

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.

MILITARY CAREGIVER LEAVE

Qualifying Reasons for Leave, General: To care for a covered service member with a serious injury or illness, if the employee is the spouse, son, daughter, parent or next of kin of the servicemember.

Definitions: Next of kin of covered service member: nearest blood relative (other than covered service member's spouse, parent, son or daughter). There is a specific order of priority and the covered service member can designate another blood relative for FML purposes.

Leave to Care for a Family Member or a Covered Service member: Needed to care for a family member or a covered service member means both physical and psychological care.

Leave to Care for a Covered Service member with a Serious Injury or illness:

- ❖ Covers current members of the regular armed forces, reserves and National Guards, and those on temporary disability retirement lists who are in out-patient status.
- ❖ The covered service member must have a serious injury or illness incurred in the line of duty on active duty for which she is undergoing medical treatment, recuperation, therapy or is in outpatient status or on the temporary disability retired list.
- ❖ "Serious injury or illness" means incurred in the line of active duty that may render the service member medically unfit to perform the duties of her office, grade, rank or rating.
- ❖ The employee must be spouse, parent, son, daughter or next of kin of covered service member.

- ❖ The employee can take leave to care for injured son or daughter who is 18 or older.
- ❖ The employer can require confirmation of covered family relationship to covered service member.
- ❖ The employee gets up to 26 workweeks for this FMLA purpose in a "single 12 month period."
- ❖ The employer's leave year immaterial for determining entitlement here as the 12-month period begins on the first day the employee takes leave to care for the covered service member and ends 12 months after that date.
- ❖ If the employee does not use all of the 26 weeks during this single 12-month period, the rest is forfeited for that 12-month period.
- ❖ This is per injury per covered service member.
- ❖ If the employee takes care of more than one covered service member or the same covered service member with a subsequent serious injury or illness, the employee is limited to taking no more than 26 workweeks of leave in any single 12-month period.
- ❖ The employee who takes FML for both a "traditional" purpose and to care for a covered service member under this section is limited to a total of 26 weeks during a single 12-month period and can take no more than 12 workweeks of that time for the "traditional" reasons.
- ❖ The employer cannot double designate if leave qualifies both as leave to care for a covered service member and leave to care for a family member with a SHC.
- ❖ "As with other leaves for qualifying reasons," the employer may back designate.

Certification for Military Caregiver Leave: Special forms are available for this leave and there are designated HCPs who make this certification.

Failure to Provide Certifications: Recertification does not apply to leave to care for a covered service member.

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

Your request for leave is approved and

_____ 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 FOR MILITARY CAREGIVER LEAVE
(LEAVE DUE TO SERIOUS INJURY OR ILLNESS OF COVERED SERVICEMEMBER)
Family and Medical Leave Act (FMLA)**

SECTION I – To be completed 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 and/or the COVERED SERVICEMEMBER for whom the Employee Is Requesting Leave**

INSTRUCTIONS to the EMPLOYEE and/or COVERED SERVICEMEMBER: Please complete Section II before having Section III completed. The FMLA permits the University to require that an employee submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a serious injury or illness of a covered servicemember. If requested by the University, your response is required to obtain or retain the benefit of FMLA-protected leave. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to do so may result in a denial of an employee's FMLA request. 29 C.F.R. § 825.310(f). The University will give you at least 15 calendar days to return this form.

**SECTION III –
To be completed by a UNITED STATES DEPARTMENT OF DEFENSE (“DOD”) HEALTH CARE PROVIDER or a HEALTH CARE PROVIDER who is either: (1) a United States Department of Veterans Affairs (“VA”) health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider**

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed on Page 2 has requested leave under the FMLA to care for a family member who is a member of the Regular Armed Forces, the National Guard, or the Reserves who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list for a serious injury or illness. For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty that may render the servicemember medically unfit to perform the duties of his or her office, grade, rank, or rating.

A complete and sufficient certification to support a request for FMLA leave due to a covered servicemember's serious injury or illness includes written documentation confirming that the covered servicemember's injury or illness was incurred in the line of duty on active duty and that the covered servicemember is undergoing treatment for such injury or illness by a health care provider listed above. Answer, fully and completely, all applicable parts. 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 employee is seeking leave.

