The Family and Medical Leave Act requires that an employee provide his/her employer (The University of Arkansas) with 30 calendar days advance notice prior to the expected start of the leave. If 30 days advance notice is not possible, the employee must provide the employer with as much advance notice as possible, ordinarily within one or two business days of when the need for leave becomes known to the employee.

The FMLA forms are required to be completed and returned to Human Resources. These forms are required to document whether your absence from work meets the criteria to establish an FMLA eligible situation. If the circumstances surrounding your absence meet the FMLA eligibility requirements, the University has an obligation to protect your job for a period of up to twelve workweeks per calendar year or twenty-six workweeks per a 12-month period for care of a covered service member.

These forms should be returned to the Leave Administrator in Human Resources at ADMN 222 as soon as possible.

If you have any questions, please contact the Leave

Administrator: Phone: 479-575-5351

Fax: 479-575-6971

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.

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 servicemember during a single 12-month period. A covered servicemember 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 servicemembers 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.

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.

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 days 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

REQUEST FOR FAMILY AND MEDICAL LEAVE
University of Arkansas Fayetteville

Employee Name (Last, First, MI)		Date (mm/dd/yy)
Employee I.D. Number	Department	Telephone Number
Supervisor Name		Employee Job Title
Requested FMLA Begin Date (mm/dd/yy)	Requested FMLA End Date (mm/dd/yy)	

Please read and sign below:

- I am requesting Family and Medical Leave (FMLA) for the dates shown above.
- I understand that FMLA, as federally mandated, is unpaid leave. Current state policy, however, requires substitution of accrued paid leave for FMLA time request when such leave is available.
- I understand that the University of Arkansas may require a written second opinion from a health care provider at the expense of the University.
- I understand that, if approved for FMLA, the University will continue paying the Employer portion of my group health insurance, if I am a participant. I understand that I am responsible for paying the Employee's portion for the Health Plan for each pay period. If I do not pay, my Health Plan may be cancelled after 30 days.

Employee signature	Date (mm/dd/yy)

AUTHORIZATION (to be completed by HR personnel only):

☐Approved ☐Disapproved

FMLA type: ☐Personal ☐Maternity/Paternity ☐Family

Eligibility: Employed 12 mo: _____ 1,250 hrs worked _____

Approving Authority: _____

Date: _____

Revised 8/06
JB

FAMILY AND MEDICAL LEAVE ACT OF 1993 PROCEDURES
UNIVERSITY OF ARKANSAS, FAYETTEVILLE

1. Time granted under the Family and Medical Leave Act of 1993 will be counted against the annual 12-work week entitlement, which is based on a calendar year. An employee's Family and Medical Leave designation must be approved by the University of Arkansas Human Resources representative.

2. A Certification of Health Care Provider form must be completed and submitted to Human Resources for each request for Family and Medical Leave. The certification must be submitted within 15 days of each request for Family and Medical Leave or as soon as is reasonably possible in the case of unforeseen need for leave. A certification is needed for each occasion where the employee is requesting leave to assist a seriously ill family member. Under specified circumstances, the University may request re-certification after 30 days. Failure to provide certification as designated above may result in denial of Family and Medical Leave until such time as the completed certification is received or discontinuation of leave currently in effect.

3. It is Board Policy that all applicable accumulated paid leave must be exhausted before Family and Medical Leave without pay (LWOP) will be granted except for maternity leave requests. Leave requested for maternity purposes (birth or adoption of a child) will be counted toward the annual 12-work week Family and Medical Leave allotment.

4. In accordance with the Family and Medical Leave Act of 1993, the University will continue to pay the employer's matching portion of Group Health, Basic Life and Basic Long Term Disability Insurance coverage for employees on Family and Medial Leave. The employee is responsible for paying his/her portion of the premium, if his/her monthly paycheck is not sufficient to cover the premium deduction or if the employee is on full LWOP. If the employee does not continue to pay the employee portion of the premium, the insurance may be canceled.

5. Premiums should be paid to the university insurance representative. Checks should be made payable to the "University of Arkansas".

6. At the time of each premium payment, the employee must report his/her status and intention to return to work.

7. The employee may choose not to retain health coverage during Family and Medical Leave. However, the employee is entitled to be reinstated on the same terms as prior to taking the leave, without a qualifying period, physical examination, exclusion of pre-existing condition, etc., upon returning to work.

