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 or 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 with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation 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 a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

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 one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

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;
- 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. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.

DECLARATION OF RELATIONSHIP
For Family and Medical Leave (FML)

This form should be completed by the employee when the employee requests FML:

- to care for a family member with a serious health condition; or
- for parental leave.

Please note:

- This declaration is for FML purposes only and does not establish benefits eligibility for the family member.
- The University may ask for reasonable documentation to confirm the family relationship referenced below.

EMPLOYEE'S NAME (Last)	(First)	(Middle Initial)

EMPLOYEE'S DEPARTMENT

FOR REQUESTS FOR LEAVE TO CARE FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION:

☐ I am requesting FML to care for: _____

who is my: _____ and has a serious health condition.
[specify relationship with the employee]

This leave may be taken to care for the employee's **spouse, domestic partner, child** or **parent**.

Please note:

- "Child" means a biological, adopted, step, or foster child of the employee or a legal ward of the employee.
- "Child" also means a child to whom the employee stands *in loco parentis*, meaning that the employee has day-to-day responsibilities to care for or financially supports the child.
- The child must be under 18 or incapable of self-care due to a mental or physical disability.
- "Parent" means a biological, adopted, step, or foster parent.
- "Parent" also means a person who stood *in loco parentis* to the employee when the employee was a child, meaning that the person had day-to-day responsibilities to care for or financially supported the employee when the employee was a child.
- "Parent" does not mean a parent in law.

FOR REQUESTS FOR PARENTAL LEAVE:

☐ I am requesting parental leave to bond with my newborn child, _____

whose birth date was: _____ or is anticipated to be: _____

OR

☐ I am requesting parental leave to bond with: _____

a child who was or will be placed in my care on: _____

This leave must be taken within 12 months of the birth or placement of the child with the employee, as applicable. If leave is being taken in connection with the adoption or foster placement of a child, the employee may use this leave before the actual placement or adoption if the employee's absence from work is required for the adoption or foster care placement to proceed.

Please note:

- "Child" means a biological, adopted, step, or foster child of the employee or a legal ward of the employee.
- "Child" also means a child to whom the employee stands *in loco parentis*, meaning that the employee has day-to-day responsibilities to care for or financially supports the child.
- If the child is not yet named, some description of the child should be included.

SIGNATURE

I Certify that the foregoing is true.

EMPLOYEE SIGNATURE	DATE

Print Form

CERTIFICATION OF HEALTH CARE PROVIDER FOR FAMILY MEMBER'S SERIOUS HEALTH CONDITION

Family and Medical Leave Act ("FMLA") & California Family Rights Act ("CFRA")

PURPOSE of FORM: The below-named employee has requested a leave of absence to care for a family member with a health condition, which may qualify as a protected leave under the FMLA and/or CFRA. This medical certification form will provide the University with information needed to determine if the employee's requested leave is for a qualifying reason under the FMLA and/or CFRA. Section III must be fully completed by the health care provider.

INSTRUCTIONS to EMPLOYEE: Please complete and sign Section II before giving this form to your family member or his/her health care provider. You are required to submit a timely, complete, and sufficient medical certification to support your request for FMLA and/or CFRA leave due to your family member's serious health condition. Providing this completed form is required to obtain (or retain) the benefit of FMLA and/or CFRA protections for your leave. Failure to provide a complete and sufficient medical certification to the University may result in a delay or denial of your leave request.

This form should be completed and returned within 15 calendar days of the University's request for this information, or no later than _____.

If you cannot return the completed form within the stated deadline, please contact _____ with the reasons for the delay and the date when the certification will be provided. You may return the form in person, by mail, or by fax. The fax number is _____.

You should include a fax cover sheet marked "**CONFIDENTIAL**" and address your fax to:

"ATTENTION: _____."

SECTION I – To be completed by THE UNIVERSITY

Employee's Name

Name of University Representative

University Representative Department Address	Phone

SECTION II – To be completed by EMPLOYEE

INSTRUCTIONS to EMPLOYEE: Please complete and sign Section II before giving this form to your family member or his/her health care provider. You are required to submit a timely, complete, and sufficient medical certification to support your request for FMLA and/or CFRA leave due to your family member's serious health condition. Providing this completed form is required to obtain (or retain) the benefit of FMLA and/or CFRA protections for your leave. Failure to provide a complete and sufficient medical certification to the University may result in a delay or denial of your leave request.

This form should be completed and returned within 15 calendar days of the University's request for this information, or no later than _____.

If you cannot return the completed form within the stated deadline, please contact _____ with the reasons for the delay and the date when the certification will be provided. You may return the form in person, by mail, or by fax. The fax number is _____.

You should include a fax cover sheet marked "**CONFIDENTIAL**" and address your fax to:

"ATTENTION: _____."

