LSU - HEALTH CARE SERVICES DIVISION
BATON ROUGE, LOUISIANA

POLICY NUMBER:	4551-22
CATEGORY:	Human Resources
CONTENT:	Family Medical Leave Act (FMLA) Classified/Unclassified Employees
APPLICABILITY:	This policy shall be applicable to all "Qualified" classified and "regular" unclassified employees at the Health Care Services Division Administration (HCSDA) and Lallie Kemp Medical Center (LKMC). For purpose of this policy, "regular" unclassified employees are defined as monthly unclassified employees and bi-weekly unclassified employees serving in a regular, leave earning, and benefits eligible appointment.
EFFECTIVE DATE:	Issued: October 31, 2006 Reviewed: December 20, 2007 Reviewed and Revised: February 4, 2009 Reviewed: October 20, 2010 Reviewed: August 13, 2014 Reviewed: March 4, 2015 Reviewed: October 18, 2016 Reviewed: September 1, 2017 Reviewed: December 18, 2018 Reviewed: June 9, 2020 Reviewed: March 10, 2022
INQUIRIES TO:	Human Resource Administration LSU Health Care Services Division Post Office Box 91308 Baton Rouge, LA 70821-1308 Telephone: (225) 354-4843 Fax: (225) 354-4851

Note: Approval signatures/titles are on the last page.

LSU HEALTH CARE SERVICES DIVISION
FAMILY AND MEDICAL LEAVE POLICY
FOR CLASSIFIED AND UNCLASSIFIED EMPLOYEES

I. STATEMENT OF POLICY

In compliance with the Family and Medical Leave Act (FMLA) effective 08/05/93 and additions made regarding military families signed in to law on January 16, 2009, it shall be the policy of the Health Care Services Division (HCSD) to provide "qualified employees" with a minimum of 480 hours of paid, unpaid or a combination of both during the designated twelve month period for FMLA "qualifying events"; Up to (26) workweeks of leave to care for a covered service member with a serious illness or injury incurred in the line of duty in active duty status.

Leave for qualifying reasons shall be granted and charged under the applicable leave category (compensatory, annual, sick leave and leave without pay) as outlined in this policy.

Provisions of this policy extend to both classified and unclassified employees, unless otherwise noted.

Note: Any reference herein to Health Care Services Division (HCSD) also applies and pertains to Lallie Kemp Medical Center.

II. IMPLEMENTATION

This policy and subsequent revisions to this policy shall become effective upon approval signature and date of the HCSD Chief Operations Officer or Designee.

III. POLICY PROVISIONS

A. Qualified Employees

1. Employees who have been employed by the State of Louisiana for at least twelve (12) months on the date on which any FMLA qualifying event is to begin and**,** have physically worked at least 1,250 hours within state service, including overtime, during the previous twelve (12) month period. Paid and unpaid leave is not counted as part of the 1,250 hours, except for military leave.

2. The twelve (12) month employment period need not be consecutive months. If an employee is maintained on the payroll for any part of a week, the time counts as one (1) week of employment.

B. Qualifying Events

1. The birth of the employee's child and the leave to care for the newborn child. Applicable leave is to be completed within one (1) year of the birth of the child.

   Note: LA. RS 23:341C (1) and 23:342(2) (b) takes precedent over FMLA. 341C (a): Pregnancy, childbirth, and related medical conditions are treated as any other temporary disability. However, no employer shall be required to provide a female employee disability leave on account of normal pregnancy, childbirth, or related medical condition for a period exceeding six (6) weeks.

   342(2)(b): A female employee will be provided "reasonable, time off/leave", up to four (4) months of any period of time during which the female employee is medically certified disabled due to pregnancy, childbirth, or medical conditions related to pregnancy or childbirth.

2. The placement of a child with the employee for adoption or foster care if taken within one (1) year of the placement of the child.

3. To care for the employee's spouse, child, or parent suffering from a serious health condition.

   Note: Unmarried domestic partners do not qualify for family leave to care for their partners.

4. The employee has a "serious health" condition which renders him/her unable to report to work and to perform the functions of his/her job.

   Note: "Serious Health" condition does not cover short term conditions involving brief periods(s) of treatment/recovery and/or routine doctor/dental appointments and are not counted towards the twelve (12) workweek entitlement.