8. Except as required by the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), the University's obligation to maintain health benefits under the Family and Medical Leave Act ceases if and when an employee informs the employer of his/her intent not to return from leave, the employee fails to return from leave, or the employee exhausts his/her Family and Medical Leave entitlement.

9. The University will recover any premium payments missed by the employee and may recover the University's share of premiums if the employee fails to return to work or leave expires, except in certain stipulated circumstances.

10. If Family and Medical Leave is granted for the employee's own serious health condition, before the employee may return to work, she/he must provide a statement from the health care provide stipulating that the employee is able to return to work. Any restrictions must be identified on the statement.

11. The employee generally has a right to return to the same position or an equivalent position with equivalent pay, benefits and working conditions at the conclusion of the leave.

I confirm that I have read the information contained herein on _____ _____
(Date) (Employee's signature)

Certification of Qualifying Exigency For Military Family Leave (Family and Medical Leave Act)

U.S. Department of Labor

Wage and Hour Division

U.S. Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 8/31/2021

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a qualifying exigency to submit a certification. Please complete Section I before giving this form to your employee. Your response is voluntary, and while you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 CFR 825.309.

Employer name: _____

Contact Information: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II fully and completely. The FMLA permits an employer to require that you submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a qualifying exigency. Several questions in this section seek a response as to the frequency or duration of the qualifying exigency. Be as specific as you can; terms such as "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Your response is required to obtain a benefit. 29 CFR 825.310. While you are not required to provide this information, failure to do so may result in a denial of your request for FMLA leave. Your employer must give you at least 15 calendar days to return this form to your employer.

Your Name: _____
First Middle Last

Name of military member on covered active duty or call to covered active duty status:

_____
First Middle Last

Relationship of military member to you: _____

Period of military member's covered active duty: _____

A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes written documentation confirming a military member's covered active duty or call to covered active duty status. Please check one of the following and attach the indicated document to support that the military member is on covered active duty or call to covered active duty status.

☐ A copy of the military member's covered active duty orders is attached.

☐ Other documentation from the military certifying that the military member is on covered active duty (or has been notified of an impending call to covered active duty) is attached.

☐ I have previously provided my employer with sufficient written documentation confirming the military member's covered active duty or call to covered active duty status.

PART A: QUALIFYING REASON FOR LEAVE

1. Describe the reason you are requesting FMLA leave due to a qualifying exigency (including the specific reason you are requesting leave):

_____

_____

_____

_____

2. A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes any available written documentation which supports the need for leave; such documentation may include a copy of a meeting announcement for informational briefings sponsored by the military; a document confirming the military member's Rest and Recuperation leave; a document confirming an appointment with a third party, such as a counselor or school official, or staff at a care facility; or a copy of a bill for services for the handling of legal or financial affairs. Available written documentation supporting this request for leave is attached.

Yes ☐ No ☐ None Available ☐

PART B: AMOUNT OF LEAVE NEEDED

1. Approximate date exigency commenced: _____

Probable duration of exigency: _____

2. Will you need to be absent from work for a single continuous period of time due to the qualifying exigency?

Yes☐ No☐

If so, estimate the beginning and ending dates for the period of absence:

_____

3. Will you need to be absent from work periodically to address this qualifying exigency? Yes☐ No☐

Estimate schedule of leave, including the dates of any scheduled meetings or appointments:

_____

_____

_____

Estimate the frequency and duration of each appointment, meeting, or leave event, including any travel time (i.e., 1 deployment-related meeting every month lasting 4 hours):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours ___ day(s) per event.

PART C:

If leave is requested to meet with a third party (such as to arrange for childcare or parental care, to attend counseling, to attend meetings with school, childcare or parental care providers, to make financial or legal arrangements, to act as the military member's representative before a federal, state, or local agency for purposes of obtaining, arranging or appealing military service benefits, or to attend any event sponsored by the military or military service organizations), a complete and sufficient certification includes the name, address, and appropriate contact information of the individual or entity with whom you are meeting (i.e., either the telephone or fax number or email address of the individual or entity). This information may be used by your employer to verify that the information contained on this form is accurate.

Name of Individual: _____ Title: _____

Organization: _____

Address: _____

Telephone: (_____) _____ Fax: (_____) _____

Email: _____

Describe nature of meeting: _____

_____

_____

_____

_____

_____

_____

_____

PART D:

I certify that the information I provided above is true and correct.

Signature of Employee _____ Date _____

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. 2616; 29 CFR 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution AV, NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE EMPLOYER.**