

MILITARY FAMILY LEAVE ENTITLEMENT

Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the service member medically unfit to perform his or her duties for which the service member is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

QUALIFYING EXIGENCY LEAVE

Definitions: "Son or daughter on active duty status or called to active duty status" means the employee's biological, adopted or foster child, legal ward or child for whom the employee stood in loco parentis regardless of age.

Leave Because of a Qualifying Exigency: This leave is for the employees who have a spouse, parent, son or daughter who is a "covered military member." To be a covered military member, she must be on active duty or (federal) call to active duty in support of a contingency operation when they are members of the National Guard or the Reserves or are a retired member of the regular armed services or Reserves. A covered military member does not include a member of the regular armed forces. The following are the kinds of things for which this leave is available:

- ❖ short-notice deployment - limited to seven calendar days beginning with the date of the call/order to active duty;
- ❖ military events and related to call to active duty;
- ❖ childcare and school activities;
- ❖ financial and legal arrangements;
- ❖ counseling; rest and recuperation - the employees can have five days off (note that California law provides 10 days' unpaid leave for spouses of military members (see California Military and Veterans Code, section 345.10; there are lesser notice and certification requirements for the California leave);

- ❖ post deployment activities (includes matters arising from the death of the military member while on active duty status);
- ❖ other matters which the employer and employee agree qualify as exigency and they agree on the time off;
- ❖ the employer's standard leave year applies.

Employee Notice Obligations for Foreseeable Leave: Notice for foreseeable leave for a qualifying exigency must be given as soon as practicable regardless of how far in advance such leave is foreseeable.

Certification of a Leave Taken for Qualifying Exigency: See special forms for this leave. The employer may ask for copies of military member's duty orders, facts regarding exigency, dates of service and date of commencement of exigency. The orders need only be provided once. There are also rules regarding certification for use of intermittent/reduced-schedule leave and meetings with third parties.

Failure to Provide Certification: Recertification does not apply to leave taken for a qualifying exigency.

LEAVE OF ABSENCE REQUEST

SECTION I – TO BE COMPLETED BY THE EMPLOYEE

EMPLOYEE'S NAME	TELEPHONE ()	CAMPUS
DEPARTMENT	TITLE	EMPLOYEE ID

<input type="checkbox"/> Initial Application <input type="checkbox"/> Amendment to LOA that began on _____	<p style="text-align: center;">Reason for Leave of Absence:</p> <table style="width:100%;"> <tr> <td><input type="checkbox"/> Own Injury/Illness (not work-related)</td> <td><input type="checkbox"/> Union Business</td> <td><input type="checkbox"/> Administrative</td> </tr> <tr> <td><input type="checkbox"/> Care for Injured/III Family Member</td> <td><input type="checkbox"/> Work-Incurred Injury/Illness</td> <td><input type="checkbox"/> Military</td> </tr> <tr> <td><input type="checkbox"/> Pregnancy/Disability</td> <td><input type="checkbox"/> Professional Development</td> <td><input type="checkbox"/> Other (specify):</td> </tr> <tr> <td><input type="checkbox"/> Care for Newborn/Placed Child</td> <td><input type="checkbox"/> Military Caregiver Leave</td> <td></td> </tr> <tr> <td>Date of Birth/Placement _____</td> <td><input type="checkbox"/> Qualifying Exigency Leave</td> <td></td> </tr> </table>	<input type="checkbox"/> Own Injury/Illness (not work-related)	<input type="checkbox"/> Union Business	<input type="checkbox"/> Administrative	<input type="checkbox"/> Care for Injured/III Family Member	<input type="checkbox"/> Work-Incurred Injury/Illness	<input type="checkbox"/> Military	<input type="checkbox"/> Pregnancy/Disability	<input type="checkbox"/> Professional Development	<input type="checkbox"/> Other (specify):	<input type="checkbox"/> Care for Newborn/Placed Child	<input type="checkbox"/> Military Caregiver Leave		Date of Birth/Placement _____	<input type="checkbox"/> Qualifying Exigency Leave	
<input type="checkbox"/> Own Injury/Illness (not work-related)	<input type="checkbox"/> Union Business	<input type="checkbox"/> Administrative														
<input type="checkbox"/> Care for Injured/III Family Member	<input type="checkbox"/> Work-Incurred Injury/Illness	<input type="checkbox"/> Military														
<input type="checkbox"/> Pregnancy/Disability	<input type="checkbox"/> Professional Development	<input type="checkbox"/> Other (specify):														
<input type="checkbox"/> Care for Newborn/Placed Child	<input type="checkbox"/> Military Caregiver Leave															
Date of Birth/Placement _____	<input type="checkbox"/> Qualifying Exigency Leave															
Requested start date _____/_____/_____	Requested intermittent or reduced work schedules															
Anticipated return date: _____/_____/_____																