5. To care for the employee's family member or next of kin that are covered servicemembers with a serious illness or injury incurred in the line of duty on active duty, as determined by the U.S. Department of Defense. (See Military/Leave Entitlement section for more details)

6. Helps families of activated National Guard or Reserves deal with "any qualifying exigency" that might come up. (See Military Leave/Entitlement section for more details)

C. Entitlement

1. An eligible employee's FMLA leave entitlement is limited to a total of 12 workweeks of leave (480 hours) during any 12-month period for any one or more of the following reasons:

   a. The birth of the employee's son or daughter, and to care for the newborn child.
   b. The placement with the employee of a son or daughter for adoption or foster care, and to care for the newly placed child.
   c. To care for the employee's spouse, son, daughter or parent with a serious health condition.
   d. For the employee's own serious health condition.
   e. Qualified exigencies due to a covered service member being called to covered active duty.
   f. To care for a covered service member who is injured or becomes ill while on covered active duty.

2. Just because an employee qualifies for FMLA leave for one or several needs, he or she may not take more than 12 workweeks (480 hours) of leave within a 12-month period. It is not an entitlement of twelve (12) weeks by category.

3. Entitlement is limited to a combined total of twelve (12) workweeks when the employee and his/her spouse are both employed by the State and FMLA is necessary due to the following:

4. The twelve (12) workweek entitlement period shall begin with the date of first usage.

   Example: 10/04/93 - 1st date of FMLA entitlement
   10/03/94 - 12 month period ends

5. FMLA entitles an eligible employee who takes FMLA leave to be restored to the same position that the employee held when the leave started, or to an equivalent position. Equivalent pay and other terms and conditions of employment, including group health coverage, benefits, shift assignment, etc. in place prior to commencement of FMLA leave must also be restored.

D. Definitions/Record Keeping

Refer to Attachment #1 for FMLA definitions, Attachment #2 for Examples of Serious Health Conditions, & Attachment #3 for record keeping requirements.

E. Requests for Leave/Employee Notice Forms

1. FMLA Request and Notice of Leave Rights Form (Attachment #4) shall be provided to and completed by the employee for each occurrence of leave qualifying under FMLA. When need for leave is foreseeable, the employee shall make every effort to provide a minimum of 30 days advanced notice to their appointing authority or his/her designated representative. When need for leave is not foreseeable, the employee shall make every effort to submit their request and notice as soon as possible prior to commencement of leave, normally within one or two business days of the date the employee learns of the need for leave.
   a. Failure on the part of the employee to complete and submit appropriate request and employee notice forms may result in delay/denial of leave and/or, disciplinary action as deemed appropriate by the appointing authority.
   b. Absence of request or notice form does not preclude the designation of FMLA leave when absences are for unquestionable FMLA qualifying reasons.

F. Certification/Documentation:

1. When leave (sick, annual, compensatory, LWOP) is utilized due to a medical necessity, the appointing authority or supervisory staff charged with responsibility for administering leave will require certification of physician/practitioner (See "Certification of Physician or Practitioner" Attachment #8) when:
   a. The leave is due to the "serious health" condition of the employee or the employee's spouse, child or parent under the 12 workweek FMLA leave entitlement.
   b. The leave (sick, annual, compensatory, LWOP) is utilized due to medical necessity. i.e., incidental occurrences of leave which are not necessarily applicable to FMLA (routine, doctor, dental appointments, etc.)

2. For purposes of FMLA leave regulations, the employee notice of FMLA leave is to indicate the requirement for timely submission of a physician/practitioner certification. Failure of the employee to provide the timely basis (usually no later than 15 days from the date requested) may result in delay or denial of leave and/or, disciplinary action as deemed appropriate by the appointing authority (Attachment #5).

3. Notification must be sent to the employee if after the FMLA Coordinator reviews the Physician Certification Form and finds that the illness indicated does not qualify them entitlement under the Family and Medical Leave Act (Attachment #6).

4. The absence of required forms does not preclude the designation of FMLA leave when absences are for unquestionable FMLA

qualifying reasons.

5. Documentation may be required to establish the legal relationship of the employee to spouse, child, parent and/or "Loco Parentis"; or, to document the official placement of a child for adoption or foster care.

G. Designation of Leave

1. It shall be the responsibility of the appointing authority or the staff who have been delegated authority for leave administration to designate leave, paid or unpaid, as FMLA qualifying, based upon information provided by the employee; and to determine the appropriate leave category to be charged. (Attachment #7)

2. The designation of leave as an FMLA qualifying event requires that employees be provided a Notice of designation and the employee's responsibilities. (Attachment #4). At this point, any leave that was coded under FMLA needs to be corrected.

