

# Extended Leave of Absence Resource Guide



This guide is for Employees and Supervisors to assist employees in applying for Family Illness Leave

Family Illness Leave (FIL) and Shared Leave are available to employees for *authorized medical and compelling family reasons* that force an employee to be absent for an extended period of time, (three days or more) and for frequent intermittent absences.

For specific information about:

**Family Illness Leave**, please refer to the State Personnel Manual, Section 5; Page 27.1

<http://www.osp.state.nc.us/manuals/manual99/FIL.doc>

**Shared Leave**, please refer to Personnel Information Memorandum # 29

<http://www.hr.uncc.edu/policies/pim29.htm>

Please contact the Benefits Counselor at ext. 7-2892 should you have any additional questions.

NOTE: This guide is not intended to inform you about the various types of leave available, rather guides you through the process of applying for extended leave.

***All leave application/medical forms should be returned to:***

***UNC Charlotte Benefits Office***

***226 King Building***

***University of North Carolina at Charlotte***

***9201 University City Boulevard***

***Charlotte, NC 28223-0001***

***Fax: (704) 687-3892***

***All information received is confidential***

## INSTRUCTIONS FOR THE EMPLOYEE

*All of the forms mentioned in the steps outlined below are included within this resource guide. The forms mentioned in steps 1 through 4 should be completed in advance of beginning leave, unless an emergency situation arises. It is your responsibility, as the employee, the one requesting leave, to ensure that all forms are completed, approved, and submitted to the UNC Charlotte Benefits Office before taking leave as well as before returning to work. Approval for the leave is determined by the Benefits Office and when a decision is made, a letter will be mailed to you, the employee, with a copy sent to the supervisor.*

- Step 1 Complete Part I of the **Family Illness Leave/Shared Leave Application** and return it to the Benefits Office. Note: This form is used to apply for (section 1) Family Illness Leave and/or (section 2) Shared Leave. You may apply for one or both of these programs. Return completed form to the Benefits Office.
- Step 2 Complete Part I of the **Certification by Medical Practitioner** form. Then give the form to your healthcare provider so that he/she can complete Part II. After completion, please return to the Benefits Office (King 226).
- Step 3 Provide your supervisor with completed timesheets and leave slips for your anticipated leave period. A copy of the timesheets/leave slips must be forwarded to the Benefits Office. If you plan on taking intermittent or reduced schedule FIL, then you will also need to submit the timesheets for the time you work to the Benefits Office.
- Step 4 Provide your supervisor with periodic reports on your status and intent to return to work (at least every 30 days) and prior to your expected return to work date if your leave is extended.

**REMEMBER:** *It is your responsibility to ensure that all forms have been completed and submitted to the UNC Charlotte Benefits office in advance of the leave.*

## INSTRUCTIONS FOR THE SUPERVISOR

- Step 1      Confirm with your employee that the **Family Illness Leave/Shared Leave Application** form has been completed and submitted to the Benefits Office (King 226).
- Step 2      Complete the **Certification of Leave Balance/Approval of Shared Leave** form and return it to the Benefits Office.
- Step 3      Have your employee complete a set of leave slips for each week, he/she anticipates being away from work. Your employee needs to designate which hours are to be from accumulated compensatory time (if any), sick leave, annual leave, bonus leave, leave without pay, etc. Please remember to use up any outstanding compensatory time first. *Also, remember that an employee cannot receive shared leave until sick, annual and bonus leave are exhausted.*

Your employee should periodically (at least every 30 days) report his/her status and intent to return to work. By processing leave slips weekly, you can assure that the employee's leave balance will not be charged if recovery and return is sooner than expected.

Please note that if your employee is taking intermittent or reduced schedule leave, you will also need to complete timesheets for the time worked and leave slips for the time not worked.

- Step 4      Submit time sheets and Leave Slips as outlined below, making **two copies** of both the **time sheet** and **leave slip** and distributing as follows:

Payroll:      One (1) **copy** of the time sheet and the original leave slip.

Benefits:      One (1) **copy** of the time sheet and one (1) **copy** of the leave slip.

Department: Keep the original time sheet and keep one (1) **copy** of the leave slip.

*All Applicable Extended Leave Application Forms Follow*



## Family Illness Leave / Shared Leave Application

for all 12 month employees of UNC Charlotte

**(Medical certification is required before leave can be granted. Complete this and submit this with the Certification by Medical Practitioner, included, to the Benefits office.)**

