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. Leave entitlement under this eligibility is for up to 26 workweeks.

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 Office of Human Resources 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 the Office of Human Resources as soon as you become aware of the need for a FMLA covered absence.

Contact person: Monica Waters, monica.waters@morgan.edu, 443-885-2000

MORGAN STATE UNIVERSITY

Request for Family and Medical Leave

EMPLOYEE INFORMATION	
1. Name: **Social Security #:**	**2. Title:** **Department:**

3. Reason for requesting leave:

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).

4. If 3c is checked, please indicate: ☐ **Child** ☐ **Parent** ☐ **Spouse** ☐ **Legal Dependent**

5. Name and Address of Family Member:

6. Effective Date of Leave Request:	**7. Date of anticipated return to work:**

8. Are you requesting leave on an intermittent or reduced work schedule?

☐ **Yes*** ☐ **No**

*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.

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.)**

Employees seeking leave because of Reason 3c or 3e must 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 **also** 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.

EMPLOYEE AGREEMENT

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 if I am in need of additional leave once my FMLA coverage expires, I will be required to submit additional medical documentation to the Office of Human Resources at the end of each 30-day period after my FMLA coverage has expired.

Signed: **Date:**

MORGAN STATE UNIVERSITY

Request for Family and Medical Leave (Continuation)

TO BE COMPLETED BY THE APPOINTING AUTHORITY
Employees on leave must contact the Office of Human Resources after having been on leave for thirty calendar days and at the end of each thirty-day period afterwards regarding their status and intention to return to work. This portion of the form is to be used by the Office of Human Resources to keep track of the periodic reports by the employee.

SCHEDULE OF EMPLOYEE'S PERIODIC REPORTS DURING LEAVE

Date of Periodic Report	Status of Health Condition	Date of Anticipated Return to Work	Periodic Report Conducted By

REMARKS:

MORGAN STATE UNIVERSITY

Family and Medical Leave
Return to Work Medical Certification Form

(Type or Print)

PART I EMPLOYEE INFORMATION

❶ Name: Social Security Number:	❸ Date Leave Commenced:
❷ Title: Department:	❹ Date of Return to Work:

❺ Employee's Signature: _____ Date: _____

PART II TO BE COMPLETED BY EMPLOYEE'S HEALTH CARE PROVIDER

❻ 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: _____

❼ Health Care Provider's Name, Address and Telephone Number:

PART III TO BE COMPLETED BY EMPLOYER

Employer Remarks:

This form should be delivered or mailed to:

Morgan State University
Office of Human Resources
Calvin & Tina Tyler Hall
1700 E. Cold Spring Lane
Baltimore MD 21251

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

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.

Employer Name and Contact:

MORGAN STATE UNIVERSITY – OFFICE OF HUMAN RESOURCES – (443) 885-3195

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**

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. Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

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.

Provider's Name and Business Address:

_____

Type of Practice/Medical Specialty:

_____

Telephone: (_____) _____
Fax: (_____) _____

PART A: MEDICAL FACTS

1. Condition and 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 relevant medical facts, 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):

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:

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

DO NOT SEND COMPLETED FORM TO THE EMPLOYER; RETURN TO THE PATIENT.