Family and Medical Leave
Employee Checklist

Request time off work

Follow your department's normal procedure for requesting leave. Provide as much advance notice of the need for leave as possible. If 30 days advance notice is not possible, you are required to request leave as soon as you know you will need to be away from work. **If the need for leave is due to an emergency, you must provide notification as required by your department and are required to notify your manager before leaving the workplace.**

Request for Leave of Absence (LOA) or Modified Work Schedule Form

The following items MUST be included on the request form in order for HR to process your request:

- **Indicate a start date and end date for the leave** ("Indefinite" dates or "leave as needed" are not acceptable and cannot be approved).
- **Identify type of leave being requested** (LOA - continuous or intermittent, or a reduced or modified work schedule). For intermittent leave, identify frequency and duration of leave needed.
- **Identify reason for request** (i.e., personal health condition, pregnancy or parental leave)
- **Indicate if you are applying for Washington Paid Family Leave (PFML)** Employees interested in taking Paid Family and Medical Leave (PFML) should contact the Employment Security Department (ESD) at https://paidleave.wa.gov/ to determine if they are eligible.
- **Obtain manager's signature** (this acknowledges his/her receipt of your request for LOA or intermittent, reduced or modified work schedule)
- **Send** a copy of the signed and completed form to the appropriate **Human Resources Office** (see contact information below).
- **Your Leave Specialist** will review your request in conjunction with your rights under FMLA and the University's Policies. If your request is complete, you will receive an approval letter confirming your leave details.

Certification of Health Care Provider Form

- **Complete employee information** on Part 1 of the form and upper right corner of page 2
- **Give entire form to your Health Care Provider** for completion of Part 2 (NOTE: For intermittent leave requests, an estimate of the intermittent frequency, duration, and start/end dates must be provided by the Health Care Provider. Intermittent leave requests cannot be evaluated without this information.)
- **Return the completed form directly to HR** (the confidential health information on this form should not be shared with your manager)

Make Additional Arrangements for your Leave of Absence (if applicable)

- **Contact your department** timekeeper/manager to discuss use of benefit time during your leave (i.e., vacation, holiday, sick leave, compensatory time, leave without pay)
- **Contact UW Integrated Service Center (ISC)** to discuss your health care coverage and/or new dependent information at 206-543-8000 or https://isc.uw.edu/contact-us/
- **Contact Commuter Services** to find out about discontinuing parking deductions while on leave: 206-744-3254 (Harborview) or 206-221-3701 (UWMC)
- **Contact your Leave specialist** as soon as possible should any dates need to be changed or adjusted, or if you have any additional questions.

Return, scan or fax forms directly to your HR Office (copies are acceptable; however, HR reserves the right to request the originals for clarification):

Harborview Medical Center
HR Operations Office
Fax: (206) 598-4610
325 Ninth Avenue
Box 359715
Seattle, WA 98104
Or, MedCtrFMLA@uw.edu

UW Medical Center Montlake & Northwest
HR Operations Office
Fax: (206) 598-4610
1959 NE Pacific #BB150
Box 356054
Seattle, WA 98195
Or, MedCtrFMLA@uw.edu

Your leave request cannot be approved without these completed forms.
Incomplete forms may delay the approval process.

REQUEST FOR LEAVE OF ABSENCE OR MODIFIED WORK SCHEDULE
FAMILY AND MEDICAL LEAVE
Personal Medical, Family Medical, Disability, or Parental Leave; or Leave related to a Family Member's Military Service

This form is used when an employee is requesting leave (full or intermittent) or a reduced or modified work schedule. Complete the portions of this form that are relevant to your request and **submit the form to your manager for signature**.

