

**UCLA HEALTH SYSTEM
EMPLOYEE LEAVE OF ABSENCE PACKET**

This packet includes 1) Statement of Your Rights and Obligations, 2) Leave of Absence Request Form, 3) Medical Certification Form, and 4) Return to Work Certification Form

**YOUR RIGHTS AND OBLIGATIONS
UNDER THE FEDERAL FAMILY AND MEDICAL LEAVE ACT OF 1993**

(R3/01)

It is the policy of the University of California to provide family and medical leave to eligible employees in accordance with the federal [Family and Medical Leave Act of 1993](#) (FMLA) and the California Family Rights Act of 1993. This notice sets forth your rights and obligations under FMLA. If you are eligible and the leave you have requested pursuant to [University policy or collective bargaining agreement](#) qualifies as family and medical leave, up to 12 workweeks will be counted against your annual entitlement of 12 workweeks in a calendar year.

Eligibility for Leave

If you have at least 12 months of service (all prior University service counts) and if you have worked at least 1,250 hours during the 12 months prior to the requested leave, you are covered by the provisions of FMLA.

Purpose of Leave

- To care for your child after birth or placement by adoption or foster care;
- To care for your spouse, child, or parent who has a serious health condition;
- For your own serious health condition.

Family Member Defined

- A son or daughter is a biological, adopted or foster child, a legal ward, or a child for whom the employee has day-to-day responsibility to care for and financially support (i.e. *loco parentis* status).
- The employee applying for FML, based on *loco parentis* status, need not have sole responsibility to care and financially support the child. It may be a shared responsibility.
- A parent is a biological, adopted or foster parent, an individual who assumed the day-to-day responsibility to care for and financially support the employee while he/she was a child (i.e. *loco parentis* status).
- A spouse is the legal spouse of the employee.
- The department may require a declaration of relationship for FML. The Declaration of Relationship (for Family and *In Loco Parentis* Medical Leave Purposes) form is included in the FML Packet.

Length of Leave

Under FMLA, you are entitled to up to 12 workweeks of family and medical leave during a calendar year. FMLA leave on an intermittent basis or on a reduced work schedule may be requested when medically necessary for a serious health condition. When possible, you should attempt to schedule medical treatments to minimize disruption to your department. Additional leave beyond 12 workweeks may be requested pursuant to State law if you take pregnancy disability leave that runs concurrently with family and medical leave under federal law or pursuant to other provisions of

the University's leave policies and collective bargaining agreements (see the applicable [personnel policy or collective bargaining agreement](#)).

Pay

Family and medical leave is normally unpaid leave; however, you may request or be required to substitute paid leave (i.e., accrued vacation, sick leave, or extended sick leave) for all or a portion of the unpaid leave in accordance with the appropriate policies and collective bargaining agreements.

If you have requested family and medical leave for your own serious health condition, you may be eligible during the unpaid portion of your leave for temporary disability payments under the University-Paid Disability Plan and/or the Employee-Paid Disability Plan or temporary disability payments under the Workers Compensation Act.

Advance Notice

30 days advance notice is required if your need for family and medical leave is foreseeable (e.g., the birth of child or a planned medical treatment). If you fail to provide 30 days notice for a foreseeable leave, your department may deny leave until 30 days after the date you provide notice.

If your need for leave is not foreseeable, you should provide notice within a reasonable time after learning of the need for leave. Written notice is recommended.

Medical Certification

Written certification from a health care provider may be required (see the applicable [personnel policy or collective bargaining agreement](#)) for either your own serious health condition or the serious health condition of your family member. Failure to provide required certification within 15 calendar days of the date you receive this notice may result in delay or denial of leave until the certification is provided. Recertification of your own serious health condition or the serious health condition of your family member may be required periodically. If required, a medical certification form will be provided by your department.

If the leave you have requested is for your own serious health condition, you will be asked to authorize your health care provider to provide your diagnosis. Failure to disclose the diagnosis of your serious health condition is one of the reasons why your department, at its own expense, may require you to obtain the opinion of a second health care provider, and if the second opinion differs from the original certification, the opinion of a third health care provider. The opinion of the third health care provider shall be final and binding.

