Family Medical Leave Act (FMLA) Employee Packet
Family Medical Leave Act (FMLA)
Introduction and Qualifications

Clemson University recognizes that during an employee’s career, situations requiring prolonged or intermittent absences from work can occur.

Clemson University and the Family and Medical Leave Act (FMLA) provide you with the right to take job-protected leave with continued medical benefits.

Who Can Use FMLA?
In order to take FMLA leave, you must work for a covered employer such as Clemson University and have met these additional criteria:

- You must have been employed by the University for at least 12 months.
  - These 12 months must not be consecutive, but your break in service cannot have been more than a seven-year period.
- You must have worked for the University for at least 1250 hours in the last 12 months before you take leave.
  - This minimum 1250 hours calculation includes actual hours worked, including overtime hours worked.
  - This minimum 1250 hours calculation excludes annual, sick, personal, holiday, or compensatory time.

When Can You Use FMLA?
If you are an eligible employee, you can take up to 12 weeks of FMLA leave in any 12-month period for a variety of reasons, including:

Serious Health Condition
- You are unable to work because of your own serious health condition.
- You need to care for your spouse, child or parent who has a serious health condition.

Military Family Leave
- Your leave is for specified reasons related to certain military deployments.
- You need to care for a covered service member with a serious injury or illness.

Expanding Your Family
- You are unable to work because of the birth of a child and to bond with the newborn child.
- You are unable to work because of the placement of a child for adoption or foster care and to bond with that child.

What Can the FMLA Do for You?
Approved FMLA leave offers you the following:

- 12 weeks of leave in any 12-month period.

- Uninterrupted health care insurance. The University will continue to pay the employer portion of your health insurance premiums, and you will continue to pay your portion of the insurance premiums.

- Job protection. As long as you are able to return to work before you exhaust your FMLA leave, you will be returned to the same job (or one nearly identical to it).

- Flexibility:
  - You can take FMLA leave as a single block of time or in multiple, smaller blocks of time, or on a part-time basis if the need to do so has been medically documented.
By itself, FMLA leave is unpaid leave. However, if you are eligible for paid leave and have sick leave, annual leave, grant personal leave or other paid leave available, you will be required to use your available balances.

**Application Suggestions**
- When possible, give the University at least 30-days advance notice.
- Immediately contact the University leave administrator (864-656-2000) in the event of an emergency situation.
- Provide the University information, which allows the leave administrator to act as your advocate when necessary and to determine whether your leave can be covered by the FMLA, affording you job protection.

**Step I**
Review the Department of Labor “Employee Rights and Responsibilities under the Family Medical Leave Act” poster included on page 5 of this packet.

**Step II**
Complete and sign the enclosed “FMLA Employee Request Form,” obtain your supervisor’s signature within form, and submit the completed form to the University leave administrator, Samantha Bass, within the Office of Human Resources.

**Step III**
If the need for FMLA is a serious health condition, provide the enclosed “Medical Certification Form” to the treating physician. Suggested: If you are the patient, include a copy of your current position description.

**Step IV**
Provide prompt follow-up. Supply the University Leave Administrator the “Medical Certification Form” and / or any additional documentation that supports your application.

**What You Can Expect**
You will receive two communications from the Office of Human Resources throughout the request process. These communications will be mailed to your home address listed in the human resources information system:

1. Within five business days of receiving your “Employee Request Form,” the Office of Human Resources will notify you whether you are eligible for FMLA leave and if additional documentation is needed to determine if your leave qualifies as FMLA leave. Documentation must be provided in a timely manner.

2. Within five business days of receiving all requested documentation, the Office of Human Resources will notify you if your leave has been approved as FMLA leave and the final decision regarding your request.

**Questions**
If you have any questions regarding the Family Medical Leave Act, please contact the University Leave Administrator, Samantha Bass, at sbass@clemson.edu or at (864) 656-2002.
Family medical leave is governed by the Dept. of Labor’s Family Medical Leave Act of 1993. This request for leave must be accompanied by the Clemson University Medical Certification Form, which is to be completed by your health care provider.