Employee Information

Full Name (print):	Employee ID #:
Phone:	Email:
Department Name:	Date:
**Department Manager Name: Phone: Email:	Supervisor Name (if different than Manager): Phone: Email:

Leave Request Information *(Please check box)*

Leave Start Date (Required):_____ **Leave End Date (Required):** _____

I am requesting a:

☐ **Full Leave of Absence** *(off work entirely during the dates requested above)*

☐ **Intermittent Leave of Absence** - *Describe the time you will need off* (e.g., absent two times/month during the timeframe noted above):_____

☐ **Reduced Work Schedule** – *Describe the reduction you are requesting* (e.g., 100% FTE to 80% FTE during the timeframe noted above):

_____

☐ **Modified Work Schedule** – *Describe the work schedule you are requesting* (e.g., work M, T, & W versus T, W, Th during the timeframe noted above):

_____

All leave requests, **including requests for intermittent leave or reduced/modified work schedules,** need to have a start and end date. Health Care Provider documentation will be used to verify the requested dates and schedules (please estimate if unsure).

Are you Applying for Washington Paid Family Leave (PFML)?

☐ **Yes** ☐ **No**

Reason for Request *(Please check box)*

☐ **Leave for my own serious health condition, including pregnancy** (Requirement: Attached **"Certification of Health Care Provider"** form must be completed in order to verify the need for leave)

☐ **Leave for a family member's serious health condition** (Requirement: Attached **"Certification of Health Care Provider"** form must be completed in order to verify the need for leave)

Relationship of family member _____ If Child, child's age _____

Is leave due to an injury/illness associated with a family member's military service? ☐Yes ☐No

☐ **Parental Leave** (Requirement: Attached **"Certification of Health Care Provider**" form must be completed in order to verify the need for leave **OR** If leave is for adoption/foster care, **verification from the appropriate agency** confirming the date of birth or placement is required to verify the need for leave)

Anticipated date of birth_____ OR **Anticipated date of placement** _____

☐ **Leave for a family member who is called to active duty** (Requirement: Attached "**Certification of Qualifying Exigency**" form must be completed in order to verify the need for leave)

Request Verification	**Leave Request Receipt by Manager**
_____ **Employee Signature** (date)	_____ ****Department Manager Signature** (date)

****REQUIRED: <u>Department Manager must sign this request prior to sending it to Human Resources</u>.**
Approval/denial of this FMLA request will be determined by Human Resources.

University of Washington
Medical Centers Human Resources

Family & Medical Leave
Certification of Health Care Provider
Care for a Family Member

To Employee - Please Print & Complete on Each Page	
Employee Name:	
Employee EID #:	
Department:	
Employee Phone:	Employee Email:

Please complete Part 1, and arrange for your family member's health care provider to complete Part 2. Return the completed form as soon as possible, but no later than 15 calendar days from the date you receive it. Return to your Human Resources Office.

☐ Harborview Medical Center	☐ UW Medical Center Montlake	☐ UW Medical Center Northwest
Fax: (206) 598-4610 325 Ninth Avenue Box 359715 Seattle, WA 98104 Or, MedCtrFMLA@uw.edu	Fax: (206) 598-4610 1959 NE Pacific #BB150 Box 356054 Seattle, WA 98195 Or, MedCtrFMLA@uw.edu	Fax: (206) 598-4610 1959 NE Pacific #BB150 Box 356054 Seattle, WA 98195 Or, MedCtrFMLA@uw.edu

PART 1 – To Be Completed by Employee

Family Member's Name (please print):	Family Member's Relationship to You:

Medical Facts – TO BE COMPLETED BY HEALTH CARE PROVIDER

Our employee is requesting leave from work to care for a family member with a serious health condition. Please provide the information requested below so that we can process our employee's leave request. Only provide information regarding the condition(s) that relate to our employee's request to take leave.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Describe the medical facts related to the condition(s) that require our employee to be off work and/or to work a reduced or intermittent work schedule (medical facts may include symptoms, diagnosis, or any plan for continuing treatment or therapy):

Was your patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? Yes ☐ No ☐

If yes, dates of admission: _____

Date(s) you treated patient for this condition: _____

Will your patient need to have treatment visits at least twice per year due to the condition? Yes ☐ No ☐

