be used for the medical condition identified on the doctor's certification form.

___When the Intermittent FMLA medical condition prevents you from working more than 3 consecutive days, an application for Continuous FMLA Leave must be completed.

___Partial day absences will count toward the total Intermittent FMLA absence allowance.

___Intermittent Leave ***does*** expire. If the need for leave still exists after the expiration date, it is your responsibility to request an updated leave.

___FMLA time reported on your timesheet should be selected with the designation "FMLA" in the time reporting code drop down menu.

___Extended benefits (150 hours) are not payable while on an Intermittent Leave. Only sick, vacation, or comp time can be used for these absences.

___Employee is responsible for adhering to the frequency and duration of their intermittent leave approval. If frequency and/or duration needs to be changed during the approval period, please contact your Benefit Counselor.

Applicant signature:____ Date: _______________

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Illinois State University

FMLA Certification of Health Provider for Family Member

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.

For Completion by the EMPLOYEE

Your name: ____

Name of family member for whom you will provide care: ___________________________________

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

For Completion by 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. Please be sure to sign the form on the last page.

MEDICAL FACTS: Part A

Approximate date condition commenced: ____

Probable duration of condition: ____

1. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

   ____No ____Yes If yes, dates of admission: _____________________________________
2. Date(s) you treated the patient for condition
3. Will the patient need to have treatment visits at least twice per year due to the condition? _____No _____Yes
4. Was medication, other than over-the-counter medication, prescribed? _____No _____Yes
5. Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? _____No _____Yes If yes, state the nature of such treatments and expected duration of treatment: ____
6. Is the medical condition pregnancy? _____No _____Yes If yes, expected delivery date: ______________________
7. 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):____

____

-- See Reverse --

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AMOUNT OF CARE NEEDED: Part B *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.*

1. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? _____No _____Yes
   If yes, estimate the beginning and ending dates for the period of incapacity:
2. During this time, will the patient need care? _____No _____Yes
   Explain the care needed by the patient and why such care is medically necessary in Comments Section below.
3. 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: ____
4. Explain the care needed by the patient, and why such care is medically necessary in Comments Section below.
5. 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 from ____________________ through _________________________

   ________ days per week from ____________________ through _________________________

   Explain the care needed by the patient and why such care is medically necessary in Comments Section below.
6. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? _____No _____Yes
   If yes, does the patient need care during these flare-ups? _____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

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

____

____

Signature of Health Care Provider ______________________________ **Date**_________________________

Provider's name and business address: ____

____

Type of practice/medical specialty: ____

Telephone: (____) - _____________________________

Fax: (____) - __________________________________

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