



## 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](mailto: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](mailto: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](mailto: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](mailto: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](https://policy.illinoisstate.edu) and the Human Resources site at [hr.illinoisstate.edu/benefits](https://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.



# HUMAN RESOURCES

*Illinois State University*

## 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)*

**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: \_\_\_\_\_



# HUMAN RESOURCES

*Illinois State University*

## 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: \_\_\_\_\_

# Certification for Serious Injury or Illness of Covered Service Member for Military Family Leave

## SECTION I: For Completion by the EMPLOYEE and/or the COVERED SERVICE MEMBER for whom the Employee Is Requesting Leave.

This section must be completed first before Section II can be completed by a health care provider.

Name of Employee Requesting Leave to Care for Covered Service Member:

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Name of Covered Service Member (for whom employee is requesting leave to care):

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Relationship of Employee to Covered Service Member Requesting Leave to Care:

Spouse  Parent  Son  Daughter  Next of Kin

Is the Covered Service Member a Current Member of the Regular Armed Forces, the National Guard or Reserves?  Yes  No

If yes, please provide the covered service member's military branch, rank and unit currently assigned to:

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Is the covered service member assigned to a military medical treatment facility as an outpatient or to a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients (such as a medical hold or warrior transition unit)?  Yes  No

If yes, please provide the name of the medical treatment facility or unit: \_\_\_\_\_

Is the Covered Service Member on the Temporary Disability Retired List (TDRL)?  Yes  No

Describe the Care to Be Provided to the Covered Service Member and an Estimate of the Leave Needed to Provide the Care:

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**SECTION II: For Completion by a UNITED STATES DEPARTMENT OF DEFENSE (“DOD”) HEALTH CARE PROVIDER or a HEALTH CARE PROVIDER who is either: (1) a United States Department of Veterans Affairs (“VA”) health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider. INSTRUCTIONS to the HEALTH CARE PROVIDER:**

The employee listed on Section I has requested leave under the FMLA to care for a family member who is a member of the Regular Armed Forces, the National Guard, or the 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. For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty that may render the service member medically unfit to perform the duties of his or her office, grade, rank, or rating.

A complete and sufficient certification to support a request for FMLA leave due to a covered service member’s serious injury or illness includes written documentation confirming that the covered service member’s injury or illness was incurred in the line of duty on active duty and that the covered service member is undergoing treatment for such injury or illness by a health care provider listed above. 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 “indeterminate” may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave.

Health Care Provider’s Name and Business Address:

\_\_\_\_\_  
\_\_\_\_\_

Telephone: (    ) \_\_\_\_\_ Fax: (    ) \_\_\_\_\_ Email: \_\_\_\_\_

Type of Practice/Medical Specialty: \_\_\_\_\_

Please check the appropriate box as to whether you are either: \_\_\_ a DOD health care provider; \_\_\_ a VA health care provider; \_\_\_ a DOD TRICARE network authorized private health care provider; or \_\_\_ a DOD non-network TRICARE authorized private health care provider.

Covered Service Member’s medical condition is classified as (Check One of the Appropriate Boxes):

\_\_\_ **(VSI) Very Seriously Ill/Injured** – Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

\_\_\_ **(SI) Seriously Ill/Injured** – Illness/injury is of such severity that there is cause for immediate concern, but there is no imminent danger to life. Family members are requested at bedside. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

\_\_\_ **OTHER Ill/Injured** – a serious injury or illness that may render the service member medically unfit to perform the duties of the member’s office, grade, rank, or rating.

\_\_\_ **NONE OF THE ABOVE**

Was the condition for which the Covered Service member is being treated incurred in line of duty on active duty in the armed forces? \_\_\_ Yes \_\_\_ No

Approximate date condition commenced: \_\_\_\_\_

Probable duration of condition and/or need for care: \_\_\_\_\_

Is the covered service member undergoing medical treatment, recuperation, or therapy?  Yes  No

If yes, please describe medical treatment, recuperation or therapy:

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Will the covered service member need care for a single continuous period of time, including any time for treatment and recovery?  Yes  No

If yes, estimate the beginning and ending dates for this period of time: \_\_\_\_\_

Will the covered service member require periodic follow-up treatment appointments?  Yes  No

If yes, estimate the treatment schedule: \_\_\_\_\_

Is there a medical necessity for the covered service member to have periodic care for these follow-up treatment appointments?  Yes  No

If yes, please estimate the frequency and duration of the periodic care:

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**Signature of Health Care Provider:** \_\_\_\_\_ **Date:** \_\_\_\_\_