

Family and Medical Leave Act of 1993

Reasons for Taking Leave

The Family and Medical Leave Act requires an employer to provide an eligible employee with a total of 12 work weeks of unpaid leave during any 12-month period for one or more of the following reasons:

- The birth of a child of the employee and in order to care for such child after birth.
- The placement of a child with the employee for adoption or foster care.
- To care for the employee's spouse, parent or child who has a serious health condition.
- For an employee's serious health condition that makes the employee unable to perform the essential functions of the employee's job.
- Family leave is allowed for military caregivers.
- A qualifying exigency arising out of the fact that a covered family member is on active duty or called to active duty status.

A "serious health condition" is defined as "an illness, injury, impairment, or physical or mental condition that involves inpatient care in a hospital, hospice or residential medical care facility; or continuing treatment by a health care provider.

Eligibility

Employees are eligible to take leave under the FMLA if they have been employed by Loyola Medicine for at least 12 months and have worked for at least 1,250 hours during the previous 12-month period.

Advance Notice

Employees are required to provide notice the Loyola Medicine of the need to take FMLA leave at least 30 days before FMLA leave is to begin, or as soon as possible (usually within one or two business days). Failure to provide advance notice for a foreseeable leave may result in the leave being delayed or the time not being protected.

Medical Certification

Employees are required to have a licensed health care provider complete a Certification of Health Care Provider with regard to a serious health condition. In accordance with the Americans with Disabilities Act, all medical information will be kept separate from the employee's personnel file. Employers have the right to request second or third opinions (at the employer's expense). Employers also have the right to request subsequent recertifications on a reasonable basis. If the FMLA leave is because of an employee's own serious health condition, upon return to work the employee must present a health care provider certification that the employee is able to return to work.

Job and Benefits Protection

For the duration of FMLA leave, the employer must maintain the employee's health coverage under the conditions coverage would have been provided if the employee had continued in employment continuously. If the employee's share of premiums is not paid through payroll deductions, the employee is responsible to make arrangements for payment of premiums owed. The FMLA also requires that, upon return to work, the employee be restored to his/her original or an equivalent position with equivalent pay and benefits.

For Additional Information

Contact the Loyola Medicine Human Resources Department (loyola.wired/dept/hr/benefits) or the nearest office of the Wage and Hour Division, listed in most telephone directories under U.S. Government, Department of Labor (www.dol.gov).



LOYOLA UNIVERSITY MEDICAL CENTER FAMILY/MEDICAL LEAVE REQUEST FOR LEAVE FORM

SECTION 1: EMPLOYEE

EMPLOYEE NAME	EMPLOYEE ID #	JOB TITLE	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time DATE OF HIRE:
DEPARTMENT NAME		LEAVE START DATE	ANTICIPATED DATE OF RETURN

SECTION 2: EMPLOYEE

1. Reason for Leave:

A. () Birth of a child of the employee and in order to care for such a son or daughter.

B. () Placement of a child with employee for adoption or foster care.

C. () In order to care for spouse, child or parent ("covered relation") with a serious health condition.* (see #2)

D. () Serious health condition which makes me unable to perform the functions of my position.**

E. () Care for spouse, child, parent or next of kin with illness or injury incurred in the line of duty.

F. () Qualifying exigency arising out of employee's spouse, child or parent on active duty.

2. If "C", please check one: () Spouse () Child () Parent

Name: _____ Address: _____

3. Leave(s) taken in last 12 months: _____ From: _____ To: _____

4. Is this request for an Intermittent or Reduced Leave Schedule? () Yes () No

If "yes", please provide copy of adjusted schedule

5. Is your spouse employed by Loyola? () Yes () No If "yes", indicate:

Name: _____ Department: _____ Employee ID #: _____

* Employees seeking leave because of reason "1(C)", "1(D)" or 1(E) above must complete the attached Medical Certification Form and return it within 15 days or as soon as practicable. I understand that my leave may be delayed until I provide a completed Medical Certification Form.

** Employees seeking to return to work after a leave because of their own serious illness (reason "1(D)") must complete the attached Return to Work Medical Certification Form before they are allowed to resume work. I understand that I may not be permitted to resume my position with Loyola University Medical Center until I provide a completed Return to Work Medical Certification Form.