Under federal regulations, a "health care provider" is defined as: a doctor of medicine or osteopathy, podiatrist, dentist, chiropractor, clinical psychologist, optometrist, nurse practitioner, nurse-midwife, or a clinical social worker who is authorized to practice by the State and performing within the scope of their practice as defined by State law, or a Christian Science practitioner. A health care provider also is any provider from whom the University or the employee's group health plan will accept medical certification to substantiate a claim for benefits.

Health Benefits

Coverage under any group health plan (medical, dental, optical) will be maintained during any leave covered by FMLA (up to 12 workweeks) to the extent coverage would be maintained if you had been actively at work during the leave period. You are responsible for arranging with the Payroll Office for the payment of the

employee portion of any premiums that are not fully covered by a University contribution. Failure to pay the employee portion of the premiums within 30 days of the due date will result in cancellation of your enrollment in that plan.

If you do not return to work at the conclusion of your approved family and medical leave, you will be liable for payment of the health plan premiums (medical, dental, optical) paid by the University during any unpaid portion of your leave. The University may recover its share of health plan premiums by taking deductions, to the extent permitted by law, from your unpaid wages, if any, vacation pay, or other pay due you, or by initiating legal action. However, you will not be liable for the premiums if your failure to return to work is due to continuation of your own serious health condition or other reasons beyond your control. You will be considered to have returned to work if you work for at least 30 calendar days commencing with your scheduled return date.

Reinstatement

Under federal law (FMLA), you must be reinstated to the same position you had prior to taking the leave, or to an equivalent position provided that you return to work immediately following the conclusion of family and medical leave. If your position is unavailable (due to, for example, a temporary or indefinite layoff), you have no greater right to reinstatement than had you been continually employed during the FMLA leave period. You are not entitled to reinstatement if your appointment end date occurs before your scheduled return date from family and medical leave.

The University may require periodic notice of your intent to return to work following family and medical leave. The University's responsibility to continue your health plan coverage ends (except for COBRA continuation coverage) upon notice that you do not intend to return to work at the end of the approved leave, even though you are able to work at that time.

If the FMLA leave you have requested is for your own serious health condition, you may be required to present medical certification upon your return stating that you are able to return to work to perform the functions of your job. If required, a return to work medical certification form will be provided by your department.

University Designated FMLA Leave

The University may designate leave as FMLA leave if the leave meets the requirements listed above, even when an employee does not specifically request FMLA or family and medical leave.

University Personnel Policies and Collective Bargaining Agreements

For more information about family and medical leave and related leaves, please contact the Human Resources Office. Questions regarding employee benefits should be directed to the Benefits Office.

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 _____	Reason for Leave of Absence:		
	<input type="checkbox"/> Own Injury/Illness (not work-related) <input type="checkbox"/> Care for Injured/III Family Member <input type="checkbox"/> Pregnancy/Disability <input type="checkbox"/> Care for Newborn/Placed Child Date of Birth/Placement _____	<input type="checkbox"/> Union Business <input type="checkbox"/> Work-Incurred Injury/Illness <input type="checkbox"/> Professional Development <input type="checkbox"/> Military Caregiver Leave <input type="checkbox"/> Qualifying Exigency Leave	<input type="checkbox"/> Administrative <input type="checkbox"/> Military <input type="checkbox"/> Other (specify): _____
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
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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: ()
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SECTION II – TO BE COMPLETED BY THE UNIVERSITY

APPROVAL/DENIAL OF LEAVE REQUEST

<input type="checkbox"/> Your request for leave is approved and	Begins on _____ and ends on _____
____ weeks ____ days ____ hours qualify as FM leave under FMLA	Begins on _____ and ends on _____
____ weeks ____ days ____ hours qualify as FML leave under CFRA	Begins on _____ and ends on _____
____ weeks ____ days ____ hours qualify as PDL leave under PDLL	Begins on _____ and ends on _____
____ weeks ____ days ____ hours qualify as (Specify) _____	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 OF HEALTH CARE PROVIDER
FOR FAMILY MEMBER'S SERIOUS HEALTH CONDITION**
Family and Medical Leave Act (FMLA) & California Family Rights Act (CFRA)

PURPOSE of FORM: The below-named employee has requested a leave of absence to care for a family member with a health condition, which may qualify as a protected leave under the FMLA and/or CFRA. This medical certification form will provide the University with information needed to determine if the employee's requested leave is for a qualifying reason under the FMLA and/or CFRA. Section III must be fully completed by the health care provider.