Was medication, other than over-the-counter medication, prescribed? Yes ☐ No ☐

Was your patient referred to other health care provider(s) for evaluation or treatment? Yes ☐ No ☐
If yes, describe the nature and expected duration of the treatments:

University of Washington
Medical Centers Human Resources

Family & Medical Leave
Certification of Health Care Provider
Care for a Family Member

To Employee - Please Print & Complete on Each Page	
Employee Name:	
Employee EID #:	
Department:	
Employee Phone:	Employee Email:

Several of the following questions ask about the frequency or duration of a condition or treatment. We know that health conditions can vary or change over time, so please provide your best estimate in response to these questions, being as specific as you can. Using terms such as "lifetime," "unknown," or "indeterminate" may not be specific enough for us to determine leave eligibility for our employee under the Family and Medical Leave Act.

Please describe the assistance our employee will provide to their family member for absences indicated below. Your patient's need for care may include assistance with basic medical, hygienic, nutritional, safety, or transportation needs, or the provision of psychological care.

Continuous Leave: Will your patient be incapacitated for a single, continuous period of time including time for treatment and recovery? Yes ☐ No ☐ If yes, estimate the beginning and ending dates for the period of incapacity:

From (date): _____ **to (date):** _____

Intermittent Leave: Will the condition(s) cause episodic flare-ups that prevent your patient from performing his/her job functions? Yes ☐ No ☐

Based upon your patient's medical history and your knowledge of the medical condition, estimate the frequency and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 time per 3 months, 2 days per episode)

Frequency: _____ absence(s) per ☐ week – **OR-** ☐ month

Duration: _____ hour(s) or _____ day(s) per absence

From (date): _____ **to (date):** _____

Appointments: Will there be a need for planned medical appointments and/or absences? Yes ☐ No ☐

Frequency: _____ absence(s) per ☐ week – **OR-** ☐ month

Duration: _____ hour(s) per appointment (please also include to/from travel time)

From (date): _____ **to (date):** _____**From (date):**

Part C: Health Care Provider Information (please complete or attach business card with information)

Name (please print): _____ Specialty: _____

Business Address: _____

Phone: _____ Fax: _____

To the best of my knowledge, the information provided throughout this form is true and correct.

Health Care Provider Signature: _____ Date: _____

Paid Family and Medical Leave

Statement of Employee Rights

You may qualify for Paid Family and Medical Leave

As of Jan. 1, 2020, Washington employees who have worked 820 hours or more in the qualifying period and experience (d) a qualifying event have access to Paid Family and Medical Leave.

Employees who have missed work due to family or medical reasons may be eligible for paid family or medical leave for the following qualifications:

- Care for and bond with a child younger than 18 following birth or placement
- Care for yourself or a family member experiencing a serious health condition
- Certain military-connected events.

Paid Family and Medical Leave requires that you give your employer(s) written notice at least 30 days in advance of when you plan to take leave. However, if the reason you need leave was not foreseeable, you may notify your employer(s) as soon as possible.

The Paid Family and Medical Leave Benefit Guide provides information on how to apply for benefits and submit weekly claims. It also explains your rights and responsibilities under the law. Download the guide at: www.paidleave.wa.gov/benefit-guide.

For more information about how to apply, contact us at 833-717-2273 or visit www.paidleave.wa.gov.

Important information for when you apply

- Employer UBI #: **178019988** (or **91-1631806** for HMC employees)
- Employer offers supplemental benefits: Y For more information about UW's supplemental benefits program visit the UW's How to file for PFML webpage for your employment program:
    - Staff and student employees: https://hr.uw.edu/ops/leaves/paid-family-and-medical-leave-pfml/how-to-file-for-pfml/
    - Faculty and other academic personnel: https://ap.washington.edu/ahr/policies/leaves/washington-state-paid-family-and-medical-leave-pfml/

Note: Except during the waiting week, employees cannot use employer provided paid time off at the same time as Paid Family and Medical Leave, unless the employer chooses to offer a "supplemental benefit." Supplemental benefits can be used along with Paid Family and Medical Leave to provide additional pay while an employee receives partial wage replacement through Paid Leave benefits. Employees may accept or reject supplemental benefit payments.