Name of family member for whom you will provide care:

If family member is your child, date of birth:	Relationship of family member to you:

If the child is 18 years of age or older, is the child incapable of self-care because of a mental or physical disability?	☐ No ☐ Yes

(1) Describe care you will provide to your family member and estimate the duration of leave needed to provide care.

(2) Are you requesting leave on an intermittent or reduced schedule basis?	☐ No ☐ Yes

If yes, please describe the leave schedule you are requesting:

SIGNATURE

EMPLOYEE SIGNATURE	DATE

SECTION III – To be completed by HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA and/or CFRA to care for your patient. Please answer, fully and completely, all applicable parts below. 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 "indefinite," "unknown," or "indeterminate" may not be sufficient to determine FMLA/CFRA coverage.

THE GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA): 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.

NOTE: DO NOT DISCLOSE ANY UNDERLYING DIAGNOSES WITHOUT THE PATIENT'S CONSENT.

Limit your responses to the condition for which the patient needs the employee's care. Please be sure to sign and date the form on Page 2.

Provider's Name:

Business Address:

Telephone	Fax

PART A: MEDICAL FACTS

(1) Approximate date condition commenced: _____	Probable duration of condition: From: _____ To: _____

(2) Page 3 describes what is meant by a "serious health condition" under both the FMLA and CFRA. Does the patient's condition qualify under any of the categories described? ☐ No ☐ Yes

If yes, which type of serious health condition listed on Page 3 applies:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

PART B: AMOUNT OF CARE NEEDED

When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

(1) Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ☐ No ☐ Yes

Estimate the beginning and ending dates for the period of incapacity:

During this time, does the patient's condition warrant the participation of the employee? (In answering this question, please review the employee's statement of care in Section II, page 1.) ☐ No ☐ Yes

(2) If the employee has requested leave on an intermittent or reduced schedule leave basis (see answer in Section II, page 1, question 2), is it medically necessary for the patient to receive care on an intermittent or reduced schedule basis, including any time for recovery? ☐ No ☐ Yes

If yes, estimate the hours the patient needs care from the employee:

Hours per Day _____	Days Per Week: _____	From: _____	Through: _____

SIGNATURE

Signature of HEALTH CARE PROVIDER	Date

Print Form

Serious Health Conditions

A "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves one of the following:

1. Inpatient Care

Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

2. Incapacity of More Than 3 Consecutive Days Plus Continuing Treatment by a Health Care Provider

A period of incapacity of more than three consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:

(a) Treatment two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provided, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; OR

(b) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider (e.g., a course of prescription medication, or therapy requiring special equipment, to resolve or alleviate the health condition). Note: This does not include taking over-the-counter medications or activities that can be initiated without a visit to a health care provider (e.g., bed rest, exercise, drinking fluids).

3. Pregnancy

A period of incapacity due to pregnancy, childbirth, or related medical conditions. This includes severe morning sickness and prenatal care.

4. Chronic Conditions Requiring Treatment

A chronic condition which:

(a) Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;
(b) Continues over an extended period of time (including recurring episodes of a single underlying condition); and
(c) May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

5. Permanent/Long-Term Conditions Requiring Supervision

A period of incapacity that is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

6. Multiple Treatments (Non-Chronic Conditions)

Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.) severe arthritis (physical therapy), or kidney disease (dialysis).

Print Form

RETURN TO WORK CERTIFICATION
For Family and Medical Leave (FML)

SECTION I – To be completed by THE EMPLOYER

EMPLOYEE'S NAME (LAST, FIRST, MIDDLE INITIAL)

EMPLOYEE'S DEPARTMENT

DEPARTMENT CONTACT

DEPARTMENT CONTACT'S MAILING ADDRESS

PHONE	FAX	E-MAIL

SECTION II – To be completed by HEALTH CARE PROVIDER

NAME OF HEALTH CARE PROVIDER

ADDRESS	PLACE ADDRESS STAMP HERE:

PLEASE COMPLETE THE FOLLOWING AND RETURN THE FORM TO THE EMPLOYEE

OR TO THE DEPARMENT CONTACT LISTED ABOVE PRIOR TO THE RETURN TO WORK DATE

Important: Please limit your answers below to the serious health condition for which the Employee has been on leave.

THE GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA): 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.

1. Is the employee now able to perform those essential functions of his or her job that she could not previously perform because of the serious health condition for which the employee has been on leave?

   ☐ No.
   ☐ Yes.
   ☐ Yes, with restrictions

2. Employee released to return to work effective: _____ *[indicate date]*

3. If the Employee is released to work but is restricted in his or her ability to perform the essential functions of his or her job as a result of the serious health condition for which the employee has been on leave, please describe those restrictions:

4. The foregoing restrictions are:

   ☐ Permanent
   ☐ Temporary, until: _____ *[indicate date]*

SIGNATURE

SIGNATURE OF HEALTH CARE PROVIDER	DATE

Print Form