Employee Responsibilities Sheet for University Medical and FMLA Leave

(A) APPLICATION

1. Find the appropriate Leave of Absence Form on the www.gvsu.edu/hro website.
2. Actual medical facts must be stated or described on the form to support the need for leave.
3. Vague and ambiguous information and/or unanswered questions could render the form incomplete and insufficient and could result in the form being returned to the staff member.
4. The form should be submitted to Human Resources as far in advance of the leave as possible.
5. Employee is responsible for ensuring the treating physician completes the form in its entirety.
6. An employee requesting medical leave is automatically reviewed for FMLA coverage. Where applicable, medical and FMLA leave will be processed concurrently.

(B) COMMUNICATION WITH HUMAN RESOURCES

1. Contact your HR Business Partner (see chart: www.gvsu.edu/hro/hrbp); call (616) 331-2215; or fax (616) 331-3216.
2. It is the employee's responsibility to follow all directions or requests from Human Resources.
3. It is the employee's responsibility to speak directly with their Human Resources Business Partner via phone, e-mail, or in person. Voicemail is acceptable to request a return call.

(C) COMMUNICATION WITH SUPERVISOR

1. It is the employee's responsibility to update their supervisor regarding changes in return dates, work restrictions, or returns that result in less than a full-time work schedule, if applicable.

Failure to follow these instructions could result in denial or interruption of leave

Grand Valley State University
Human Resources

Revised February 2022

Application/Certification of Health Care Provider for Employee's Serious Health Condition

(Family and Medical Leave Act and University Medical Leave)

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. The employer must give the employee at least 15 calendar days to provide the certification. If the employee fails to provide complete and sufficient medical certification, his or her FMLA leave request may be denied.

SECTION I: For Completion By the EMPLOYER

Instructions to the EMPLOYER: Either the employee or the employer may complete Section I. While use of this form is optional, this form asks the health care provider for the information necessary for a complete and sufficient medical certification. You may not ask the employee to provide more information than allowed under the FMLA regulations. Additionally, you may not request a certification for FMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care. Employers must generally maintain records and documents relating to medical information, medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance if the Americans with Disabilities Act applies, and in accordance if the Genetic Information Nondiscrimination Act applies.

Date (certification required): _____

Date certification must be returned by: _____

Employer name and contact: _____

Employee's job title: _____

Regular work schedule: _____

Employee's essential job functions:

☐ Check if job description is attached

SECTION II: For Completion By the EMPLOYEE

Instructions to the EMPLOYEE: Please complete Section II before giving this form to your 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 and/or University Medical Leave due to your own serious health condition. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA and/or University Medical Leave request.

It is mandatory to complete each question in order to process the leave accurately.

Employee's Name	
Employee's G#	
Employee's Mailing Address	
Employee's Phone Number	
Actual/Estimated Last Day of Work	

I understand and acknowledge the following:

1. I am responsible for ensuring that UltraTime is completed with salary continuation/sick leave, or that my supervisor completes UltraTime in my absence (Payroll will ONLY input short term disability and the supplement if requested). I must inform Payroll if I or my supervisor needs Payroll to complete UltraTime in my absence.

2. If I do not have enough salary continuation/sick leave available for the first twenty days of short term disability (always check your salary continuation/sick time balance); the Payroll Department will automatically use lost time for the hours not covered by salary continuation/ sick leave. However:

   ☐ I have available vacation and want to use it for the hours not covered by salary continuation/ sick leave. (Check if applicable)

   For MGS staff: If I do not have enough sick leave available for the first twenty days of short term disability (always check your sick time balance), I will be able to use the Short Term Disability Benefit Hours Pool (if available), or my accrued vacation balance will be used for the hours not covered by sick leave. My supervisor will input any necessary vacation time in UltraTime in my absence.

3. Beginning on the 21st work day, short term disability is paid at 75% of base weekly rate and I would like to:

   ☐ Supplement vacation with the maximum of 2 hours per day until vacation has been exhausted or the leave expires, whichever comes first. Payroll will log vacation supplement if requested. (Also check this box for workers' compensation leave if you would like to supplement with salary continuation/sick leave or vacation)

4. If the circumstances of my leave change, I must inform my supervisor and my Human Resources Business Partner.

5. If I have requested additional vacation time, my supervisor or I am responsible for logging vacation hours.

Signature: _____ Date: _____

Authorization to Release Information: I hereby authorize my Physician(s) to release any information acquired in the course of my examination or treatment, but limited to the condition described on this form.

SECTION III: For Completion By the HEALTH CARE PROVIDER

Instructions to the EMPLOYEE: Please provide your contact information, complete all relevant parts of this Section, and sign the form. Your patient has requested leave under the FMLA and/or University Medical Leave. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of the employee. For FMLA purposes, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves inpatient care or continuing treatment by a health care provider. For more information about the definitions of a serious health condition under the FMLA, see the chart on pages 5-6.