3. FMLA leave shall be approved intermittently; or, when agreed on by the employee and the appointing authority, a reduced work schedule when requested by the employee and to be medically necessary. If the need for a reduced workweek or to take leave intermittently is foreseeable, based on planned medical treatment, an appointing authority may temporarily transfer the employee to a position with equivalent pay and benefits in order to better accommodate recurring periods of leave and to meet the needs of the agency. Employees must make a reasonable effort to schedule such treatments to prevent unnecessary disruptions of the employer's business operations.

4. HCSD shall require the use of all applicable accrued balances of paid leave (annual, sick and compensatory) prior to granting unpaid leave (LWOP).

5. FMLA leave whether annual, sick, compensatory, or LWOP, etc., shall be administered in accordance with this policy.

IV. MILITARY LEAVE/ENTITLEMENT

A. Qualified Employees

1. Employees who have been employed by the State of Louisiana for at least twelve (12) months on the date on which any FMLA qualifying event is to commence and, have worked at least 1,250 hours within state service during the previous twelve (12) month period.

2. The twelve (12) month employment period need not be

consecutive months. If an employee is maintained on the payroll for any part of a week, the time counts as one (1) week of employment.

B. Qualifying Event

1. To care for the employee's family member or next of kin that are covered servicemembers with a serious illness or injury incurred in the line of duty on active duty, as determined by the U.S. Department of Defense.

2. Helps families of activated National Guard or Reserves deal with "any qualifying exigency" that might come up. Examples of this could be:
   a. Short-notice deployment, meaning a call or order that's given no more than seven calendar days before deployment (the employee can take up to seven (7) days beginning on the date of notification).
   b. For military events and related activities, such as official military-sponsored ceremonies and family support and assistance programs sponsored by the military and related to the family member's call to duty.
   c. For urgent (as opposed to recurring and routine) child-care and school activities, such as arranging for child care.
   d. For financial and legal tasks, such as making or updating legal arrangements to deal with the family member's active duty.
   e. For counseling for the employee or his/her minor child that isn't already covered by the FMLA.
   f. To spend time with the covered service member on rest and recuperation breaks during deployment, for up to five (5) days per break.
   g. For post-deployment activities such as arrival ceremonies and reintegration briefing or to address issues from the service member's death while on active duty.
   h. Other purposes arising out of the call to duty, as agreed to by the employee and employer.

C. Entitlement

1. To care for the employee's family member or next of kin that are covered servicemembers with a serious illness or injury incurred in the line of duty on active duty.

   Entitlement is limited to a combined total of twenty-six (26) workweeks when the employee and his/her spouse are both employed by the State and FMLA is necessary due to the following.
   a. The 26 weeks of leave may be taken in a single block or intermittently.
   b. The 26 weeks' entitlement may not be carried over from

year to year.

Example # 3: Military caregiver
Spouse of a qualified servicemember may take 26 weeks of military caregiver leave for her spouse's qualifying leg injury in year one and take additional military caregiver leave in year two for her daughter's qualifying injury or for her spouse's second, unrelated illness or injury.

2. Helps families of activated National Guard or Reserves deal with "any qualifying exigency" that might come up.
   a. Entitlement allows eligible employees to take up to 12 weeks of FMLA leave for a "qualifying exigency" arising from the fact their spouse, child, or parent is on active duty or has been called to active duty.
   b. The 12 weeks of leave may be taken in a single block or intermittently.
   c. The 12 weeks' entitlement may not be carried over from year to year.

3. An employee returning from active military duty must be treated as if he were continuously employed. If the time spent on military leave combined with the time worked over the preceding 12 months equals 1250 hours, the employee is eligible and entitled to FMLA qualifying events.

D. Certification/Documentation
   1. The leave is due to the recovering for an illness and injury of the employee or employee's family member or next of kin incurred in the line of duty on active duty under the 26 workweek FMLA leave entitlement. (Attachment # 9)
      a. Employees seeking caregiver leave must follow existing FMLA notice rules, including the requirement to work with you to schedule leave without unduly disrupting operations.
      b. Documentation stating that the servicemember's injury or illness was incurred in the line of duty on active duty and they are undergoing treatment for such injury or illness by a health care provider (Attachment # 9).

