Western Illinois University
HUMAN RESOURCES

FAMILY AND MEDICAL LEAVE ACT (FMLA)

Under federal law, as an employee at Western Illinois University, you may take up to twelve weeks of job-protected leave during any fiscal year for certain family and medical reasons. You are eligible for this leave if you have worked at WIU for at least one year and have worked 1250 hours over the last 12 months.

REASONS FOR TAKING LEAVE: Leave will be granted for any one, or more, of the following reasons:

1. To care for your newborn child after birth or for placement for adoption or foster care
2. To care for your spouse, child, or parent with a serious health condition
3. For a serious health condition that does not allow you to perform the duties of your job

"**Serious health condition**" means an illness, injury, impairment, or physical or mental condition that involves either:

Inpatient care (*i.e.*, an overnight stay) in a hospital, hospice, or residential medical-care facility, including any period of incapacity (*i.e.*, inability to work, attend school, or perform other regular daily activities) or subsequent treatment in connection with such inpatient care; **or**

Continuing treatment by a health care provider, which includes:

(1) A period of incapacity lasting more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition that **also** includes:

treatment two or more times by or under the supervision of a health care provider (*i.e.*, in-person visits, the first within 7 days and both within 30 days of the first day of incapacity); **or**

one treatment by a health care provider (*i.e.*, an in-person visit within 7 days of the first day of incapacity) with a continuing regimen of treatment (*e.g.,* prescription medication, physical therapy); **or**

(2) Any period of incapacity related to pregnancy or for prenatal care. A visit to the health care provider is not necessary for each absence; **or**

(3) Any period of incapacity or treatment for a chronic serious health condition which continues over an extended period of time, requires periodic visits (at least twice a year) to a health care provider, and may involve occasional episodes of incapacity. A visit to a health care provider is not necessary for each absence; **or**

(4) A period of incapacity that is permanent or long-term due to a condition for which treatment may not be effective. Only supervision by a health care provider is required, rather than active treatment; **or**

(5) Any absences to receive multiple treatments for restorative surgery or for a condition that would likely result in a period of incapacity of more than three days if not treated.

Although most leaves will be continuous, some leaves may require intermittent leave or a shortened work day to adapt to the need. Under some circumstances, employees may take FMLA leave intermittently – taking leave in separate blocks of time for a single qualifying reason – or on a reduced leave schedule – reducing the employee's usual weekly or daily work schedule. When leave is needed for planned medical treatment, the employee must make a reasonable effort to schedule treatment so as not to unduly disrupt the employer's operation. If FMLA leave is for birth and care, or placement for adoption or foster care, use of intermittent leave is subject to the employer's approval.

ADVANCE NOTICE: You must notify your immediate supervisor and the Office of Human Resources, (309) 298-1971 or HR-Benefits@wiu.edu, at least 30 days before going on leave under the FMLA. If 30 days notice is not possible, then notification must be given as soon as possible. In case of a serious medical condition, you will be required to provide written documentation to support the absence as soon as possible, but no later than 15 calendar days following the FMLA request date.

PROTECTION OF YOUR JOB AND BENEFITS:

1. While you are on FMLA leave, WIU will continue your insurance coverage as it exists prior to your leave. You will be billed for normal payroll deductions.

2. When you return from FMLA leave, you will be restored to your original position or to a position with equivalent pay, benefits and other terms and conditions of employment, contingent upon the employee's continued ability to perform the essential functions of the job.

3. If you use FMLA leave, you will not lose any employment benefit that accrued prior to the start of your leave.

4. You will not accrue vacation/sick benefits while on unpaid FMLA leave.

FOR ADDITIONAL INFORMATION AND TO APPLY FOR FMLA LEAVE: Call the Office of Human Resources at 298-1971 or email HR-Benefits@wiu.edu. The application form requesting FMLA must be processed prior to leave approval. The medical certification form for the employee is available at www.dol.gov/whd/forms/WH-380-E.pdf. The medical certification form to be used for the employee's family member is available at www.dol.gov/whd/forms/WH-380-F.pdf. You may also visit the U.S. Department of Labor website at www.dol.gov/whd/regs/compliance/whdfs28.htm to view a Fact Sheet on the FMLA Act of 1993.

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I hereby make application for leave under the Family and Medical Leave Act.

Name_____Employee ID Number_____

Home Address (City, State, Zip) _____ Phone _____

Work Department_____Supervisor_____Work Phone _____

Leave requested is: ☐ continuous block ☐ *intermittent ☐ *reduced schedule

USING:

☐ Sick Leave ☐ Vacation Leave ☐ Without Pay ☐ *Combination of leave without pay and sick/vacation

Begin date for continuous leave:_____Planned return to work date:_____Number of weeks ____

Begin date for the period that intermittent leave is requested:_____ *(describe intermittent schedule below)

*If a reduced or intermittent schedule is requested, describe the time you will need off (e.g., absent two times/month during the timeframe noted above or describe the reduction in work schedule requested (e.g. 100% FTE to 80% FTE.). If a combination of paid sick/vacation and leave without pay will be used, describe the planned usage or attach a schedule of planned usage for leave period.

_____

_____

Reason for Leave:

☐ Care for my newborn or placement for adoption or foster care.

☐ Care for spouse, child, or parent with serious health condition
(**I will submit medical certification using the form provided**). www.dol.gov/whd/forms/WH-380-F.pdf

Family member requiring my assistance: Name _____ Relationship _____

☐ Serious health condition which makes me unable to perform my job
(**I will submit medical certification using the form provided and I will also submit a Physician's Work Release form prior to returning to work**). www.dol.gov/whd/forms/WH-380-E.pdf

Applicant's Signature:_____ Date:_____

Supervisor's Signature Acknowledging Leave Request:_____ Date:_____

APPROVAL
Human Resources Department:_____ Date:_____