FAMILY MEMBER

IMPORTANT INFORMATION

MEDICAL-FMLA LEAVE OF ABSENCE FORMS:

MUST BE FORWARDED DIRECTLY TO:

LEAVE OF ABSENCE

HUMAN RESOURCES

30 BERGEN STREET, PO BOX 27050

NEWARK, NJ 07101-6750

FAX: (973) 972-0549

EMAIL: MYLOA@UHNJ.ORG

POLICIES CAN BE FOUND ONLINE AT

Policy Manager - MCN Healthcare (ellucid.com)

FOR NJ SHORT TERM DISABILITY OR NJ PAID FAMILY LEAVE INSURANCE, YOU MUST APPLY DIRECTLY WITH THE STATE ONLINE. OUR OFFICE DOES NOT RECEIVE OR REVIEW THESE INQUIRES.

APPLY ONLINE:

https://www.myleavebenefits.nj.gov/

TO BE ELIGIBLE FOR JOB PROTECTION UNDER FMLA, YOU MUST HAVE BEEN EMPLOYED AT UH FOR A MINIMUM OF 12 MONTHS AND HAVE WORKED 1,000 HOURS IN THE LAST 12 MONTHS.

YOU ARE REQUIRED TO FOLLOW YOUR DEPARTMENT CALL OUT PROCEDURE UNTIL YOU RECEIVE WRITTEN CORRESPONDENCE FROM HUMAN RESOURCES ADVISING THE STATUS OF YOUR REQUESTED LEAVE.

University HOSPITAL
Newark, NJ

REQUEST FOR LEAVE OF ABSENCE

For Medical/Family Medical Leave (FMLA), Personal, Academic or Military

Employees must provide 30 days' advance notice for birth, adoption, foster care, planned medical treatment for self, family member or covered service member. Failure to provide timely notice to your department and Human Resources will result in absences been unprotected and may subject the employee to discipline. You are required to follow your department call out procedures until you receive written correspondence from Human Resources advising the status of your requested leave.

Employee's Name: _____ Employee ID #: _____ Date of Hire: ___/___/_____

Position Title: _____ Department: _____

Home Address: _____ Telephone: _____

Personal Email: _____ Supervisor Full Name: _____

MEDICAL/FMLA LEAVE:

- ☐ Baby Bonding/Adoption/Foster Care
- ☐ Serious health condition of self
- ☐ Serious health condition of self - Maternity
- ☐ Serious health condition of family member -**Relationship**: _____
- ☐ Military

OTHER LEAVE TYPES:

- ☐ Personal-Unpaid
- ☐ Academic-Unpaid

Employees must select an option below. For employees applying for New Jersey Temporary Disability, accrued sick time must be used first and exhausted. Selection cannot be changed once a request is submitted.

*For Medical Leave of Absence for self, you will use (**in daily increments, not hours**)*

_____ Sick Day(s) and//

☐ Apply for NJ Short Term Disability

☐ Use all float and vacation days as per Medical/FMLA Leave of Absence policy.

For Medical Leave of Absence for a serious health condition of family member, you will:

☐ Use ten (10) sick days as per Medical/ FMLA Leave of Absence policy then apply for NJ Paid Family Leave Insurance.

☐ Use ten (10) sick days as per Medical/ FMLA Leave of Absence policy, use all float and vacation days, then apply for NJ Paid Family Leave Insurance

For Medical Leave of Absence for baby bonding/adoption/foster care, you will:

☐ Use up to ten (10) days of your float and vacation days then apply for NJ Paid Family Leave Insurance

☐ Use all float and vacation days as per Medical/FMLA Leave of Absence policy then apply for NJ Paid Family Leave Insurance

or

☐ Currently receiving NJ Short Term Disability, will transition onto NJ Paid Family Leave Insurance

DURATION OF LEAVE:

☐ Continuous LOA Start Date: ___/___/_____

☐ Intermittent or Reduced Schedule Estimated Return Date: ___/___/_____

NOTE:
It is the employee's responsibility to make any necessary arrangements with the Human Resources Benefits Office to ensure continuity of health, life insurance and retirement benefits prior to beginning a leave and immediately upon return from leave. Depending on the duration of a leave of absence, an employee's health, life insurance and retirement benefits may be affected; if arrangements are not made, such benefits may cancel and employees may be subject to COBRA coverage.

Personal Leaves and Academic Leaves are approved by the employee's department in consultation with the Department of Human Resources.

SIGNATURES:
My signature below certifies that I have read and understand the above information as well as the UH Medical/FMLA Leave policy and to the best of my knowledge, all information I have provided or will provide supporting my request for leave is accurate.