INSTRUCTIONS to EMPLOYEE: Please complete and sign Section II before giving this form to your family member or his/her health care provider. You are required to submit a timely, complete, and sufficient medical certification to support your request for FMLA and/or CFRA leave due to your family member's serious health condition. Providing this completed form is required to obtain (or retain) the benefit of FMLA and/or CFRA protections for your leave. Failure to provide a complete and sufficient medical certification to the University may result in a delay or denial of your leave request.

This form should be completed and returned within 15 calendar days of our request for this information. If you cannot return the completed form within the stated deadline, please contact _____ with the reasons for the delay and the date when the certification will be provided.

You may return the form in person, by mail, or by fax. The fax number is _()_____.

You should include a fax cover sheet marked "CONFIDENTIAL" and address your fax to:

"ATTENTION: _____."

SECTION I – To be completed by THE UNIVERSITY

EMPLOYEE'S NAME	EMPLOYEE'S JOB TITLE
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EMPLOYEE'S REGULAR WORK SCHEDULE

NAME OF UNIVERSITY REPRESENTATIVE	UNIVERSITY REPRESENTATIVE MAILING ADDRESS
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TELEPHONE ()	FAX ()	E-MAIL
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SECTION II – To be completed by EMPLOYEE

Name of family member for whom you will provide care:	Relationship of family member to you:
---	---------------------------------------

If family member is your child, date of birth: ____|____|____

If the child is 18 years of age or older, is the child incapable of self-care because of a mental or physical disability? Yes No

(1) Describe care you will provide to your family member and estimate the duration of leave needed to provide care.

(2) Are you requesting leave on an intermittent or reduced schedule basis? Yes No

If yes, please describe the leave schedule you are requesting:

SIGNATURE

EMPLOYEE SIGNATURE	DATE
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SECTION III – To be completed by HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA and/or CFRA to care for your patient. Please 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 “indefinite,” “unknown,” or “indeterminate” may not be sufficient to determine FMLA/CFRA coverage. **Limit your responses to the condition for which the patient needs the employee’s care.** Please be sure to sign and date the form on Page 2.

PROVIDER’S NAME

BUSINESS ADDRESS

TELEPHONE

()

FAX

()

PART A: MEDICAL FACTS

(1) Approximate date condition commenced:

_____|_____|_____

Probable duration of condition:

From: _____|_____|_____ To: _____|_____|_____

(2) Page 3 describes what is meant by a “serious health condition” under both the FMLA and CFRA. Does the patient’s condition qualify under any of the categories described?

Yes No

If yes, which type of serious health condition listed on Page 3 applies:

1 2 3 4 5 6

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:

(1) Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery?

Yes No

Estimate the beginning and ending dates for the period of incapacity:

Beginning: _____|_____|_____ Ending: _____|_____|_____

During this time, does the patient’s condition warrant the participation of the employee? (In answering this question, please review the employee’s statement of care in Section II, page 1.)

Yes No

(2) If the employee has requested leave on an intermittent or reduced schedule leave basis (see answer in Section II, page 1, question 2), is it medically necessary for the patient to receive care on an intermittent or reduced schedule basis, including any time for recovery?

Yes No

If yes, estimate the hours the patient needs care from the employee:

_____ Hours per Day _____ Days Per Week From: _____|_____|_____ through: _____|_____|_____

SIGNATURE

SIGNATURE OF HEALTH CARE PROVIDER

DATE

Serious Health Conditions

A “serious health condition” means an illness, injury, impairment, or physical or mental condition that involves one of the following:

1. Inpatient 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. Incapacity of More Than 3 Consecutive Days Plus Continuing Treatment by a Health Care Provider

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:

- (a) Treatment 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
- (b) 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 (e.g., a course of prescription medication, or therapy requiring special equipment, to resolve or alleviate the health condition). Note: This does not include taking over-the-counter medications or activities that can be initiated without a visit to a health care provider (e.g., bed rest, exercise, drinking fluids).

3. Pregnancy (only covered under FMLA)

A period of incapacity due to pregnancy, childbirth, or related medical conditions. This includes severe morning sickness and prenatal care.

4. Chronic Conditions 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 period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

5. Permanent/Long-Term Conditions Requiring Supervision

A period of incapacity that 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 therefrom) 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), or kidney disease (dialysis).

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