**SECTION II –
To be completed by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the Employee Is Requesting Leave:** (This section must be completed first before any of the below sections can be completed by a health care provider.)

Part A: EMPLOYEE INFORMATION (To be completed by the EMPLOYEE)

Name of employee requesting leave to care for Covered Servicemember:

FIRST	MIDDLE	LAST
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Name of Covered Servicemember (for whom employee is requesting leave to care):

FIRST	MIDDLE	LAST
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Relationship of Covered Servicemember to employee requesting leave:

 Spouse Domestic Partner Parent Son Daughter Next of Kin
I certify that the information I provided above is true and correct.

SIGNATURE OF EMPLOYEE	DATE
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Part B: COVERED SERVICE MEMBER INFORMATION (To be completed by the EMPLOYEE and/or the COVERED SERVICEMEMBER)

(1) Is the Covered Servicemember a current member of the Regular Armed Forces, the National Guard or Reserves? Yes No

If yes, please provide the Covered Servicemember's military branch, rank and unit currently assigned to:

Is the Covered Servicemember assigned to a military medical treatment facility as an outpatient or to a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients (such as a medical hold or warrior transition unit)? Yes No

If yes, please provide the name of the medical treatment facility or unit:

(2) Is the Covered Servicemember on the Temporary Disability Retired List (TDRL)? Yes No

Part C: CARE TO BE PROVIDED TO THE COVERED SERVICEMEMBER (To be completed by the EMPLOYEE)

Describe the care to be provided to the Covered Servicemember and an estimate of the leave needed to provide the care:

SECTION III –

To be completed by a United States Department of Defense (“DOD”) Health Care Provider or a Health Care Provider who is either: (1) a United States Department of Veterans Affairs (“VA”) health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider.

If you are unable to make certain of the military-related determinations contained below in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care

coordinator). (Please ensure that Section II above has been completed before completing this section.) Please be sure to sign the form on the last page.

Part A: HEALTH CARE PROVIDER INFORMATION

HEALTH CARE PROVIDER'S NAME		BUSINESS ADDRESS
TELEPHONE ()	FAX ()	E-MAIL

Type of Practice/Medical Specialty:

Please state whether you are either:

- a DOD health care provider;
- a VA health care provider;
- a DOD TRICARE network authorized private health care provider; or
- a DOD non-network TRICARE authorized private health care provider: _____

PART B: MEDICAL STATUS

(1) Covered Servicemember's medical condition is classified as (Check One of the Appropriate Boxes):

- (VSI) Very Seriously Ill/Injured** – Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)
- (SI) Seriously Ill/Injured** – Illness/injury is of such severity that there is cause for immediate concern, but there is no imminent danger to life. Family members are requested at bedside. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)
- OTHER Ill/Injured** – a serious injury or illness that may render the servicemember medically unfit to perform the duties of the member's office, grade, rank, or rating.
- NONE OF THE ABOVE** (Note to Employee: If this box is checked, you may still be eligible to take leave to care for a covered family member with a "serious health condition" under the FMLA and/or CFRA. If such leave is requested, you may be required to submit the University's Certification of Health Care Provider for Family Member's Serious Health Condition.)

(2) Was the condition for which the Covered Servicemember is being treated incurred in the line of duty on active duty in the armed forces?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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(3) Approximate date condition commenced:	____ ____ ____
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(4) Probable duration of condition and/or need for care: From ____ ____ ____ To ____ ____ ____

(5) Is the Covered Servicemember undergoing medical treatment, recuperation, or therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please describe medical treatment, recuperation or therapy:	

PART C: COVERED SERVICEMEMBER'S NEED FOR CARE BY FAMILY MEMBER

(1) Will the Covered Servicemember need care for a single continuous period of time, including any time for treatment and recovery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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If yes, estimate the beginning and ending dates for this period of time:

From ____|____|____ To ____|____|____

(2) Will the Covered Servicemember require periodic follow-up treatment appointments?

Yes No

If yes, estimate the treatment schedule:

(3) Is there a medical necessity for the Covered Servicemember to have periodic care for these follow-up treatment appointments?

Yes No

4) Is there a medical necessity for the Covered Servicemember to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)?

Yes No

If yes, please estimate:

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

Flare-ups may occur from: ____|____|____ through: ____|____|____

SIGNATURE

SIGNATURE OF HEALTH CARE PROVIDER

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