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 Benefits Office** to discuss your health care coverage and/or new dependent information at 206-543-4444 or benefits@uw.edu.
- ☐ **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):

UW Medical Center Montlake, HCM & 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 Personal Health Condition/Pregnancy**	**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 indicated below.

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

Medical Facts – TO BE COMPLETED BY HEALTH CARE PROVIDER

Our employee is requesting leave from work and/or a modified work schedule under the FMLA for a 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 or adopt a modified work schedule.

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:

For Pregnancy Related Incapacity

Expected date of delivery: ______________________ Planned C-Section? Yes ☐ No ☐	Expected dates of your patient's physical incapacity due to pregnancy (not parental leave): From (date):__________________ to (date):______________________

University of Washington Medical Centers Human Resources **Family & Medical Leave** **Certification of Health Care Provider** **Personal Health Condition/Pregnancy**	**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.

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: _____ hours per appointment (please also include to/from travel time)

From (date): ______________________ **to (date):** ______________________

Reduced/Modified Work Schedule: Will your patient require a reduction in or modification of the amount of time worked per week due to his/her medical condition, including any time for treatment and recovery? Yes ☐ No ☐

If yes, describe the reduced or modified work schedule that you believe is medically necessary:

This work schedule needs to be in place **from (date):** ____________________ **to (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: https://www.ecfr.gov/current/title-29/part-825
- 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
Disability Services Office	DSO@uw.edu
Disability Services Office TTY	206-543-6452

Your Employee Rights Under the Family and Medical Leave Act

What is FMLA leave?

The Family and Medical Leave Act (FMLA) is a federal law that provides eligible employees with **job-protected leave** for qualifying family and medical reasons. The U.S. Department of Labor's Wage and Hour Division (WHD) enforces the FMLA for most employees.

Eligible employees can take **up to 12 workweeks** of FMLA leave in a 12-month period for:

- The birth, adoption or foster placement of a child with you,
- Your serious mental or physical health condition that makes you unable to work,
- To care for your spouse, child or parent with a serious mental or physical health condition, and
- Certain qualifying reasons related to the foreign deployment of your spouse, child or parent who is a military servicemember.

An eligible employee who is the spouse, child, parent or next of kin of a covered servicemember with a serious injury or illness **may take up to 26 workweeks** of FMLA leave in a single 12-month period to care for the servicemember.

You have the right to use FMLA leave in **one block of time**. When it is medically necessary or otherwise permitted, you may take FMLA leave **intermittently in separate blocks of time, or on a reduced schedule** by working less hours each day or week. Read Fact Sheet #28M(c) for more information.

FMLA leave is **not paid leave**, but you may choose, or be required by your employer, to use any employer-provided paid leave if your employer's paid leave policy covers the reason for which you need FMLA leave.

Am I eligible to take FMLA leave?

You are an **eligible employee** if all of the following apply:

- You work for a covered employer,
- You have worked for your employer at least 12 months,
- You have at least 1,250 hours of service for your employer during the 12 months before your leave, and
- Your employer has at least 50 employees within 75 miles of your work location.

Airline flight crew employees have different "hours of service" requirements.

You work for a **covered employer** if one of the following applies:

- You work for a private employer that had at least 50 employees during at least 20 workweeks in the current or previous calendar year,
- You work for an elementary or public or private secondary school, or
- You work for a public agency, such as a local, state or federal government agency. Most federal employees are covered by Title II of the FMLA, administered by the Office of Personnel Management.

How do I request FMLA leave?

Generally, **to request FMLA leave you must**:

- Follow your employer's normal policies for requesting leave,
- Give notice at least 30 days before your need for FMLA leave, or
- If advance notice is not possible, give notice as soon as possible.

You **do not have to share a medical diagnosis** but must provide enough information to your employer so they can determine whether the leave qualifies for FMLA protection. You **must also inform your employer if FMLA leave was previously taken** or approved for the same reason when requesting additional leave.

Your **employer may request certification** from a health care provider to verify medical leave and may request certification of a qualifying exigency.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

State employees may be subject to certain limitations in pursuit of direct lawsuits regarding leave for their own serious health conditions. Most federal and certain congressional employees are also covered by the law but are subject to the jurisdiction of the U.S. Office of Personnel Management or Congress.

What does my employer need to do?

If you are eligible for FMLA leave, your **employer must**:

- Allow you to take job-protected time off work for a qualifying reason,
- Continue your group health plan coverage while you are on leave on the same basis as if you had not taken leave, and
- Allow you to return to the same job, or a virtually identical job with the same pay, benefits and other working conditions, including shift and location, at the end of your leave.

Your **employer cannot interfere with your FMLA rights** or threaten or punish you for exercising your rights under the law. For example, your employer cannot retaliate against you for requesting FMLA leave or cooperating with a WHD investigation.

After becoming aware that your need for leave is for a reason that may qualify under the FMLA, your **employer must confirm whether you are eligible** or not eligible for FMLA leave. If your employer determines that you are eligible, your **employer must notify you in writing**:

- About your FMLA rights and responsibilities, and
- How much of your requested leave, if any, will be FMLA-protected leave.

Where can I find more information?

Call **1-866-487-9243** or visit **dol.gov/fmla** to learn more.

If you believe your rights under the FMLA have been violated, you may file a complaint with WHD or file a private lawsuit against your employer in court. **Scan the QR code to learn about our WHD complaint process**.

WAGE AND HOUR DIVISION
UNITED STATES DEPARTMENT OF LABOR