

# Family and Medical Leave Act (FMLA) FACT SHEET

**NOTE:** FMLA DOES NOT PRECLUDE AN EMPLOYEE'S USE OF ANY LEAVE, ACCRUED OR DONATED, PROVIDED ALL RELATIVE REQUIREMENTS ARE MET.

The FMLA law requires employers to grant job-protected absences to eligible employees for any of the following reasons:

- ❖ the birth of a child, and to care for the newborn child (**SICK LEAVE MAY BE USED ONLY FOR THE PERIOD OF ABSENCE THAT IS DOCUMENTED, BY THE TREATING HEALTH CARE PROVIDER, AS A MEDICAL NECESSITY**);
- ❖ the placement with the employee of a child for adoption or foster care;
- ❖ necessary care for the employee's spouse, child or parent with a serious health condition, or an adult child who cannot care for himself or herself;
- ❖ a serious health condition that makes an employee unable to perform the functions of the employee's job, and
- ❖ the FMLA also entitles an eligible employee who is the spouse, son, daughter, parent or next of kin of a covered service member to care for a member of the Armed Forces, who is undergoing medical treatment, recuperation or therapy.

**FMLA Period of Absence** - The FMLA law entitles eligible employees to an **absence of up to 12 workweeks of unpaid leave** in any 12 month period. Appropriate paid leave, earned or accrued by the employee, may be substituted for the unpaid leave.

## **Required FMLA Forms**

The University is **required to provide FMLA information and forms to employees who may be absent from duty three (3) days or more due to medical reasons.** Note required and attached forms:

- ❖ **Request for Family and Medical Leave Form (HR44).** This form must be completed by employee or designee of employee and returned for approval prior to beginning FMLA leave.
- ❖ **The FMLA Medical Certification Form (HR45).** This form must be completed by treating Health Care Provider and returned for approval with the HR 44 request form.
- ❖ **Return to Work Medical Certification Form (HR46).** This form must be completed and presented to the Office of Human Resources, ***immediately***, upon employee's return to duty.

**Health Benefits** - An absence under FMLA could be either paid or unpaid leave. Should the leave be unpaid, group health insurance **continues only as the employee continues to pay the employee's share of the premium. Should a contractual employee have health insurance, it continues only as the full premium is paid by the employee.** Contact the OHR to arrange payment of premiums.

**When To Apply** – **Apply as soon as possible.** If need for FMLA coverage is foreseeable based on pregnancy, adoption/foster care, or planned medical treatment for a serious illness of employee or family member, employees are asked to **provide 30 days advance notice** before the absence is to begin.

**How to Apply for the FMLA** - **Complete and submit the HR44 and HR45 (which follow this fact sheet for your convenience)** directly to MSU, Office of Human Resources, Rm. 100, CGW Bldg., as soon as you become aware of the need for a FMLA covered absence.  
Contact person: **Barbara Watkins, ext. 4410**

**MORGAN STATE UNIVERSITY**  
**Request for Family and Medical Leave**

<b>EMPLOYEE INFORMATION</b>	
<b>1. Name:</b>  <b>Social Security #:</b>	<b>2. Title:</b>  <b>Department:</b>
<b>3. Reason for requesting leave:</b> a. Birth of a child; b. Placement of a son or daughter for adoption/foster care; c. Care for child, spouse, parent or legal dependent with a serious health condition (please answer #4 and #5 below); d. Serious health condition which makes me unable to perform the functions of my position; or e. Armed Services member Family Leave (up to 26 weeks).	
<b>4. If 3c is checked, please indicate:</b> <b>Child</b> <b>Parent</b> <b>Spouse</b> <b>Legal Dependent</b>	
<b>5. Name and Address of Family Member:</b>  	
<b>6. Effective Date of Leave Request:</b>	<b>7. Date of anticipated return to work:</b>
<b>8. Are you requesting leave on an intermittent or reduced work schedule?</b> <b>Yes*</b> <b>No</b> *If yes, please provide a certification from a health care provider justifying the necessity for intermittent leave. The HR45 form may be used for this justification. On a separate sheet, give a schedule of when you anticipate you will be unavailable for work.	
<b>9. I wish to use            paid and/or            unpaid leave. (The Office of Human Resources may make the decision that paid    leave must be used if it has such a written policy.)</b>	
<b>Employees seeking leave because of Reason 3c or 3e <u>must</u> have a health care provider complete the Certification of Health Care Provider Form (HR45) and return to the Office of Human Resources within fifteen (15) days, or as soon as practicable. Leave may be delayed until a completed HR45 is provided. Employees seeking to return to work after a leave because of Reason 3d <u>also</u> must complete the Return to Work Medical Certification Form (HR46) before they will be allowed to resume work. Employees may not be permitted to resume any position until a completed Return to Work Medical Certification (HR46) is provided.</b>	
<b><u>EMPLOYEE AGREEMENT</u></b>	
<p>I hereby agree that while I am on leave, I will continue to pay my share of health insurance premiums, unless I elect to discontinue such coverage. I also agree that if I fail to return to work at the end of the leave period, I will reimburse my agency for the cost of health benefits provided during my leave, unless I fail to return to work because of the continuation, recurrence, or onset of a serious health condition or because of other circumstances beyond my control. If I am unable to return to work because of a serious health condition, I will provide medical certification from the appropriate health care provider stating that I am unable to perform the functions of my position on the date that my leave expired, or that I am needed to care for a covered relative because he/she has a serious health condition on the date that my leave expired. I understand that while on FMLA leave, I will contact the Office of Human Resources after I have been on leave thirty calendar days and at the end of each 30-day period afterwards.</p>	
<b>Signed:</b>	<b>Date:</b>