   2. The leave is due to the "qualifying exigency" arising out of the active duty or call to active duty status of a spouse, son, daughter, or parent under the 12 workweek FMLA leave entitlement. (Attachment # 10)
      a. When seeking qualifying exigency leave the employee must give reasonable and practicable notice if the exigency is foreseeable. The notice must indicate that a family member is on active duty or has been called to active duty status, cite a listed reason for leave, and give the anticipated

length of absence.

b. Qualifying employees must complete (Attachment # 10), that provides documentation of the service member active-duty orders. After getting the complete, sufficient certification supporting a request for qualifying exigency leave, you many NOT request additional information. Recertification isn't permitted.

V. EXCEPTIONS

Any exceptions to this policy must be approved by the HCSD Chief Operations Officer (COO) or Designee. Requests for exception shall be submitted to the HCSD Human Resources Administration for review and forwarding to the COO.

FMLA DEFINITIONS

CHILD - A biological, adopted or foster child, a stepchild, a legal ward, or a child of a person standing in loco parentis, who is under 18 years of age.

A biological, adopted or foster child, a stepchild, a legal ward, or a child of a person standing in loco parentis, who is 18 years of age or older and incapable of self care because of a mental or physical disability.

Note: Incapable of self care is defined as individual needs active assistance or supervision to provide daily self care in a minimum of three (3) of the "activities of daily living (ADL).

Activities of daily living (ADL) examples: caring appropriately for one's grooming/hygiene, bathing, dressing, eating; OR instrumental activities of daily living (IADL) such as cooking, cleaning, shopping, taking public transportation, paying bills, maintenance of residence, using telephone, etc.

A child 18 years of age or older who meets the definition of child due to incapability of self care as described within this definition will need physician certification indicating permanent or long term serious health conditions, or physical/mental disability.

Note: Transitions such as recovery from surgery would be short time and NOT substantially limiting.

Child with regards to active duty or call to active duty status means the employee's biological, adopted, or foster child, stepchild, legal ward, or a child for whom the employee stood in loco parentis, who is of any age.

NEXT OF KIN – means the nearest blood relative other than the covered servicemember's spouse, parent, son or daughter, in the following order of priority (brother, sister, grandparent, aunts and uncles, and first cousins unless specifically designated in writing another blood relative as his or her nearest blood relative for purposes of military caregiver leave under the FMLA.

QUALIFYING EXIGENCY LEAVE – Something needing immediate action or a difficult situations requiring urgent action. This leave can only be used by families of National Guard and reserves and certain retired member of the military. This leave applies only to a federal call to duty or a state call under order of the President.

QUALIFYING SERVICE MEMBER – Regular armed forces, the reserves, the National Guard or can be anyone in those categories on a temporary disability retired list (TDRL).

CONTINUING TREATMENT BY A HEALTH CARE PROVIDER

1. The employee or family member must be incapacitated for more than three (3) consecutive, full days and has made two (2) visits to a health care provider within 30 days from the first day of incapacity.
2. The employee or family member is treated for the injury or illness two or more times by a provider of health care services (e.g., physical therapist) under orders of or on referral by a health care provider, or is treated for the injury or illness 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 (for example, a course of medication or therapy) to resolve health condition

HEALTH CARE PROVIDER

1. A doctor of medicine or osteopathy who is authorized to practice medicine or surgery;
2. Podiatrists, dentists, clinical psychologists, optometrists, and chiropractors (limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray to exist) authorized to practice, and performing within the scope of their practice;
3. Nurse practitioners and nurse-midwives who are authorized to practice, and who are performing within the scope of their practice; or
4. Christian Science practitioners listed with the First Church of Christ Scientist in Boston, Massachusetts.

INCAPACITY – Inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment, or recovery.

INCAPABLE OF SELF CARE - The individual requires active assistance or supervision to provide daily self-care in three or more activities of the "activities of daily living (ADLs)" or instrumental activities of daily living (IADLS). (i.e., caring appropriately for one's grooming and hygiene, bathing, dressing, eating, cooking, cleaning, shopping, taking public transportation, paying bills, maintaining a residence; using a post office, telephones, directories, etc.)

INTERMITTENT LEAVE - Leave taken in separate periods of time due to a single illness or injury, rather than for one continuous period of time, and may include leave of periods from a half-hour or more to several weeks (i.e., leave taken on an occasional basis for medical appointments, or leave taken several days at a time spread over a period of six months, such as for chemotherapy).

LOCO PARENTIS - The term for those individuals with day-to-day responsibilities for caring for a child. Regulations add the term to include those with day-to-day responsibilities to "care for and financially support" a child. A biological or legal relationship is not necessary; however, documentation of the responsibility for care and support may be required; i.e.: affidavit signed by notary and/or two witnesses, income tax returns, etc...

