HUMAN RESOURCES
Illinois State University

Leave of Absence Fact Sheet

When applying for a leave, please follow the steps below. Any questions may be directed to your Benefits Counselor in Human Resources at 309-438-8311 or hrbenefits@ilstu.edu.

Step 1: Review the papers in this packet. Submit all pages of the application materials to Human Resources at 101 Nelson Smith Building, via email at hrbenefits@ilstu.edu, or via fax at 309-438-2102. We request your application for leave at least 30 days prior to your leave begin date. If 30-days' notice is not feasible, then notification must be as soon as possible.

Step 2: Provide Human Resources with the required supporting documentation within 15 calendar days of your leave begin date or application submission date, whichever is later. If you anticipate a delay in providing this documentation, please contact your Benefits Counselor to discuss the situation. Documentation can be submitted to Human Resources at 101 Nelson Smith Building, via fax at 309-438-2102, or via email at hrbenefits@ilstu.edu. It is your responsibility to ensure Human Resources has received the required documentation.

Step 3: Advise your Benefits Counselor throughout your leave of any changes to your anticipated leave start or return to work date(s).

Step 4: Returning to Work

If you have been on a leave for your own serious health condition, you must provide a physician's release to Human Resources as soon as you receive it.

> If your physician returns you to work with restrictions or on a part-time basis, the University may need up to five working days to determine if you will be able to perform your duties according to your job description. During this five-day period, you will remain on leave. You cannot return to work until the University agrees to accept the limitations.

If you are an individual with a disability and need a reasonable accommodation under the Americans with Disabilities Act (ADA) or other state or federal law, you may request an accommodation by contacting the Office of Equal Opportunity and Access at 309-438-3383. More information is available at: https://policy.illinoisstate.edu/conduct/1-3-1.shtml

If you have been on a leave to care for a family member, you do not need to provide a physician's release to Human Resources. You do need to communicate your return to work date to your Benefits Counselor as soon as it is known.

Communication

Communication regarding your leave request will be sent via e-mail to your ilstu.edu account. It is your responsibility to ensure your email account remains active while on leave. Contact the Technology Support Center at 309-438-4357 for assistance.

Employee Rights and Responsibilities

Please refer to the reverse side of this notice to review the Employee Rights and Responsibilities related to FMLA protected leaves. More information may also be found on the Human Resources website. For any questions, please contact your Benefits Counselor by calling 309-438-8311. If you feel your rights have been denied, please forward your appeal to the AVP of Human Resources.

For full policy information, please see the University Policy website at policy.illinoisstate.edu and the Human Resources site at hr.illinoisstate.edu/benefits.

Notice of Rights and Responsibilities for FMLA Protected Leaves

FMLA Leave Entitlement

You have a right under the FMLA to take unpaid, job-protected FMLA leave in a 12-month period for certain family and medical reasons, including up to **12 weeks** of unpaid leave in a 12-month period for the birth of a child or placement of a child for adoption or foster care, for a leave related to your own or a family member's serious health condition, or for certain qualifying exigencies related to the deployment of a military member to covered active duty. You also have a right under the FMLA to take up to **26 weeks** of unpaid, job-protected FMLA leave in a single 12-month period to care for a covered servicemember with a serious injury or illness (*Military Caregiver Leave*).

The 12-month period for FMLA leave is calculated as a "rolling" 12-month period measured backward from the date of any FMLA leave usage. (*Each time an employee takes FMLA leave, the remaining leave is the balance of the 12 weeks not used during the 12 months immediately before the FMLA leave is to start*).

All FMLA leave must be used for the designated leave purpose.

Substitution of Paid Leave

You have a right under the FMLA to request that your accrued paid leave be substituted for your FMLA leave. This means that you can request that your accrued paid leave run concurrently with some or all of your unpaid FMLA leave, provided you meet any applicable requirements of our leave policy. Concurrent leave use means the absence will count against both the designated paid leave and unpaid FMLA leave at the same time. If you do not meet the requirements for taking paid leave, you remain entitled to take available unpaid FMLA leave in the applicable 12-month period. Even if you do not request it, the FMLA allows us to require you to use your available sick, vacation, or other paid leave during your FMLA absence.

*University policy requires you to use all of your available paid leave during your FMLA leave. Any paid leave taken for this reason will also be designated as FMLA leave and counted against the amount of FMLA leave you have available to use in the applicable 12-month period.

Maintain Health Benefits

Your health benefits must be maintained during any period of FMLA leave under the same conditions as if you continued to work. During any paid portion of FMLA leave, your share of any premiums will be paid by the method normally used during any paid leave. During any unpaid portion of FMLA leave, you must continue to make any normal contributions to the cost of the health insurance premiums by paying the State of Illinois directly. Failure to submit payment to the State of Illinois for premiums may result in cancellation of coverage.

You may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave if you do not return to work following unpaid FMLA leave for a reason other than: the continuation, recurrence, or onset of your or your family member's serious health condition which would entitle you to FMLA leave; or the continuation, recurrence, or onset of a covered servicemember' s serious injury or illness which would entitle you to FMLA leave; or other circumstances beyond your control.