**MORGAN STATE UNIVERSITY**  
**Family and Medical Leave**  
**Certification of Health Care Provider**

<b>1. Employee's Name:</b>
<b>2. Patient's Name</b> <i>(if different from Employee):</i>
<p><b>3. The HR45</b> (last page of this form) describes what is meant by a serious health condition under the Family and Medical Leave Act. Does the patient's condition<sup>1</sup> qualify under any of the categories described? If so, please check the applicable category.</p> <p>1. <input type="checkbox"/>    2. <input type="checkbox"/>    3. <input type="checkbox"/>    4. <input type="checkbox"/>    5. <input type="checkbox"/>    6. <input type="checkbox"/>    or None of the above</p>
<p><b>4. Describe the medical facts</b> which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories:</p>    
<p><b>5a. State the approximate date</b> the condition commenced, and the probable duration of the condition <i>(and also the probable duration of the patient's present incapacity<sup>2</sup> if different):</i></p>   
<p><b>5b. Will it be necessary for the employee to work</b> only intermittently or to work on a less than full schedule as a result of the condition <i>(including for treatment described in Item #6 below)?</i>                      Yes    No</p> <p>If yes, give the probable duration: _____</p>
<p><b>5c. If the condition is a chronic condition (condition #4) or pregnancy</b>, state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity:</p>    

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<sup>1</sup> Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking FMLA leave.

<sup>2</sup> "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 there for, or recovery there from.

**6a. If additional treatments will be required for the condition,** provide an estimate of the probable number of such treatments:

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

**6b. If any of these treatments will be provided by another provider of health services** (e.g., *physical therapist*), please state the nature of the treatments:

**6c. If a regimen of continuing treatment by the patient is required under your supervision,** provide a general description of such regimen (e.g., *prescription drugs, physical therapy requiring special equipment*):

**7a. 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*), is the employee unable to perform work of any kind?

**7b. If able to perform some work,** is the employee unable to perform any one or more of the essential functions of the employee's job (*the employee or the employer should supply you with information about the essential job functions*)?

**If yes,** please list the essential functions the employee is unable to perform:

**7c. If neither “a” or “b” applies,** is it necessary for the employee to be absent from work for treatment?

**8a. If leave is required to care for a family member** of the employee with a serious health condition, does the patient require assistance for basic medical or personal needs or safety, or for transportation?

**8b. If no, would the employee’s presence to provide psychological comfort** be beneficial to the patient or assist in the patient’s recovery?

**8c. If the patient will need care only intermittently or on a part-time basis,** please indicate the probable duration of this need and the schedule of such care:

*Signature of Health Care Provider*

*Date*

*Printed Name of Health Care Provider*

*Type of Practice*

*Address*

*Telephone Number*

The following to be completed by the Employee needing Family Leave to care for a Family Member:

State the care you will provide and an estimate of the period during which care will be provided, including a schedule, if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule:

_____ Employee Signature	_____ Date

**Family and Medical Leave  
Definition of a Serious Health Condition**

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 or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

- a. A period of incapacity of more than three consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:
  - i. Treatment<sup>3</sup> 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

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<sup>3</sup>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.

- ii. Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment<sup>4</sup> under the supervision of a health care provider.

### 3. Pregnancy

Any period of incapacity due to pregnancy, or prenatal care.

### 4. Chronic Conditions Requiring Treatments

A chronic condition which:

- a. 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;
- b. continues over an extended period of time (including recurring episodes of a single underlying condition); and
- c. may cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

### 5. Permanent/Long-Term Conditions Requiring Supervision

A period of incapacity 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, 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 there from) by a health care provider or by a provider of health care services under orders of, or on referral by a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity 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), kidney disease (dialysis).

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<sup>4</sup>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.

**MORGAN STATE UNIVERSITY**  
**Family and Medical Leave**  
**Return to Work Medical Certification Form**

*(Type or Print)*

<b>PART I EMPLOYEE INFORMATION</b>	
<b>1</b> Name:  Social Security Number:	<b>3</b> Date Leave Commenced:
<b>2</b> Title:  Department:	<b>4</b> Date of Return to Work:
<b>5</b> Employee's Signature: _____ Date: _____	
<b>PART II TO BE COMPLETED BY EMPLOYEE'S HEALTH CARE PROVIDER</b>	
<b>6</b> I certify that on _____ (date), I examined the above-named employee and on the basis of my examination, this employee is ready to return to work and is able to perform the functions of his/her position.  Signed: _____ Date: _____	
<b>7</b> Health Care Provider's Name, Address and Telephone Number:	
<b>PART III TO BE COMPLETED BY EMPLOYER</b>	
Employer Remarks:	

**This form should be delivered or mailed to:**

Morgan State University  
Office of Human Resources  
Suite 100, Carter-Grant-Wilson Bldg.  
1700 E. Cold Spring Lane  
Baltimore MD 21251

HR46 (07/08)