PARENT - Defined as the biological parent or an individual who stands or stood in loco parentis when the employee was a child. This term does not include parents "in-law".

PHYSICAL OR MENTAL DISABILITY - Physical or mental impairment that substantially limits one or more of the major life activities (i.e., lifting, standing, stooping, hearing, seeing, etc..).

REDUCED LEAVE SCHEDULE - Leave schedule that reduces the usual number of hours per work week or hours per work day.

SPOUSE - A husband or wife as defined or recognized under State law for purposes of marriage.

SERIOUS HEALTH CONDITION - An illness, injury, impairment, or physical or mental condition that involves: (See Attachment #2 for examples)

1. Conditions requiring an overnight stay in a hospital or other medical care facility (I.e. hospice, or residential medical care facility)
2. Conditions that incapacitate you or your family member (for example, unable to work or attend school) for more than three (3) consecutive days and have ongoing medical treatment (either multiple appointments with a health care provider, or a single appointment and follow-up care.
3. Continuing treatment by (or under supervision of) a health care provider for a chronic or long-term health condition that is incurable or so serious that, if not treated, would likely result in a period of incapacity of more than three (3) calendar days.
4. Pregnancy (including prenatal medical appointments, incapacity due to morning sickness, and medically required bed rest)

Note: Voluntary or cosmetic treatments (such as most treatment for orthodontia or acne) which are not medically necessary are not "serious health conditions", unless inpatient hospital care is required. Restorative dental surgeries after an accident or removal of cancerous growths are serious health conditions provided all the other conditions are met (1, 2, or 3). Treatments for allergies or stresses, or for substance abuse, are serious health conditions if all conditions are met (1, 2, or 3). Prenatal care is included as a serious health condition. Routine preventive physical examinations are excluded.

STRESS – Stress in and of itself is not an FMLA qualifying condition unless it meets the definition of serious health condition. Even if an employee gets a doctor to write a note “prescribing” rest, the employee does not qualify for FMLA unless there’s some additional treatment ordered, such as medication or counseling.

EXAMPLES OF SERIOUS HEALTH CONDITIONS (NOT INCLUSIVE)

Appendicitis.
Back conditions requiring extensive therapy or surgical procedures.
Emphysema.
Heart Attack.
Heart conditions requiring bypass or valve operations.
Injuries caused by accidents
Most cancers.
Ongoing pregnancy, severe morning sickness, prenatal care, childbirth and recovery.
Pneumonia
Restorative dental surgery after an accident
Removal of cancerous growths
Allergies
Stress (if all conditions are met and under continuing treatment of a health care provider, such as medication or counseling).
Severe arthritis.
Severe nervous disorders
Severe respiratory conditions.
Severely ill but not receiving continuing active care from a doctor, such as Alzheimer's, late-stage cancer.
Strokes
Treatment for substance abuse if inpatient treatment is required.
Treatment for serious, chronic health condition which, if left untreated, would likely result in an absence of more than (3) days

EXAMPLES OF SERIOUS HEALTH CONDITIONS/INTERMITTENT OR REDUCED LEAVE SCHEDULE MEDICALLY NECESSARY

1. A course of medication or therapy to resolve condition.
2. Treatment for early stage cancer (chemotherapy).
3. Physical therapy after a hospital stay or because of severe arthritis.
4. Prenatal care.

FMLA Record Maintenance

1. Basic payroll and identifying employee data, including name, address, and occupation; rate or basis of pay and terms of compensation; daily and weekly hours worked per pay period; additions to or deductions from wages; and total compensation paid;

2. Dates FMLA is taken by employees;

3. If FMLA leave is taken in increments of less than one full day, the hours of the leave;

4. Copies of employee notices of leave (application for leave shall indicate FMLA in "Remarks " section);

5. Any documents describing employees benefits or employer policies and practices regarding the taking of paid and unpaid leave;

6. Premium payments of employee benefits;

7. Records of any dispute between the employer and an employee regarding designation of leave as FMLA leave;

Medical certifications, re-certification or medical histories of employees or employee's family members shall be maintained in separate files and be treated as confidential.