University of Washington

Family and Medical Leave Act Information Summary

(*For Non-Academic Employees)*

The UW provides this information for employees who have requested or are taking leave that could be covered by the federal Family and Medical Leave Act (FMLA) and provides additional information that is unique to Washington State, UW employment, or that you should otherwise know about. The federal poster "Employee Rights and Responsibilities under the Family and Medical Leave Act" summarizes employee and employer rights and responsibilities under the FMLA and is attached at the end of this document. You can also download the poster at: http://tinyurl.com/FMLA-notice.

The FMLA allows eligible employees to take job protected leave from work for the reasons and the amount of time described on the FMLA poster. While the FMLA provides for unpaid time off, depending on the reason you need to take leave, your employment program, and your leave balances, you may have paid time off that you can use during your FMLA leave including: annual leave, sick leave, compensatory time, discretionary leave, personal holiday, and/or shared leave that has been donated by other employees. If you are eligible, you may also receive long-term disability insurance payments during the unpaid portion of FMLA leave.

In Washington State leave to care for a newborn child is in addition to any leave the birth mother may need for sickness or temporary disability because of pregnancy or childbirth.

Certification of Leave

You may be required to provide certification from a health care provider to support the need for leave due to your own serious health condition or to care for a family member with a serious health condition. If certification is requested, you will need to arrange for completion of a Family and Medical Leave Certification of Health Care Provider Statement, and return it to the Human Resources Office serving your unit within 15 days. Failure to do this may delay approval of your leave request. The University may ask you to provide periodic updates regarding your ability to return to work, and the University may require a second medical opinion at its expense.

For leave related to a family member's active duty in the armed services, certification of the family member's military orders or status, or the reason for the leave may be required.

Return to Work Certification

Upon returning to work from FMLA-covered leave, you may be required to provide certification from a health care provider that you are fit to return to work. Contact your manager as soon as you know your expected return to work date.

Additional Resources

- Definitions of terms used in the Family Medical Leave Act: http://tinyurl.com/FMLA-definitions
- UW Benefits: UWHR Life Events web pages https://hr.uw.edu/benefits/

If you have questions about this information, please consult the following resources:

Office Listings	Office email
UW Medicine - Human Resources Leave Team	MedCtrFMLA@uw.edu
Risk Services *(for on-the-job illness or injury)*	workcomp@uw.edu
Integrated Service Center	ischelp@uw.edu
Disability Services Office	DSO@uw.edu
Disability Services Office TTY	206-543-6452

EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- for incapacity due to pregnancy, prenatal medical care or child birth;
- to care for the employee's child after birth, or placement for adoption or foster care;
- to care for the employee's spouse, son, daughter or parent, who has a serious health condition; or
- for a serious health condition that makes the employee unable to perform the employee's job.

Use of Leave

An employee does not need to use this leave entitlement in one block.

Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Military Family Leave Entitlements

Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status 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:

(1) a current member of the Armed Forces, including a member of the National Guard or 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*; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness.*

***The FMLA definitions of "serious injury or illness" for current service members and veterans are distinct from the FMLA definition of "serious health condition".**

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months*, and if at least 50 employees are employed by the employer within 75 miles.

***Special hours of service eligibility requirements apply to airline flight crew employees.**

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Substitution of Paid Leave for Unpaid Leave
Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take

FMLA leave when the need is foreseeable. When 30-day notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- interfere with, restrain, or deny the exercise of any right provided under FMLA; and
- discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement, which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulation 29 C.F.R. § 825.300(a) may require additional disclosures.

For additional information:
1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627
WWW.WAGEHOUR.DOL.GOV
U.S. Department of Labor | Wage and Hour Division WHD Publication 1420 · Revised February 2013