Do you have UC medical insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have UC dental insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have UC optical insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No
---	--	---

Have you or will you be filing a University Disability Insurance claim? Yes No

A leave of absence is normally leave without pay. Paid leave (accrued sick, vacation, or CTO) may be substituted for all or a portion of the unpaid leave in accordance with appropriate policies/contracts.

I wish to use paid leave as indicated below: (attach additional sheets if necessary)

_____ Hours/Days of accrued sick	Begins on _____ and ends on _____
_____ Hours/Days of accrued vacation	Begins on _____ and ends on _____
_____ Hours/Days of accrued compensatory time	Begins on _____ and ends on _____
_____ Hours/Days of leave without pay	Begins on _____ and ends on _____

EMPLOYEE'S SIGNATURE:	DATE:	TELEPHONE: ()
-----------------------	-------	-------------------------

SECTION II – TO BE COMPLETED BY THE UNIVERSITY

APPROVAL/DENIAL OF LEAVE REQUEST

<input type="checkbox"/> Your request for leave is approved and ____ weeks ____ days ____ hours qualify as FM leave under FMLA ____ weeks ____ days ____ hours qualify as FML leave under CFRA ____ weeks ____ days ____ hours qualify as PDL leave under PDLL ____ weeks ____ days ____ hours qualify as (Specify) _____	Begins on _____ and ends on _____ Begins on _____ and ends on _____ Begins on _____ and ends on _____ Begins on _____ and ends on _____
---	--

Family and Medical Leave

Your request for FML is not approved for the reasons set forth on the Designation Notice.

Other Leaves

Your requested leave is not approved for the following reason(s): _____

PAY STATUS DURING LEAVE

Sick Leave _____ hours to be applied	Begins on _____ and ends on _____
Extended Sick Leave _____ hours to be applied	Begins on _____ and ends on _____
Vacation _____ hours to be applied	Begins on _____ and ends on _____
CTO _____ hours to be applied	Begins on _____ and ends on _____
Leave without pay _____ hours to be applied	Begins on _____ and ends on _____

(Attach additional sheets if necessary)

SUPERVISOR OR DEPARTMENT HEAD'S SIGNATURE

NAME (PRINT)	
SIGNATURE	DATE

**CERTIFICATION FOR QUALIFYING EXIGENCY LEAVE
LEAVE ARISING OUT OF THE ACTIVE DUTY OR CALL TO ACTIVE DUTY
OF A COVERED MILITARY MEMBER
Family and Medical Leave Act (FMLA)**

SECTION I: For Completion by THE UNIVERSITY

CAMPUS/LABORATORY		DEPARTMENT OR OTHER WORK UNIT	
NAME OF UNIVERSITY REPRESENTATIVE		UNIVERSITY REPRESENTATIVE MAILING ADDRESS	
TELEPHONE () () ()	FAX () () ()	E-MAIL	

SECTION II – To be completed by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II fully and completely. The FMLA permits the University to require that you submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a qualifying exigency arising out of the active duty or call to active duty of a Covered Military Member. Several questions in this section seek a response as to the frequency or duration of the qualifying exigency. Be as specific as you can; terms such as "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Your response is required to obtain a benefit. 29 C.F.R. § 825.310. While you are not required to provide this information, failure to do so may result in a denial of your request for FMLA leave. The University will give you at least 15 calendar days to return this form.

1. Your Name

FIRST	MIDDLE	LAST
-------	--------	------

2. Name of Covered Military Member on active duty or call to active duty status in support of a contingency operation

FIRST	MIDDLE	LAST
-------	--------	------

RELATIONSHIP OF COVERED MILITARY MEMBER TO YOU:	PERIOD OF COVERED MILITARY MEMBER'S ACTIVE DUTY: FROM _____ _____ _____ TO: _____ _____ _____
---	--

3. A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes written documentation confirming a Covered Military Member's active duty or call to active duty status in support of a contingency operation.