I agree that while I am on leave, I will continue to pay the appropriate Loyola health insurance premiums, unless I elect to discontinue such coverage.

EMPLOYEE SIGNATURE	DATE
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SECTION 3: DEPARTMENT SUPERVISOR

SIGNATURE	DATE
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SECTION 3: HUMAN RESOURCES

SIGNATURE	DATE
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LOYOLA UNIVERSITY MEDICAL CENTER
CERTIFICATION OF HEALTH CARE PROVIDER
(Family and Medical Leave Act of 1993)

*** TO BE COMPLETED BY HEALTH CARE PROVIDER ***

1. Employee Name: _____
2. Patient's Name (if different from employee): _____
3. Attached is a sheet which describes what is meant by a "serious health condition" under the Family and Medical Leave Act. Does the patient's condition qualify under any of the categories described? If "yes", please indicate the applicable category:
 - Pregnancy
 - Hospital Care
 - Absence from Work (5 or more days) Plus Treatment
 - Chronic Condition Requiring Treatment
 - Permanent/Long Term Condition Requiring Treatment
 - Multiple Treatments for Multiple Conditions
4. Type of leave the Employee will need to take:
 - Continuous
 - Intermittent/Periodic
 - Reduced Work Schedule
 - Medical Appointments Only
5. Describe the medical facts which support your certification and a brief statement as to how the patient's condition meets the criteria of one of these categories:

6. Beginning Date of Leave _____ End Date (if known) _____
7. If the employee is currently incapacitated, please state the anticipated duration of the current incapacity:

8. If the condition will require the employee to be absent from work intermittently or to work a reduced schedule, state the likely frequency and duration of future episodes of incapacity (e.g. will the employee need several days each month, a full day, several hours, certain times of day, etc.):

9. If a regimen of continuing treatment is required for the patient, provide a general description of such regimen (e.g. prescription drugs, physical therapy, etc.):

10. If future treatments will be required for the condition, provide an estimate of the probable number and duration of such treatments, actual or estimated dates of treatment and period required for recovery, if any:

Are treatment appointments available outside the employee's scheduled working hours? () Yes () No

11. If any of these treatments will be provided by another provider of health services (e.g. physical therapist), state the nature and frequency of the treatments:

12. If able to perform work, is the employee able to perform all of the essential functions of his/her job? (The employee should provide you with the information about the essential job functions) () Yes () No

If no, list the essential functions the employee is unable to perform and the anticipated duration:

IF LEAVE IS REQUIRED TO CARE FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION, COMPLETE THE FOLLOWING:

13. Does the patient require assistance for basic medical or personal needs or safety, or for transportation?

() Yes () No

14. If the patient will need care only intermittently or on a part-time basis, indicate the probable duration and frequency of this need:

Signature of Health Care Provider

Date

Name of Health Care Provider (Please Print)

Type of Practice

Address

Telephone Number

TO BE COMPLETED BY EMPLOYEE ONLY WHEN LEAVE IS NEEDED TO CARE FOR A FAMILY MEMBER

State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule.

Employee Signature

Date

TO BE COMPLETED BY OCCUPATIONAL HEALTH

Reviewed and Approved

Signature

Date



**LOYOLA UNIVERSITY MEDICAL CENTER
FAMILY/MEDICAL LEAVE
RETURN TO WORK MEDICAL CERTIFICATION FORM**

SECTION 1: EMPLOYEE

EMPLOYEE NAME	EMPLOYEE ID #	JOB TITLE
DEPARTMENT NAME	LEAVE START DATE	ANTICIPATED DATE OF RETURN
EMPLOYEE SIGNATURE		DATE

SECTION 2: TO BE COMPLETED BY EMPLOYEE'S HEALTH CARE PROVIDER

HEALTH CARE PROVIDER NAME _____

ADDRESS _____ OFFICE PHONE _____

I Certify that on _____ Date, _____ Name of Employee may return to work

with reasonable accommodations/restrictions

Please list accommodations/restrictions in detail: _____

When is employee anticipated to return to work without restrictions? _____ Date

with NO accommodations or restrictions

HEALTH CARE PROVIDER SIGNATURE	DATE
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NOTE:

This form should be provided to Occupational Health or Department Manager.