Employee's Signature: _____ Date: ___/___/_____

Supervisor/Department Head Signature Required for Personal/Academic Leave Requests Only

Supervisor/Department Head Signature: _____ Date: ___/___/_____

Certification of Healthcare Provider for
Family Member's Serious Health Condition
(Family and Medical Leave Act)

INSTRUCTIONS to the EMPLOYEE:

YOU MUST RETURN THE COMPLETED FORM WITHIN 15 DAYS. FAILURE TO PROVIDE A COMPLETE AND SUFFICENT CERTIFICATION IN A TIMELY MANNER MAY RESULT IN THE DENIAL OF YOUR FMLA REQUEST.

Employee: _____ Employee ID: _____
First Middle Last If available

My Mailing Address: _____ Phone: _____

I am caring for: _____ Relation: _____
First Middle Last

Family member date of birth: ____/____/____

Describe the care you will provide to your family member and estimate leave needed to provide care:

_____

_____

_____

Employee's Signature: _____ Date: _____

INSTRUCTIONS to the FAMILY MEMBER (PATIENT):

By my signature below, I demonstrate my informed consent and authorization to allow my healthcare provider to release, disclose and communicate to my family member's employer or employer representative such healthcare records and information concerning my current medical condition(s) as is necessary to support my family member's request for a leave of absence and/or any additional benefits his/her employer may provide. I further authorize my family member's employer or employer representative to contact my healthcare provider directly for the purposes of clarification and verification of the authenticity of this certification. This authorization shall be valid for one (1) year from the date shown below, unless revoked by me in writing at an earlier date. Although I understand that I may revoke this authorization in writing at any time, I also understand that any such revocation will not apply to any information that has already been released in reliance on this authorization, and that any revocation may have an adverse effect on the receipt of my family member's Employer-provided benefits. I understand that information disclosed by my healthcare provider to my family member's employer or employer representative may be subject to redisclosure and not protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The information shall not be released to my family member's immediate supervisor.

I authorize my healthcare provider to provide this certification form directly to my family member's employer via fax or mail.

Family Member's Signature: _____ **Date**: _____
(Patient)

If the family member (Patient) does not sign this authorization and upon request, the employee fails to obtain clarification of incomplete or inconsistent responses, the employee's leave of absence may be denied under FMLA. 29 C.F.R. §825.307(a). You have a right to obtain a copy of this authorization after you sign it.

The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of a family member. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C.§§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 20 C.F.R. §825.313.

Certification of Health Care Provider for Family Member's Serious Health Condition under the Family and Medical Leave Act

UNIVERSITY HOSPITAL
Newark, New Jersey

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR. RETURN TO THE PATIENT.

OMB Control Number: 1235-0003
Expires: 6/30/2023

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave to care for a family member with a serious health condition to submit a medical certification issued by the family member's health care provider. 29 U.S.C. §§ 2613, 2614(c)(3); 29 C.F.R. § 825.305. The employer must give the employee **at least 15 calendar days** to provide the certification. If the employee fails to provide complete and sufficient medical certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

SECTION I - EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, this form asks the health care provider for the information necessary for a complete and sufficient medical certification, which is set out at 29 C.F.R. § 825.306. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308.** Additionally, you **may not** request a certification for FMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care.

Employers must generally maintain records and documents relating to medical information, medical certifications, recertifications, or medical histories of employees or employees' family members created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

(1) Employee name: _____
First *Middle* *Last*

(2) Employer name: _____ Date: _____ *(mm/dd/yyyy)*
(List date certification requested)

(3) The medical certification must be returned by _____ *(mm/dd/yyyy)*
(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee's diligent, good faith efforts.)

SECTION II - EMPLOYEE

Please complete and sign Section II before providing this form to your family member or your family member's health care provider. The FMLA allows an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of your family member. If requested by your employer, your response is required to obtain or retain the benefit of the FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). **You are responsible for making sure the medical certification is provided to your employer within the time frame requested, which must be at least 15 calendar days.** 29 C.F.R. §§ 825.305-825.306. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA leave request. 29 C.F.R. § 825.313.

(1) Name of the family member for whom you will provide care: _____

(2) Select the relationship of the family member to you. The family member is your:

☐ Spouse ☐ Parent ☐ Child, under age 18

☐ Child, age 18 or older and incapable of self-care because of a mental or physical disability

Spouse means a husband or wife as defined or recognized in the state where the individual was married, including in a common law marriage or same-sex marriage. The terms "child" and "parent" include *in loco parentis* relationships in which a person assumes the obligations of a parent to a child. An employee may take FMLA leave to care for an individual who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave to care for a child for whom the employee has assumed the obligations of a parent. No legal or biological relationship is necessary.

Employee Name: _____

(3) Briefly describe the care you will provide to your family member: *(Check all that apply)*

☐ Assistance with basic medical, hygienic, nutritional, or safety needs ☐ Transportation

☐ Physical Care ☐ Psychological Comfort ☐ Other: _____

(4) Give your **best estimate** of the amount of leave needed to provide the care described: _____

_____

(5) If a **reduced work schedule** is necessary to provide the care described, give your **best estimate** of the reduced schedule you are able to work. From _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*, I am able to work _____ *(hours per day)* _____ *(days per week)*.