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FAMILY/MEDICAL LEAVE REQUEST FORM/NOTICE OF LEAVE RIGHTS

Please read and acknowledge by signature below

Name:_____Position/Dept/Sec/Unit:_____

Date(s) for which leave is requested: _____

FMLA Entitlement: I understand that the requested leave will be counted as part of my available 12 workweeks of FMLA leave entitlement and that the 12 month entitlement period begins on the date of first usage. **(Note: A husband and wife employed by the State of Louisiana are entitled to a combined total of 12 weeks of leave in any 12 month period defined under this policy, for the birth or placement of a child; or to care for a parent with a serious health condition)**

Medical Certification: I understand that if the request for FML is related to my own serious health condition or that of a qualified family member, I must provide medical certification of the serious health condition within 15 calendar days of the date of employer's request and/or the date of this request. I understand that failure to timely provide this certification may result in a postponement or denial of my leave request.

Leave for FMLA reason: I understand that in accordance with the FMLA, HCSD policy requires the utilization of all balances of applicable accrued paid leave, **(compensatory, annual and sick), prior to granting of leave without pay {LWOP}. I** understand that utilization of sick leave is **applicable only if I am unable to perform the functions of my job** due to a serious health condition and may not be used for the illness of a family member.

Health Insurance Premium: I understand that during this period if I go on LWOP that medical insurance premium payments must continue in order to maintain coverage. I must make arrangements through the payroll office, for continuation of premium payments in a manner agreed upon by me and the payroll department of the appointing authority. Failure to make any such payments for more than 30 days may result in termination of coverage.

Return from FMLA leave: I understand that I have a right to be restored to my former position or to an equivalent position upon my return from FMLA and that I will be obligated to supply a fitness for duty certification or **doctor's note releasing me to full duty**. I also understand that if my former position has been eliminated and it would have been eliminated even if I was not on leave, the HCSD will place me in an equivalent position provided such a position is available and I am qualified; if an equivalent position is not available, I understand that I will have no right to reinstatement.

Reporting to Supervisor: I understand that I have an obligation to report to my supervisor on a regular routine basis (weekly) during the period in which I am on FMLA to inform him/her of my status and intention to return to work. I understand that I am required to give my employer notice of any leave that needs to be taken in advance when leave is foreseeable. When leave is not foreseeable, I shall make every effort to submit my request and notice as soon as possible prior to commencement of leave. I understand that if I take FMLA, due to a serious health condition which prevents me from performing the functions of my position, I will not be allowed to return to work until I have presented a fitness for duty certification or doctors note releasing me to full duty on my first day back at work. I will not be able to return to work until I can provide a certificate indicating return to FULL DUTY.

ACKNOWLEDGMENT - All of the information which I have provided above is true and correct to the best of my knowledge. I have read and initialed all of the above statements and fully understand each of my rights, responsibilities and obligations outlined above. **I AM SIGNING THIS FORM OF MY OWN FREE WILL AFTER HAVING BEEN AFFORDED THE OPPORTUNITY TO ASK ANY QUESTIONS I HAVE REGARDING MY RIGHTS, RESPONSIBILITIES AND OBLIGATIONS OR THOSE OF THE HCSD.**

For more details refer to Family Medical Leave Act Policy 4551-07

Employee's Signature/Date: _____

Supervisor's Signature/Date:_____

SAMPLE LETTER

DATE:

Name
Address
Address

Dear Employee Name:

This is to advise you that beginning *Day of the week, Date* leave afforded you for reasons related to *your serious health condition or the serious health condition of a qualified family member* will be applied under the twelve (12) workweek Family and Medical Leave Act (FMLA) entitlement period.

The Act entitles qualified employees a total of 12 workweeks/480 hrs/60 workdays of leave or a combined total of 12 weeks if applicable. Any leave taken in relation to the aforementioned reason(s) will be applied to Family and Medical Leave, whether taken on a continual or intermittent basis. Sick leave under the FMLA entitlement period will extend through your medical release and/or return to duty, or the end of the 12 workweek entitlement period, whichever occurs first. Your leave slips will need to be completed to indicate the applicable type of leave (sick/annual), referencing family and medical leave and the reason. If for a family member, annual leave will be used and also needs to be code as well.

The enclosed "FMLA Employee Acknowledgment/Notice Form" must be read, completed & signed by you and your supervisor. The Physician Certification form must be completed, signed & dated by your physician. The physician must provide effective date of disability, injury or medical condition, prognosis/diagnosis and an estimated date of return to duty. If we find that your illness doesn't qualify you protection under the Family and Medical Leave Act we will contact you. Please return all required documents to *FMLA Coordinator's Name* attention by *Date (at lease 15 days from notice being mailed)*.