You may, but are not required to, provide other appropriate medical facts including symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment. Please note that some state or local laws may not allow disclosure of private medical information about the patient's serious health condition, such as providing the diagnosis and/or course of treatment.

Employee's name: _____

Provider's name: _____

Provider's business address: _____

Type of practice/medical specialty: _____

Phone: (____) _____ Fax: (____) _____ Email: _____

(Part A) Medical Information: Limit your response to the medical condition(s) for which the employee is seeking FMLA leave. Your answers should be your best estimate based upon your medical knowledge, experience, and examination of the patient. **After completing Part A, complete Part B to provide information about the amount of leave needed.** Note: For FMLA purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. Do not provide information about genetic tests, genetic services, or the manifestation of disease or disorder in the employee's family members.

1. State the approximate date the condition started or will start: _____

2. Provide your best estimate of how long the condition lasted or will last: _____

Employee's name: _____

3. Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

   ☐ **Inpatient care:** The patient (☐ has been / ☐ is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s):

   _____

   ☐ **Incapacity + treatment** *(e.g. outpatient surgery, strep throat)*: Due to the condition, the patient (☐ has been / ☐ is expected to be) incapacitated for more than three consecutive, full calendar days from _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy).

   The patient (☐ was / ☐ will be) seen on the following date(s): _____

   The condition (☐ has / ☐ has not) also resulted in a course of continuing treatment under the supervision of a health care provider *(e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment)*.

   ☐ **Pregnancy:** The condition is pregnancy. List the expected delivery date: _____ (mm/dd/yyyy).

   ☐ **Chronic conditions** *(e.g. asthma, migraine headaches)*: Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

   ☐ **Permanent or long term conditions** *(e.g. Alzheimer's, terminal stages of cancer)*: Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

   ☐ **Conditions requiring multiple treatments** *(e.g. chemotherapy treatments, restorative surgery)*: Due to the condition, it is medically necessary for the patient to receive multiple treatments.

   ☐ **None of the above:** If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed. Go to page 4 to sign and date the form.

4. If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave *(e.g. use of nebulizer, dialysis).*

(Part B) Amount of Leave Needed: For the medical condition(s) checked in Part A, complete all that apply. 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.

5. Due to the condition, the patient (☐ had / ☐ will have) planned medical treatment(s) (scheduled medical visits *(e.g. psychotherapy, prenatal appointments))* on the following date(s): _____

Employee's name: _____

6. Due to the condition, the patient (☐ was / ☐ will be) referred to other health care provider(s) for evaluation or treatment(s).

   State the nature of such treatments *(e.g. cardiologist, physical therapy)*:

   _____

   Provide your best estimate of the beginning date _____ (mm/dd/yyyy) and end date _____ (mm/dd/yyyy) for the treatment(s).

   Provide your best estimate of the duration of the treatment(s), including any period(s) of recovery *(e.g. 3 days/week)*: _____

7. Due to the condition, it is medically necessary for the employee to work a reduced schedule.

   Provide your best estimate of the reduced schedule the employee is able to work. From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy) the employee is able to work *(e.g. 5 hours/day, up to 25 hours a week)*:

   _____

8. Due to the condition, the patient (☐ was / ☐ will be) incapacitated for a continuous period of time, including any time for treatment(s) and/or recovery.

   Provide your best estimate of the beginning date _____ (mm/dd/yyyy) and end date _____ (mm/dd/yyyy) for the period of incapacity.

9. Due to the condition, it (☐ was / ☐ is / ☐ will be) medically necessary for the employee to be absent from work on an intermittent basis (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your best estimate of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

   Over the next 6 months, episodes of incapacity are estimated to occur _____ times per (☐ day / ☐ week / ☐ month) and are likely to last approximately _____ (☐ hours / ☐ days) per episode.

(Part C) Essential Job Functions: If provided, the information in Section I Essential Job Functions may be used to answer this question. If the employer fails to provide a statement of the employee's essential functions or a job description, answer these questions based upon the employee's own description of the essential job functions. An employee who must be absent from work to receive medical treatment(s), such as scheduled medical visits, for a serious health condition is considered to be not able to perform the essential job functions of the position during the absence for treatment(s).

10. Due to the condition, the employee (☐ was not able / ☐ is not able / ☐ will not be able) to perform one or more of the essential job function(s). Identify at least one essential job function the employee is not able to perform:

    _____

_____ _____

Signature of Health Care Provider Date (mm/dd/yyyy)

Definitions of a Serious Health Condition
Inpatient Care
• An overnight stay in a hospital, hospice, or residential medical care facility. • Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.
Continuing Treatment by a Health Care Provider (any one or more of the following)
Incapacity Plus (+) Treatment: A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either: • Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or, • At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.
Pregnancy: Any period of incapacity due to pregnancy or for prenatal care.
Chronic Conditions: Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.
Permanent or Long-term Conditions: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.
Conditions Requiring Multiple Treatments: Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.

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 15 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 Avenue, N.W., Washington, D.C. 20210.

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