

Indiana University FMLA - Form #1

FMLA Leave Notice or Request, Approval and Information

This section to be completed by the department if the employee does not wish to do so:

This Family/Medical Leave of Absence is for the following **qualifying reason**:

- Birth of a child and to care for a newborn child of the employee, spouse as defined by Indiana law, or qualified same sex domestic partner.
- Placement with the employee of a child through adoption or foster care of a child
- Care for the employee's spouse, qualified same sex domestic partner, dependent child, child of the qualified same sex domestic partner, or parent of the employee who has a serious health condition

Name/Relationship of person: _____

Note: Same sex domestic partner and children of partnership coverage must be qualified by the University's Affidavit of Domestic Partnership.

- A serious health condition that renders the employee unable to perform the functions of his or her job

Anticipated date FMLA leave is to begin: _____ **end:** _____ (if known)

If the purpose of FMLA is to care for a sick family member or because of the employee's serious health condition, the leave may be taken intermittently or on a reduced schedule provided such arrangements are medically necessary. Departmental approval for intermittent leave is required if the leave is taken because of a birth or placement of a child. The employee must make a reasonable effort to schedule intermittent leave so as not to disrupt operations and may be temporarily transferred to another position with equivalent pay and benefits.

Employee signature (optional)

Department

Employee name (please print)

Date

This section is to be completed by the department. Copies of this form are to be provided to the employee and to University Human Resource Services or the campus HR office (also see bottom of page 2):

- Leave of absence **approved** (FMLA eligibility requirements met)
- Leave of absence **conditionally approved** pending receipt of medical certification (FMLA eligibility met)
Medical certification due by _____ (at least 15 days must be allowed)
- Leave of absence **denied** because:
- Employee does not meet FMLA eligibility requirements:
 - Employee has not been employed by IU for 12 months
 - Employee has not worked 1250 actual work hours in past 12 months
 - Employee does not have a **qualifying reason** for FMLA
 - Employee's calendar year allotment of FMLA (12 weeks) has been exhausted

Departmental signature (also print name)

Date

Department Point of Contact Name/Number, if different

This "final approval" section is to be completed by the department. Final copies of this form (and Form #2 if for a serious health condition) are to be provided to the employee and to University Human Resource Services or the campus HR office: Medical certification received on _____

- Leave of absence approved (Do **NOT** approve until medical certification is **fully** completed and reviewed.)
- Leave of absence denied: Not a **qualifying reason** for FMLA
 Medical certification not provided

Departmental signature (also print name)

Date

FMLA Information for the Employee:

- You have a right under the FMLA for up to 12 weeks of leave in a calendar year for the reasons listed. This absence will be counted as a part of your annual FMLA leave entitlement of 12 weeks per calendar year.
- If medical certification is required, it must be returned by the specified date or the University may deny the leave. Sections of forms indicated for completion by the health care provider must be *fully* completed by the health care provider and NOT the employee. ALL questions and blanks need to be fully completed by the health care provider for final approval to be granted.
- If your medical leave is due to *your own* serious health condition your health care provider MUST complete the bottom section of the Release/Intent to Return to Work (Form 3) stating that you are fit to return to work. If this medical release is not received, your return to work may be delayed until provided. A release from your health care provider is not required if the FMLA has been for intermittent leave, such as for chronic conditions.
- If your medical leave is due to child placement in your home, or is determined to be intermittent by your health care provider, you will NOT be required to present a medical release prior to being restored to employment.
- Indiana University requires that employees use all accrued paid time (i.e., PTO, vacation, holidays, sick leave, and income protection time) during FMLA leave and before any unpaid time. Check with your department to designate which paid time you want to use first. If accrued overtime compensatory hours are used, it does not count as a part of the 12 weeks of FMLA
- If you now pay a portion of the premiums for health insurance and other benefits, these payments will continue during the period of FMLA leave if you remain in pay status. Contact your human resources office concerning Tax Saver Benefit, continuation of insurance, and premium payments during FMLA. Failure to follow instructions provided may cause your health care and benefits coverage to be cancelled.
- You may be required to furnish recertification relating to a serious health condition (per CFR Section 825.308 of the FMLA regulations).
- At the conclusion of FMLA leave, you will be reinstated to the same position held at the time the leave began or to an equivalent position with equivalent pay, benefits, and working conditions.
- If you do not return to work following FMLA leave for a reason other than 1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; or 2) other circumstances beyond your control, you may be required to reimburse the University for its share of health insurance premiums paid on your behalf during FMLA leave.
- FMLA information can be obtained at:
<http://www.indiana.edu/~uhhrs/policies/uwide/fmla.html>
<http://www.dol.gov/esa/regs/compliance/whd/whdfs28.htm>
If you cannot access these documents, please contact your department for copies.

This section is to be completed by the department.

Departmental signature

Printed Name

Employee's ID#

Employee's Occupational Group/Rank

Date given to employee: _____ **Via:** ___ U.S. Mail ___ Hand Delivered ___ Other (specify): _____