Other Employee Benefits

Upon your return from FMLA leave, your other employee benefits, such as pensions or life insurance, must be resumed in the same manner and at the same levels as provided when your FMLA leave began.

Return-to-Work Requirements

You must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA-protected leave. An equivalent position is one that is virtually identical to your former position in terms of pay, benefits, and working conditions. At the end of your FMLA leave, all benefits must also be resumed in the same manner and at the same level provided when the leave began. You do not have return-to-work rights under the FMLA if you need leave beyond the amount of FMLA leave you have available to use.

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FMLA Application for Military Qualifying Exigency or Caregiver Leave

Name: _____ University ID: _____

Employee Type: ☐ Administrative Professional ☐ Civil Service ☐ Faculty/Faculty Associate

Department: _____ Home/Mobile Phone.: _____

Beginning Date for Leave: _____ Estimated Length of Leave: _____

Last Day Worked: _____ Normal Workdays: _____

Type of Leave: ☐ Continuous ☐ Intermittent ☐ Reduced Schedule

Military Family Leave:

Please indicate the reason you are requesting leave:

☐ I have a qualifying exigency arising out of the fact that my ☐ spouse ☐ child ☐ parent is on active duty or call to active duty status in support of a contingency operation to a foreign country as a member of the National Guard or Reserves **OR** is active duty or has been notified of an impending call to active duty as a member of the Regular Armed Forces and is deployed to a foreign country.

Name of service member: _____

☐ I am the ☐ spouse ☐ son or daughter ☐ parent ☐ next of kin of a covered service member with a serious injury or illness.

Name of service member: _____

Personal Plus Benefit Usage:

Indicate below your intention to utilize or not utilize Personal Plus Time during your leave of absence. Personal Plus Time will be used after all other payable benefit time unless the employee indicates otherwise. The usage of Personal Plus Time will follow the indication below and cannot be changed.

☐ Yes, I wish to use Personal Plus Time, if available, during my leave of absence.

☐ No, I do not wish to use Personal Plus Time during my leave of absence.

Please see reverse side (page 2)

Nelson Smith Building 101 Campus Box 1300 Normal, IL 61790-1300
(309) 438-8311 Fax: (309) 438-2102 Email: hrbenefits@ilstu.edu

Please sign your initials to certify that you have read and understand each section below.

___ In order to determine whether your absence qualifies as FMLA leave, requested documentation must be provided within 15 calendar days following the FMLA request date. If documentation is not received within the allowed time period, your leave could be denied.

___ I understand that I will be required to use my available payable benefits during my FMLA absence. This means that I will receive my paid leave and the leave will also be considered protected FMLA leave and counted against my FMLA leave entitlement.

___ I understand that when applying for a FMLA-protected leave, I am responsible for following my normal departmental call-in procedural requirements until notification of approval has been received. When an employee does not comply with the departmental call-in procedural requirements, FMLA-protected leave may be delayed or denied.

___ I understand that if I must notify Human Resources of my impending return as soon as possible if the date changes from original anticipated return to work date.

___ I understand that based on my leave status, I should not complete any University-related work during my leave of absence either on a voluntary basis or by request from my supervisor and/or department. University personnel, including my supervisor/chair, may correspond, communicate, and request information needed to complete work in my absence. If you have any concerns about any requests or communication, please contact your Benefits Counselor to discuss.

___ I understand that while on leave I will be required to furnish Human Resources with periodic reports of my status and intent to return to work when requested.

___ Information and updates regarding my leave will be provided through your Illinois State University email account (xxxxxx@ilstu.edu). It is your responsibility to ensure that your email is active and remains active while on leave. If you require any assistance with your email notifications, please contact the Technology Support Center at 309-438-HELP (4357).

I certify that I have received and read the Leave Fact Sheet and Employee's Rights and Responsibilities. I have read and initialed each section above. I understand that I am required to provide appropriate documentation to substantiate my need for the above leave.

Applicant's Signature: _____ Date: _____

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REQUIREMENTS WHILE ON INTERMITTENT FMLA LEAVE

Please initial each of the following statements indicating that you have read, understand, and will comply with each of these requirements. If you have any questions about this form, it is your responsibility to contact your Benefits Counselor for clarification prior to signing and submitting this form. You may reach your Benefits Counselor at Human Resources by calling (309) 438-8311 (TDD/TTY 309-438-2269).

___Intermittent Leave starts with the date the application is completed or requested.

___Doctor's certification needs to be completed and returned within 15 calendar days of the signed application or the leave could be denied.

___If additional information is needed from the doctor, it will be your responsibility to provide the information within the designated time period.

___If the Intermittent Leave is for scheduled absences, you must provide the dates and times of your scheduled absences to your department (and to Human Resources, if requested).

___Calling in consistent with your department call-in procedures is required. When calling in/reporting an unscheduled absence covered by your Intermittent FMLA Leave, you must clearly designate the absence as FMLA time to whomever you are required to report your absences.

