



Family Medical Leave Act- Request for Leave of Absence

Section I: To be completed by employee

Name: _____ Home telephone # _____ Banner ID: _____
Address: _____ City: _____ State: _____ Zip: _____
School/ College/ Division: _____ Date: _____
WSU Email Address: _____ Campus Phone # _____

I HEREBY REQUEST A LEAVE OF ABSENCE UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA) FOR ONE OF THE FOLLOWING REASONS:

- Birth of a child: Estimated date of delivery _____
Placement for Adoption or Foster Care: Date of Placement _____
Family Member's "Serious Health Condition": Specify Relationship _____
My own "Serious Health Condition"

TYPE OF FMLA REQUESTED:

- Consecutive Days (up to 12 weeks) From: _____ Through: _____
Intermittent Leave (Expected Days/Weeks/Months on Leave) From: _____ Through: _____
Reduced Leave Schedule: Specify changes in schedule _____

***IF YOU ARE CURRENTLY OFF WORK YOU MUST INDICATE YOUR LAST PHYSICAL DAY AT WORK (LDW) _____

Section II: TO BE COMPLETED BY IMMEDIATE SUPERVISOR** AND/OR EMPLOYMENT SERVICES

This is to inform you that:

- You are Not Eligible for leave under the FMLA for the reason(s) listed below:
You are eligible for leave under the FMLA. The requested leave will will not be counted against your annual FMLA entitlement
Medical certification is required. Certification must be received by _____ (must be at least 15 calendar days after you are notified of this requirement) or we may delay the commencement of your leave until the certification is submitted.
Supporting documentation is required to verify adoption or foster care placement of a child.
You will be required to submit the Physician's Report on Illness form prior to your return to work.



SECTION III: TO BE COMPLETED BY IMMEDIATE SUPERVISOR AND/OR EMPLOYMENT SERVICES

You are required to substitute accrued paid time for unpaid FMLA leave: Accordingly, the following bank(s) will be charged for this leave:

- Illness/ Disability Bank
- Vacation Bank
- Any Purpose Days, Special Needs Days, etc.
- Other: _____

This is to advise you that you have a right under the FMLA for up to 12 weeks of unpaid leave in a 12-month period for the reasons listed on page 1 of this document.

You health benefits may be maintained during any period of unpaid leave under the same conditions as if you continued to work, and you will be reinstated t the same or equivalent job with the same pay, benefits, and terms and conditions of employment on your return from leave. If you normally pay portion of the health premiums, these payments must continue during the period of FMLA leave. Arrangements for payment should be discussed with Total Compensation & Wellness (577-3717). You have a minimum 30-day grace period in which to make premium payments. If timely payment is not made, your group health plan benefits may be canceled, provided WSU notifies you in writing at least 15 days before the date your health coverage will lapse.

If you do not return to work following FMLA leave for a reason other than: (1) the continuation, reoccurrence, or onset of a serious health condition which would entitle you to FMLA leave; (2) other circumstances beyond your control, you may be required to reimburse the university for its share of health insurance premiums paid on your behalf during your FMLA leave.

I have read all of the above. I understand all the terms and conditions of this leave.

Employee Signature/ Date

Department Approval/ Date

Employment Services/ Date



FOR CERTIFICATION RELATING TO CARE FOR THE EMPLOYEE'S SERIOUS-ILL FAMILY MEMBER

TO BE COMPLETED BY EMPLOYEE:

Employee Name/ Banner ID

Department/ Phone

Patient's Name/ Relationship

1. Please provide a description of the care you will provide for your family member:

Provide and an estimate of the time period during which this care will be provided, including a schedule if leave is to be taken intermittently or on a reduced leave schedule.

Beginning Date: _____

Ending Date: _____

Employee Signature: _____

Date: _____

TO BE COMPLETED BY FAMILY MEMBER'S PHYSICIAN

2. Is inpatient hospitalization of the family member (patient) required? ___ Yes ___ No

3. Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation?
___ Yes ___ No

4. After review of the employee's signed statement (see item 1 above), is the employee's presence necessary or would it be beneficial for the care of the patient? (This may include psychological comfort.) ___ Yes ___ No

5. Estimate the period of time care is needed or the employee's presence would be beneficial.

(Signature of Health Care Provider)

(Print Name)

(Specialty or Sub-Specialty)

(Address, City, State)

(Telephone Number)

(Date)



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 involves:

- i. Treatment two or more times by a health care provider, by a nurse or physician assistant under direct supervision of a health care provider, or by a provider of health care services (e.g. physical therapy), under orders of, or on referral by a health care provider; or
- ii. Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider.

3. **Pregnancy**: Any period of incapacity due to pregnancy, or for prenatal care.

4. **Chronic Condition Requiring Treatment**: 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 periods 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’s, 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 capacity of more than three consecutive days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), and kidney disease (dialysis).

- a) Here and elsewhere on this form, the information sought relates only to the condition for which the employee is requesting FMLA leave.
- b) “Incapacity,” for purpose of FMLA, is defined to mean inability to work, attend school perform other regular daily activities due to the serious health condition, treatment, or recovery there from.

- c) Treatment includes examination 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.
- d) 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.