Employee Signature _____ **Date** _____ *(mm/dd/yyyy)*

SECTION III - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form below. A family member of your patient has requested leave under the FMLA to care for your patient. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a family member with a serious health condition. For FMLA purposes, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that *involves inpatient care* or *continuing treatment by a health care provider*. For more information about the definitions of a serious health condition under the FMLA, see the chart at the end of the form.

You also may, but are **not required** to, provide other appropriate medical facts including symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment. Please note that some state or local laws may not allow disclosure of private medical information about the patient's serious health condition, such as providing the diagnosis and/or course of treatment.

Health Care Provider's name: *(Print)* _____

Health Care Provider's business address: _____

Type of practice / Medical specialty: _____

Telephone: (____) _____ Fax: (____) _____ E-mail: _____

PART A: Medical Information

Limit your response to the medical condition for which the employee is seeking FMLA leave. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. **After completing Part A, complete Part B to provide information about the amount of leave needed.** Note: For FMLA purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

(1) Patient's Name: _____

(2) State the approximate date the condition started or will start: _____ *(mm/dd/yyyy)*

(3) Provide your **best estimate** of how long the condition lasted or will last: _____

(4) For FMLA to apply, care of the patient must be medically necessary. Briefly describe the type of care needed by the patient *(e.g., assistance with basic medical, hygienic, nutritional, safety, transportation needs, physical care, or psychological comfort)*.

_____

_____

Employee Name: _____

(5) Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

☐ **Inpatient Care**: The patient (☐ has been / ☐ is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): _____

☐ **Incapacity plus Treatment**: *(e.g. outpatient surgery, strep throat)*
Due to the condition, the patient (☐ has been / ☐ is expected to be) incapacitated for *more than* three consecutive, full calendar days from _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*.

The patient (☐ was / ☐ will be) seen on the following date(s): _____

_____

The condition (☐ has / ☐ has not) also resulted in a course of continuing treatment under the supervision of a health care provider *(e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment)*

☐ **Pregnancy**: The condition is pregnancy. List the expected delivery date: _____ *(mm/dd/yyyy)*.

☐ **Chronic Conditions**: *(e.g. asthma, migraine headaches)* Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

☐ **Permanent or Long Term Conditions**: *(e.g. Alzheimer's, terminal stages of cancer)* Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

☐ **Conditions requiring Multiple Treatments**: *(e.g. chemotherapy treatments, restorative surgery)* Due to the condition, it is medically necessary for the patient to receive multiple treatments.

☐ **None of the above**: If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed. Go to page 4 to sign and date the form.

(6) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. *(e.g., use of nebulizer, dialysis)* _____

_____

PART B: Amount of Leave Needed

For the medical condition(s) checked in Part A, complete all that apply. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine if the benefits and protections of the FMLA apply.

(7) Due to the condition, the patient (☐ had / ☐ will have) **planned medical treatment(s)** (scheduled medical visits) *(e.g. psychotherapy, prenatal appointments)* on the following date(s): _____

_____

(8) Due to the condition, the patient (☐ was / ☐ will be) **referred to other health care provider(s)** for evaluation or treatment(s).

State the nature of such treatments: *(e.g. cardiologist, physical therapy)* _____

Provide your **best estimate** of the beginning date _____ *(mm/dd/yyyy)* and end date _____ *(mm/dd/yyyy)* for the treatment(s).

Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery

_____ *(e.g. 3 days/week)*

Employee Name: _____

(9) Due to the condition, the patient (☐ was / ☐ will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.

Provide your **best estimate** of the beginning date: _____ *(mm/dd/yyyy)* and end date _____ *(mm/dd/yyyy)* for the period of incapacity.

(10) Due to the condition it, (☐ was / ☐ is / ☐ will be) medically necessary for the employee to be absent from work to provide care for the patient on an **intermittent basis** (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, episodes of incapacity are estimated to occur _____ times per (☐ day / ☐ week / ☐ month) and are likely to last approximately _____ (☐ hours / ☐ days) per episode.

Signature of Health Care Provider _____ **Date** _____ *(mm/dd/yyyy)*

Definitions of a Serious Health Condition *(See 29 C.F.R. §§ 825.113-.115)*
Inpatient Care
• An overnight stay in a hospital, hospice, or residential medical care facility. • Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.
Continuing Treatment by a Health Care Provider (any one or more of the following)
Incapacity Plus Treatment: A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either: o Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or, o At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.
Pregnancy: Any period of incapacity due to pregnancy or for prenatal care.
Chronic Conditions: Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.
Permanent or Long-term Conditions: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.
Conditions Requiring Multiple Treatments: Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.

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 C.F.R. § 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 15 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 Avenue, N.W., Washington, D.C. 20210.

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