FAMILY AND MEDICAL LEAVE AUTHORIZATION FORM – Extended Absence

Employees who have worked for at least 1,250 hours during the 12-month period immediately prior to this request for FMLA leave are eligible for FMLA leave.

Name ____ T-Number _________________________

Department ____ Hire Date __________________________

TYPE OF LEAVE REQUESTED

Check one box:

[ ] Employee Family and Medical Leave
[ ] Extension of previously taken Employee Family and Medical Leave
Previous days taken were ___________________________
[ ] Leave to care for newborn or adopted child or child place (via state procedure) for foster care

The Leave will begin on __________________________ and end on _____________________________

Reason for Leave (list any medical conditions, etc, relating to the absence):
____
____
____
____
____

REASON FOR LEAVE

I request family and medical leave for the following reason (check one box):

[ ] My personal serious health condition
[ ] Serious health condition of my child
[ ] Serious health condition of my parent
[ ] Serious health condition of my spouse
[ ] Birth of my child
[ ] Adoption of a child by me or placement of a child with me for foster care
[ ] Servicemember leave for a "qualifying exigency"
[ ] Servicemember leave to care for a family member injured in the line of military duty

I understand that this time off will be recorded as FMLA time off and count towards said time off for the current year.

____
Employee Signature

____
Date

INSURANCE PREMIUM RECOVERY AUTHORIZATION FORM

I certify by my signature that I have read and understand the following:

I acknowledge the University's legal right to recover the cost of any premium paid by it to maintain my coverage in group health benefits during any period of unpaid leave under the following conditions:

- I fail to return from leave at the expiration of the leave to which I am entitled; and

- The reason I fail to return to work is not one of the following:
  - The continuation, recurrence, or onset of a serious health condition that entitles me to leave to care for a child, parent or spouse with a serious health condition, or if I am unable to perform the functions of my position due to my own serious health condition; or
  - Other conditions beyond my control prevent me from returning.

Printed Name ________________________________ T-Number _____________________

Signature ____________________________________ Date _________________________

INSURANCE PREMIUM REIMBURSEMENT AGREEMENT

I certify by my signature that I have read and agree to the do the following:

If I fail to return from leave, for any reason other than #1 and #2 above, I agree to coordinate with the University to develop a mutually acceptable schedule to reimburse the University for the cost of any premium paid by it to maintain my coverage in group health benefits during any period of unpaid leave taken by me.

Printed Name ________________________________ T-Number _____________________

Signature ____________________________________ Date _________________________

LEAVE CERTIFICATION REQUIREMENTS

Section I: To request leave for the care of a child, parent, or spouse with a serious health condition

I have attached a certification from the health care provider who is treating my child, parent, or spouse. The certification includes the following:

1. The date on which the condition commenced;
2. The probable duration of the condition;
3. The appropriate medical facts within the knowledge of the health care provider regarding the condition;
4. An estimate of the time needed to care for the individual involved (including any recurring medical treatment;
5. A statement that the condition warrants my participation to provide care.

Section II: To request leave for the care of any employee's personal serious health condition.

I have attached certification from the health care provider who is treating my own serious health condition. The certification includes the following:

1. The date on which my condition commenced;
2. The probable duration of the condition;
3. The appropriate medical facts within the knowledge of the health care provider regarding the condition;
4. A statement that I am unable to perform the functions of my position due to my condition.

Section III: Additional certification requirements for intermittent leave or for leave on a reduced leave schedule

In addition to the foregoing certifications from the health care provider involved, I have attached additional information from the health care provider as stipulated below:

- Leave for the employee
  - A statement of medical necessity for my intermittent leave or reduced leave schedule and the expected duration of the schedule;
  - A listing of the dates of my planned medical treatment and the duration of the treatment(s).
- Leave to care for a son, daughter, spouse or parent
  - A statement attesting to the necessity of intermittent leave or reduced leave for me to provide care or to assist in their recovery;
  - An estimate of the expected duration and schedule of my intermittent or reduced leave.

I certify by my signature that I have read and understand the University's certification policy.

Printed Name ____________________________________ T-Number _________________________

Signature ____ Date _____________________________

CERTIFICATION OF A PHYSICIAN OR PRACTIONER FOR FMLA

Employee's Name ____

Patient's Name ____

Diagnosis____
____

Date condition commenced ________________ Probable duration of condition ___________________

Regiment of treatment to be prescribed (indicate number of visits, general nature and duration of treatment, including referral to other provider of health services. Include schedule of visits or treatments if it is medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal schedule of hours per day or days per week:

By Physician or Practitioner: ____
____
____
____

By another provider of health services, if referred by Physician or Practitioner: _____________________
____
____
____

For care relating to the employee's serious health, complete the following:

Is inpatient hospitalization of the employee required? [ ] Yes [ ] No

Is employee able to perform work of any kind? [ ] Yes [ ] No

Is employee able to perform the functions of the employee's position?
(answer after reviewing statement by employer of essential functions
of the position or after discussing with employee) [ ] Yes [ ] No

Printed Name of Physician or Practitioner ____

Signature of Physician or Practitioner ____

Field of Specialization or Type of Practice ____

Address ____ Date _____________________

<u>For care relating to a family member's serious health, complete the following:</u>

Is inpatient hospitalization of the family member (patient) required? [ ] Yes [ ] No

Does or will the patient require assistance for basic medical
Hygiene, nutritional needs, safety, or transportation? [ ] Yes [ ] No

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

Printed Name of Physician or Practitioner ____

Signature of Physician or Practitioner ____

Field of Specialization or Type of Practice ____

Address ____ Date ____________________

<u>TO BE COMPLETED BY EMPLOYEE:</u>

When Family and Medical Leave is needed to care for a seriously-ill family member, the employee shall state the care he or she will provide and an estimate of the time period during which this care will be provided, including a schedule if leave is to be taken intermittently or on a reduced schedule:
____
____
____
____
____

<u>LEAVE REQUEST WHEN EMPLOYEE & SPOUSE BOTH WORK FOR SUU</u>

Check the leave being requested:

___________ Family & Medical Leave to care for a newly arrived child

___________ Family & Medical Leave to care for a parent with a serious health condition

I have a spouse employed at the University:

Spouse's Name ______________________________ T-Number _____________________

Department ________________________________ Hire Date _____________________

I certify by my signature that I have read the following and agree to abide by it –

In any case in which a husband and wife are:

- Both employed by Southern Utah University;
- Both entitled to leave;
- If the leave is taken for the birth or adoption of a child or to care for the serious health condition of a parent;

<u>then</u> the aggregate number of workweeks of leave to which <u>both</u> may be entitled is limited to twelve (12) workweeks during any 12-month period.

If there is a change in circumstances with respect to the above, I will notify the University immediately.

Printed Name _________________________________ T-Number _____________________

Signature _____________________________________ Date _________________________