TO BE COMPLETED BY EMPLOYEE (Please Print or Type)	
Name:	Department:
Address:	
Phone #:	
Employee ID Number:	Supervisor:
Home Phone:	Supervisor's Campus Phone:
<b>1. Reason for Requested Family and Medical Leave:</b>  <input type="checkbox"/> a. Care for Newborn Child <input type="checkbox"/> b. Care for Adopted or Foster Child <input type="checkbox"/> c. Care for the Serious Health Condition of my ◇ Child ◇ Spouse ◇ Parent	<b>2. Request for Shared Leave:</b> a. I wish to apply for Voluntary Shared Leave <input type="checkbox"/> Yes <input type="checkbox"/> No b. While soliciting contributions, please: <input type="checkbox"/> Keep the nature of my leave confidential. <input type="checkbox"/> Share the nature of my leave request.  <b>Supervisor must approve the use of shared leave</b>
<b>3. Duration / Type of Leave:</b> 3a. Date Leave Begins _____ 3b. Anticipated Date of Return _____ <input type="checkbox"/> This leave will be taken on a full-time basis 3c. Revised Date of Return _____ <input type="checkbox"/> This leave will be taken intermittently or on a reduced schedule * <i>*(If this box is checked, the applicant must provide the supervisor with a schedule, which must be approved by the supervisor.)</i>	
<b>4. Terms of Leave</b> <p>I understand that I am applying for leave that is my right to take under The Family Illness Leave (FIL) policy. I understand that the designation of this leave as Family Illness Leave may be delayed until the appropriate medical certification is received by the UNC Charlotte Benefits Office.</p> <p>If I have any sick, annual or bonus leave, I will complete the necessary leave forms designating which type of paid leave I wish to use to cover this period. I understand that I may apply for Shared Leave in accordance with Personnel Information Memorandum #29. I also understand that my supervisor must approve the use of shared leave.</p> <p>I agree that while I am on leave, I will continue to pay my share of the health insurance premiums, if applicable, unless I elect to discontinue coverage. I also agree that if I fail to return to work at the end of the leave period, I will reimburse the University for the cost of University-provided health benefits during my unpaid leave, if any, unless I fail to return to work because of the continuation, recurrence or onset of a serious health condition, or because of other circumstances beyond my control.</p> <p>If I am unable to return to work because of my family member's serious health condition, I will provide medical certification from the appropriate health care provider stating that I needed to care for my spouse, child, or parent, because he/she had a serious health condition on the date that my leave expired. I also agree that I won't commence work for another employer while on leave.</p> <p>Finally, I understand that if I do not return to work on the date indicated above (or another date as specified by me and agreed to by the University) for reasons other than my inability to return to work due to my own serious health condition my employment may be terminated by the University as of the date my leave expired.</p>	
Employee Signature: _____ Date: _____	



## Certification by Medical Practitioner

**All items must be completed. Attach additional pages, if necessary. Return to the UNC Charlotte Benefits Office prior to leave, if possible.**

Part I: TO BE COMPLETED BY EMPLOYEE (Please Print or Type)		
Employee Name:	Employee ID Number:	
Patient's Name:	Practitioner's Name:	
Relationship to Employee: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent	Practitioner's Area of Practice: (i.e. Internal Medicine)	
Practitioner's Phone Number: _____ Name of Nurse: _____	Practitioner's Address:	
PART II: TO BE COMPLETED BY MEDICAL PRACTITIONER (For patient listed in #3 above)		
1. Nature of Serious Health Condition (diagnosis):		
2. Date Condition Commenced (first treated):  Date Employee became unable to work or is needed as caregiver:		
3. Probable Duration of Condition (calculated from the day you sign this form):		
4. Prescribed Treatment: <i>(i.e. your post-operative, post-partum instructions, etc. May attach clinical notes if you prefer)</i>		
Please check "yes" or "no" as appropriate:	Yes	No
5a. Will the patient be hospitalized as either an in-patient or same-day surgery patient?		
5b. Does the patient require assistance for basic medical, or personal needs or safety, or for transportation?		
5d. Please explain why the employee is needed as a caregiver and provide an estimate of the duration the patient will need a caregiver.		
<hr style="border: none; border-top: 1px solid black; margin-bottom: 5px;"/> <b>Signature of Practitioner</b>		<hr style="border: none; border-top: 1px solid black; margin-bottom: 5px;"/> <b>Date</b>



## Certification of Leave Balances / Approval of Shared Leave

**Please have the supervisor complete this form and  
return to the Benefits Office, 226 King**

TO BE COMPLETED BY SUPERVISOR (Please Print or Type)	
Supervisor:	Department:
Employee Requesting Leave:	Employee ID Number:
<p>The above employee:</p> <p><input type="checkbox"/> has provided to the Benefits Office</p> <p><input type="checkbox"/> is in the process of obtaining</p> <p>satisfactory evidence to qualify for leave under the following program(s):</p> <p><input type="checkbox"/> Family Illness Leave (For a complete description of FIL, refer to State Personnel Manual Section 5, page 27.1)</p> <p><input type="checkbox"/> Shared Leave (For a complete description of Shared Leave, refer to PIM-29)</p>	
<p>In order for the Benefits Office to apply paid leave (sick and annual) appropriately, we must have accurate starting balances from which to draw paid leave until it is exhausted. Please provide the balances as of the following date:</p> <p style="text-align: right;">DATE LEAVE BEGINS: _____</p>	
<p>If you are unsure about your departmental records being accurate, please consult the Payroll Office to verify leave balances. Remember to deduct any leave not reflected in the monthly report last received from the Payroll Office, as well as to credit any current accruals earned as of the date above.</p> <p style="text-align: right;">SICK HOURS: _____</p> <p style="text-align: right;">BONUS LEAVE HOURS: _____</p> <p style="text-align: right;">ANNUAL LEAVE HOURS: _____</p>	
<p>➔ May the employee enter the Shared Leave Program? (please circle)      Yes      No</p>	
<p><i>I certify that the leave balances provided are accurate to the best of my knowledge, and that while the employee is out I will furnish the Payroll Office and Benefits Office with leave slips reflecting the usage of sick and annual leave in accordance with the employee's wishes.</i></p>	
_____ <i>Supervisor's Signature</i>	_____ <i>Date</i>
_____ <i>Phone Extension</i>	_____ <i>Email</i>