Please feel free to contact us at *FMLA Coordinator's phone number* should you need additional information or assistance.

cc: *Supervisor's Name*

SAMPLE LETTER

Date

Name
Address
Address

Dear *Employee Name*:

After reviewing your Physician's Certification Form, the illness indicted does not qualify you entitlement under the Family and Medical Leave Act (FMLA). Please note that this does not affect your current family member's entitlement coverage. If you have any questions please don't hesitate to contact me at *FMLA Coordinator's phone number*.

Sincerely,

FMLA Coordinator
Title

cc: *Supervisor's Name*
Timekeeper

SAMPLE LETTER

DATE: *DATE*

TO: *EMPLOYEE'S SUPERVISOR*
Title

FROM: *HR DIRECTOR'S NAME*
HR DIRECTOR

RE: FAMILY AND MEDICAL LEAVE FOR *Employee's Name*

Attached are copies of the documents which were given to *Employee's Name.*

In compliance with our FMLA monitoring procedures, the individual responsible for recording/entering/approving time for *Employee's Name* will need to send copies of information/documents listed below. This information should be provided beginning with the pay period of *first date of FMLA leave* and should continue through the duration of the FMLA entitlement period or return to duty.

Leave Slips
Payroll sign in/out forms
Time Entry Record

This correspondence should be treated as confidential should not be maintained in any employee file that would be considered public.

Please contact us at *FMLA Coordinator's phone number* should you have any problems or concerns regarding this matter.

cc: Timekeeper

MEDICAL CERTIFICATION FOR FMLA COVERED LEAVE

The purpose of this form is to obtain certification for sick leave and/or other leave covered by the FMLA (with or without pay) for the employee named below. **Date of absence and return are required for this employee to be granted leave.**

Instructions to Employee: Please complete sections **A, B (if applicable), & C**

Instructions to Health Care Provider: Please complete sections **D, E, & F (if applicable)**

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SECTION A: Demographic Information (To be completed by employee. Please print.)

Employee Name/Title: _____

Work Unit: _____Home Phone #: _____

Address: _____

I am requesting leave for an FMLA qualifying event for:

( ) MYSELF ( ) SERIOUSLY ILL FAMILY MEMBER (Complete section B)

****

SECTION B: Seriously Ill Family Member
(To be completed by employee if request for leave is for seriously ill family member. Please print.)

Patient's Name: _____

Relationship to Employee: _____

If seriously ill family member is a child, please complete:
( ) YES Child is under 18 years of age? ( ) YES Child is 18 years of age or older?

Note: A child 18 years of age or older who meets the definition of child due to incapability of self care as described within this definition will need physician certification indicating permanent or long term serious health conditions, or physical/mental disability.

(**Definition of Child**: - A biological, adopted or foster child, a stepchild, a legal ward, or a child of a person standing in loco parentis, who is under 18 years of age.

A biological, adopted or foster child, a stepchild, a legal ward, or a child of a person standing in loco parentis, who is 18 years of age or older and incapable of self care because of a mental or physical disability.

Note: Incapable of self care is defined as individual needs active assistance or supervision to provide daily self care in a minimum of three (3) of the "activities of daily living".

Activities of daily living examples: caring appropriately for one's grooming/hygiene, bathing, dressing, eating; OR instrumental activities of daily living such as cooking, cleaning, shopping, taking public transportation, paying bills, maintenance of residence, using telephone, etc.

Note: Transitions such as recovery from surgery would be short time and NOT substantially limiting.

****

SECTION C: Statement by Employee Requesting/Needing Family Leave (Please Print.)

Diagnosis: _____

Date Condition Commenced: _____

Probable duration of condition and/or care to be provided whichever is applicable:
_____

( ) YES ( ) NO Will leave be taken intermittently? If yes, provide probable schedule
_____

Employee's Signature: _____ Date: _____

****

SECTION D: Health Care Provider - Required Care of Patient

Date patient became incapacitated from work/daily activities: _____

Date patient is anticipated to no longer be incapacitated: _____

( ) YES ( ) NO Did this condition result in in-patient hospitalization (i.e., an overnight stay?)

Describe regimen of treatment prescribed by indicating number of visits, general nature and duration of treatment, including referral to other provider of health services.

_____
_____
_____
_____
_____
_____
_____
_____
_____

( ) YES ( ) NO Will this condition make it medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal scheduled hours per day or days per week?

