

**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

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 OF HEALTH CARE PROVIDER
FOR EMPLOYEE'S PREGNANCY DISABILITY
California Pregnancy Disability Leave Law (PDLL)**

PURPOSE of FORM: The below-named employee has requested a leave of absence due to a disability resulting from her pregnancy, childbirth, or related medical condition which may qualify as a protected leave under PDLL. 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 PDLL. Section II must be fully completed by the health care provider.

INSTRUCTIONS to EMPLOYEE: You are required to submit a timely, complete, and sufficient medical certification to support your request for pregnancy disability leave due to your pregnancy, childbirth, or related medical condition. Providing this completed form is required to obtain (or retain) the benefit of PDLL 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. 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

EMPLOYEE'S REGULAR WORK SCHEDULE

NAME OF UNIVERSITY REPRESENTATIVE

UNIVERSITY REPRESENTATIVE MAILING ADDRESS

TELEPHONE

FAX

E-MAIL

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Check if job description listing essential functions is attached

SECTION II – To be completed by HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient (our employee) has requested leave under the PDLL due to a disability resulting from her pregnancy, childbirth, or related medical condition. Please answer, fully and completely, all applicable parts. Your answers should be based upon your medical knowledge, experience, and examination of the employee. Be sure to sign and date the form on page 2.

NOTE: DO NOT DISCLOSE ANY UNDERLYING DIAGNOSES WITHOUT THE EMPLOYEE'S CONSENT.

PROVIDER'S NAME

BUSINESS ADDRESS

TELEPHONE

FAX

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1. Approximate date the employee became or will become disabled by pregnancy, childbirth or related medical condition:	____ ____ ____	
Probable duration of the period(s) of disability:	From ____ ____ ____	To ____ ____ ____

2. Use the information provided by the University in Section I to answer these questions. If no job description is provided, answer these questions based upon the employee's own description of her job functions.

(a) Is the employee unable to perform work of any kind without undue risk to herself, others, or the successful completion of her pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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(b) If the employee is able to perform one or more of the essential functions of her position without undue risk to herself, others, or the successful completion of her pregnancy, please answer questions (i) and (ii) below.

(i) Is it medically advisable that the employee be temporarily transferred to another position due to a health condition related to her pregnancy or childbirth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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If yes, what is the date the transfer became/will become medically advisable?	____ ____ ____	
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What is the probable duration of the period(s) of need for a transfer?	From ____ ____ ____	To ____ ____ ____
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(ii) Is it medically advisable for the employee to take leave on an intermittent or reduced schedule basis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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If the employee needs reduced schedule leave, estimate the part-time or reduced work schedule the employee needs:

Employee should work no more than:

_____ Hour(s) per day _____ Days per week From _____|_____|_____ To _____|_____|_____

If the employee needs intermittent leave, estimate the frequency of need for intermittent leave and the duration of incapacity (e.g. 1 episode every 3 months lasting 1-2 days).

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

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

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FAX

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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