Employee Name: ___________________________  Employee ID#: __________________________

Mailing Address: ________________________________________________

City: ___________________________  State: ____________  Zip Code: __________________________

Department Number: ______________________  Department Name: ________________________

Supervisor Name: ____________________________

Purpose of Leave (check one):
☐ Employee’s personal illness  Nature of illness: ____________________________
☐ Childbirth  ☐ Adoption  ☐ Foster Child  Expected date: ____________________________
☐ Military Caregiver Leave (Employee’s spouse, child, parent, or next of kin)
   Name of family member: ___________________________  Relationship: ___________________________
☐ Military Qualifying Exigency Leave (Employee’s spouse, child, or parent)
   Name of family member: ___________________________  Relationship: ___________________________
☐ Care of seriously ill family member (Employee’s spouse, child or parent)
   Name of family member: ___________________________  Relationship: ___________________________

FMLA Request Begin date: ________________  FMLA Request End date (if known): ________________

Types of leave which must be taken concurrently during FMLA, in accordance with Clemson University policy:

Paid Sick Leave:  During FMLA period for personal illness.
Paid Family Sick Leave:  During FMLA period taken for the care of a seriously ill family member for a maximum of ten calendar days per year.
Paid Annual Leave:  During any FMLA period after eligible sick leave has been exhausted or for periods of FMLA that do not qualify for sick leave.
Paid Grant Personal Leave:  During the FMLA period for personal illness or care of a seriously ill family member.
Paid Compensatory Time:  During any FMLA period after eligible sick leave has been exhausted or for periods of FMLA that do not qualify for sick leave.
Unpaid Leave:  During any FMLA period after which all other types of leave have been exhausted.
   ▪ If the unpaid leave of absence extends more than 30 days, an Extended Leave of Absence Request form must be completed.

I certify that the information above is accurate. I understand that I must provide medical documentation for any FMLA period requested and that I must notify my department and/or the Office of Human Resources immediately if any of the information above changes.

Employee signature: ___________________________  Date: ___________________________

As the supervisor of the employee named above, I am aware that the employee is applying for family medical leave.

Supervisor signature: ___________________________  Date: ___________________________
Note to employee: Family medical leave is governed by the Dept. of Labor’s Family Medical Leave Act of 1993. Have your health care provider complete this form and submit it using the mailing directions below. Applicants must submit the Family Medical Leave Request Form. Also, you are encouraged to provide your health care provider with a copy of your current position description, which can be obtained from your HR partner.

Note to Health Care Provider: “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.”

Employee Name: ________________________________

Patient Name: (If other than the employee): ________________________________

Name of Health Care Provider: ________________________________

Name and Type of Practice: ________________________________

Address: _____________________________________________ City: ________________________________

State: __________ Zip Code: __________ Telephone Number: ________________________________

Date Condition Began: ___________________________ Expected Duration/End Date: ___________________________

If FMLA is for illness of the employee, is the employee able to perform essential job functions?
☐ Yes ☐ No ☐ FMLA is not for illness of employee

If FMLA is for the care of a seriously ill family member, does the family member need assistance with basic care?
☐ Yes ☐ No ☐ FMLA is not for the care of a seriously ill family member

Is inpatient hospitalization of the patient required?
☐ Yes ☐ No Begin date: ___________________________

State reason for FMLA and the nature of care the patient requires (e.g. dependent child born premature; requires 6 weeks additional in-home, ongoing care):

______________________________________________________________________________________________________________________________________________________________________________________

Is the reason for FMLA and the care the patient requires medically necessary?
☐ Yes ☐ No

Please check one. The patient/caregiver needs FMLA:
☐ For a single continuous period of time (full-time) ☐ On a part-time or reduced schedule (intermittent)

If you selected “part-time or reduced schedule (intermittent)” above, please estimate the treatment schedule or reduced work schedule, including dates and times, reduction of hours, etc.:
______________________________________________________________________________________________________________________________________________________________________________________

Signature of Health Care Provider: ________________________________ Date: ___________________________

Health Care Provider: Please return completed form to:

Attn: Samantha Bass
Clemson University, Office of Human Resources, Box 345337 – 108 Pearman Blvd., Clemson, SC 29634-5337
Fax (864) 656-4672; Phone (864) 656-2002

The Office of Human Resources reserves the right to verify the information provided on this document, including but not limited to the patient’s medical condition, beginning and ending dates, and physician’s signature.
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, 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 whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status during a single 12-month period. A covered service member is: (1) a current member of the Armed Forces, including a member of the National Guard or 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*; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness.*

*The FMLA definitions of “serious injury or illness” for current service members and veterans are distinct from the FMLA definition of “serious health condition”.

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 12 months, have 1,250 hours of service in the previous 12 months*, and if at least 50 employees are employed by the employer within 75 miles.

*Special hours of service eligibility requirements apply to airline flight crew employees.

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