If yes, please specify the prescribed limitation:
_____
_____
_____

( ) YES ( ) NO ( ) Not Applicable Is the employee unable to perform work of any kind because of a serious health condition?
****

SECTION E. TO BE COMPLETED BY HEALTH CARE PROVIDER
Only if certification relates to care for the employee's seriously ill family member.

( ) YES ( ) NO After a review of the employee's statement in Section C above, is the employee's presence necessary or would it be beneficial for care of the patient (may include psychological comfort)?

If the patient/family member is 18 years of age or older and meets the definition of child (see Section B) due to incapability of self care because of a mental or physical disability, please provide certification below indicating permanent or long term serious health conditions, or physical/mental disability:
_____
_____
_____
_____

( ) YES ( ) NO Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation?

Estimate the period of time care is needed or the employee's presence would be beneficial.

_____

****

SECTION F: Health Care Provider's Name & Signature

I certify that I am a health care provider for the patient described above. As appropriate, I have reviewed the statements in Section C (for leave due to the employee's personal serious illness or for leave to care for a family member) and have completed this form based on that information and my evaluation of the patient's medical condition.

Health Care Provider Name (Please Print): _____

Health Care Provider Signature: _____

Date: _____ Telephone No: _____

Address: _____

Type Practice (including specialty, if any) _____

Certification for Serious Injury or illness of Covered Service member – for Military Family Leave (Family and Medical Leave Act)

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 C.F.R. § 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 C.F.R. § 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 covered military member on active duty or call to active duty status in support of a contingency operation:

_____
First Middle Last

Relationship of covered military member to you: _____

Period of covered military member's active duty: _____

A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes written documentation confirming a covered military member's active duty or call to active duty status in support of a contingency operation. Please check one of the following:

- ☐ A copy of the covered military member's active duty orders is attached.
- ☐ Other documentation from the military certifying that the covered military member is on active duty (or has been notified of an impending call to active duty) in support of a contingency operation is attached.
- ☐ I have previously provided my employer with sufficient written documentation confirming the covered military member's active duty or call to active duty status in support of a contingency operation.

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 an appointment with a counselor or school official, 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 commended: _____

   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:

   □ No □ Yes

   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? □ No □ Yes
   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, to attend counseling, to attend meetings with school or childcare providers, to make financial or legal arrangements, to act as the covered 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

Certification for Qualifying Exigency – for Military Family Leave (Family and Medical Leave Act)

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 C.F.R. § 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 C.F.R. § 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 covered military member on active duty or call to active duty status in support of a contingency operation:

_____
First Middle Last

Relationship of covered military member to you: _____

Period of covered military member's active duty: _____

A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes written documentation confirming a covered military member's active duty or call to active duty status in support of a contingency operation. Please check one of the following:

- ☐ A copy of the covered military member's active duty orders is attached.
- ☐ Other documentation from the military certifying that the covered military member is on active duty (or has been notified of an impending call to active duty) in support of a contingency operation is attached.
- ☐ I have previously provided my employer with sufficient written documentation confirming the covered military member's active duty or call to active duty status in support of a contingency operation.

PART A: QUALIFYING REASON FOR LEAVE

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

_____

_____

_____

_____

_____

4. 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 an appointment with a counselor or school official, 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

4. Approximate date exigency commended:
_____

Probable duration of exigency:
_____

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

☐ No ☐ Yes

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

_____

6. Will you need to be absent from work periodically to address this qualifying exigency? ☐ No ☐ Yes
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, to attend counseling, to attend meetings with school or childcare providers, to make financial or legal arrangements, to act as the covered 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

Document Metadata

Document Name:	4551-22 - FMLA.doc
Policy Number:	4551
Original Location:	/LSU Health/HCSD/4500 - Human Resources
Created on:	03/20/1996
Published on:	03/14/2022
Last Review on:	03/14/2022
Next Review on:	03/14/2023
Effective on:	03/07/2019
Creator:	Townsend, Kathy *HCSD Human Resources Director*
Committee / Policy Team:	Main Policy Team
Owner/SME:	Townsend, Kathy *HCSD Human Resources Director*
Manager:	Townsend, Kathy *HCSD Human Resources Director*
Author(s):	Wicker, Claire M. *PROJECT COORDINATOR*
Approver(s):	Townsend, Kathy *HCSD Human Resources Director*
Publisher:	Wicker, Claire M. *PROJECT COORDINATOR*

Digital Signatures:

Currently Signed

Approver:
Townsend, Kathy
HCSD Human Resources Director

03/14/2022