___It is the responsibility of the employee to track and know their FMLA usage.

___Approved Intermittent FMLA Leave can only be used for the medical condition identified on the doctor's certification form.

___When the Intermittent FMLA medical condition prevents you from working more than 3 consecutive days, an application for Continuous FMLA Leave must be completed.

___Partial day absences will count toward the total Intermittent FMLA absence allowance.

___Intermittent Leave ***does*** expire. If the need for leave still exists after the expiration date, it is your responsibility to request an updated leave.

___FMLA time reported on your timesheet should be selected with the designation "FMLA" in the time reporting code drop down menu.

___Extended benefits (150 hours) are not payable while on an Intermittent Leave. Only sick, vacation, or comp time can be used for these absences.

___Employee is responsible for adhering to the frequency and duration of their intermittent leave approval. If frequency and/or duration needs to be changed during the approval period, please contact your Benefit Counselor.

Applicant signature:_____ Date: _____

Nelson Smith Building 101 Campus Box 1300, Normal, IL 61790-1300
Phone: (309) 438-8311 Fax: (309) 438-2102 Email: hrbenefits@ilstu.edu

Certification for Serious Injury or Illness of Covered Service Member for Military Family Leave

SECTION I: For Completion by the EMPLOYEE and/or the COVERED SERVICE MEMBER for whom the Employee Is Requesting Leave.

This section must be completed first before Section II can be completed by a health care provider.

Name of Employee Requesting Leave to Care for Covered Service Member:

_____

Name of Covered Service Member (for whom employee is requesting leave to care):

_____

Relationship of Employee to Covered Service Member Requesting Leave to Care:

☐ Spouse ☐ Parent ☐ Son ☐ Daughter ☐ Next of Kin

Is the Covered Service Member a Current Member of the Regular Armed Forces, the National Guard or Reserves? ☐ Yes ☐ No

If yes, please provide the covered service member's military branch, rank and unit currently assigned to:

_____

Is the covered service member assigned to a military medical treatment facility as an outpatient or to a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients (such as a medical hold or warrior transition unit)? ☐ Yes ☐ No

If yes, please provide the name of the medical treatment facility or unit:_____

Is the Covered Service Member on the Temporary Disability Retired List (TDRL)? ☐ Yes ☐ No

Describe the Care to Be Provided to the Covered Service Member and an Estimate of the Leave Needed to Provide the Care:

_____

_____

_____

SECTION II: For Completion by a UNITED STATES DEPARTMENT OF DEFENSE ("DOD") HEALTH CARE PROVIDER or a HEALTH CARE PROVIDER who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider. INSTRUCTIONS to the HEALTH CARE PROVIDER:

The employee listed on Section I has requested leave under the FMLA to care for a family member who is a member of the Regular Armed Forces, the National Guard, or the Reserves who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list for a serious injury or illness. For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty that may render the service member medically unfit to perform the duties of his or her office, grade, rank, or rating.

A complete and sufficient certification to support a request for FMLA leave due to a covered service member's serious injury or illness includes written documentation confirming that the covered service member's injury or illness was incurred in the line of duty on active duty and that the covered service member is undergoing treatment for such injury or illness by a health care provider listed above. Answer, fully and completely, all applicable parts. 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 FMLA coverage. Limit your responses to the condition for which the employee is seeking leave.

Health Care Provider's Name and Business Address:

_____

_____

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

Type of Practice/Medical Specialty: _____

Please check the appropriate box as to whether you are either: ☐ a DOD health care provider; ☐ a VA health care provider; ☐ a DOD TRICARE network authorized private health care provider; or ☐ a DOD non-network TRICARE authorized private health care provider.

Covered Service Member's medical condition is classified as (Check One of the Appropriate Boxes):

☐ **(VSI) Very Seriously Ill/Injured** – Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

☐ **(SI) Seriously Ill/Injured** – Illness/injury is of such severity that there is cause for immediate concern, but there is no imminent danger to life. Family members are requested at bedside. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

☐ **OTHER Ill/Injured** – a serious injury or illness that may render the service member medically unfit to perform the duties of the member's office, grade, rank, or rating.

☐ **NONE OF THE ABOVE**

Was the condition for which the Covered Service member is being treated incurred in line of duty on active duty in the armed forces? ☐ Yes ☐ No

Approximate date condition commenced: _____

Probable duration of condition and/or need for care: _____

Is the covered service member undergoing medical treatment, recuperation, or therapy? ☐ Yes ☐ No

If yes, please describe medical treatment, recuperation or therapy:

_____

_____

_____

Will the covered service member need care for a single continuous period of time, including any time for treatment and recovery? ☐ Yes ☐ No

If yes, estimate the beginning and ending dates for this period of time: _____

Will the covered service member require periodic follow-up treatment appointments? ☐ Yes ☐ No

If yes, estimate the treatment schedule: _____

Is there a medical necessity for the covered service member to have periodic care for these follow-up treatment appointments? ☐ Yes ☐ No

If yes, please estimate the frequency and duration of the periodic care:

_____

_____

_____

Signature of Health Care Provider: _____ **Date:** _____

3/09