Please check one of the following:

- A copy of the Covered Military Member's active duty orders is attached.
- Other documentation from the military certifying that the Covered Military Member is on active duty (or has been notified of an impending call to active duty) in support of a contingency operation is attached.
- I have previously provided the University with sufficient written documentation confirming the Covered Military Member's active duty or call to active duty status in support of a contingency operation.

Part A: QUALIFYING REASON FOR LEAVE

1. Describe the specific reason(s) you are requesting FMLA leave due to a qualifying exigency:

2. A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes any available written documentation which supports the need for leave; such documentation may include a copy of a meeting announcement for informational briefings sponsored by the military, a document confirming an appointment with a counselor or school official, or a copy of a bill for services for the handling of legal or financial affairs. Available written documentation supporting this request for leave is attached.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> None Available
---	--

PART B: AMOUNT OF LEAVE NEEDED

1. Approximate date exigency commenced:		____ ____ ____
Probable duration of exigency:	FROM: ____ ____ ____	TO: ____ ____ ____
2. Will you need to be absent from work for a single continuous period of time due to the qualifying exigency?		<input type="checkbox"/> No <input type="checkbox"/> Yes
If so, estimate the beginning and ending dates for the period of absence:	FROM: ____ ____ ____	TO: ____ ____ ____
3. Will you need to be absent from work periodically to address this qualifying exigency?		<input type="checkbox"/> No <input type="checkbox"/> Yes
If so, estimate the schedule of leave, including the dates of any scheduled meetings or appointments:		

Estimate the frequency and duration of each appointment, meeting, or leave event, including any travel time (i.e., 1 deployment-related meeting every month lasting 4 hours):

Frequency: ____ Times per week(s) month(s) Duration: ____ Hours or ____ Day(s) per event

Part C:

1. If leave is requested to meet with a third party (such as to arrange for childcare, to attend counseling, to attend meetings with school or childcare providers, to make financial or legal arrangements, to act as the Covered Military Member's representative before a federal, state, or local agency for purposes of obtaining, arranging or appealing military service benefits, or to attend any event sponsored by the military or military service organizations), a complete and sufficient certification includes the name, address, and appropriate contact information of the individual or entity with whom you are meeting (i.e., either the telephone or fax number or email address of the individual or entity). This information may be used by the University to verify that the information contained on this form is accurate.

NAME OF INDIVIDUAL		TITLE
ORGANIZATION		
ADDRESS (STREET)		(CITY, STATE, ZIP)
TELEPHONE: ()	FAX ()	E-MAIL

2. Describe nature of meeting:

Part D: SIGNATURE

I certify that the information I provided above is true and correct.

SIGNATURE OF EMPLOYEE	DATE
-----------------------	------

RETURN TO WORK CERTIFICATION For Family and Medical Leave (FML)

SECTION I – To be completed by THE UNIVERSITY

EMPLOYEE'S NAME (LAST, FIRST, MIDDLE INITIAL)

EMPLOYEE'S DEPARTMENT

DEPARTMENT CONTACT

DEPARTMENT CONTACT'S MAILING ADDRESS

PHONE

()

FAX

()

E-MAIL

SECTION II – To be completed by HEALTH CARE PROVIDER

PLEASE COMPLETE THE FOLLOWING AND RETURN THE FORM TO THE EMPLOYEE OR TO THE DEPARTMENT CONTACT LISTED ABOVE PRIOR TO THE RETURN TO WORK DATE

Important: Please limit your answers below to the serious health condition for which the employee has been on leave.

NAME OF HEALTH CARE PROVIDER

PLACE ADDRESS STAMP HERE:

ADDRESS

1. Is the employee now able to perform those essential functions of his or her job that he or she could not previously perform because of the serious health condition for which the employee has been on leave?

- No
 Yes
 Yes, with restrictions

2. The employee released to return to work effective _____
[indicate date]

3. If the Employee is released to return to work but is restricted in his or her ability to perform the essential functions of his or her job as a result of the serious health condition for which the employee has been on leave, please describe those restrictions:

4. The foregoing restrictions are:

- Permanent
 Temporary, until _____
[indicate date]

SIGNATURE

SIGNATURE OF HEALTH CARE PROVIDER

DATE