

Extended Leave of Absence Resource Guide For all 9 month Faculty of



This guide is for 9 month Faculty and Department Chairpersons to assist Faculty in applying for any type of Extended Leave that is necessary

Family and Medical Leave (FMLA) is available to employees for *authorized medical compelling family and certain military 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 and Medical Leave, please refer to Personnel Information Memorandum # 9
www.uncc.edu/humanres_is/policies/pim09.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 Family and Medical leave, rather it guides you through the process of applying for extended leave for determination of your eligibility and rights.

***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 9 MONTH FACULTY MEMBER

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, or being asked to request leave, to ensure that all forms are completed, submitted to the UNC Charlotte Benefits Office, and approved before taking leave as well as before returning to work. Approval and/or eligibility for the leave is determined by Academic Affairs. The Benefits Office will send a letter to you, the employee, indicating approval/denial of the leave as FMLA eligible, with a copy sent to the Department Chair, Dean, and Provost.

- Step 1 Provide your Department Chair with the form **(AA-32) – Request for Leave of Absence for a Member of the Faculty on 9-Month Appointment**. Once this form has been completed and the necessary parties have signed page two (2), return the completed form with a copy of your Leave Agreement to the Benefits Office, King 226. The form AA-32 is available through the Academic Affairs website in the forms section.
- Step 2 Complete the **Family and Medical Leave Application for Nine-Month Faculty** and return it to the Benefits Office. Note: This form is used to apply for Family and Medical Leave and to indicate the semester you wish to take as leave. It is also used to validate your need for extended absences even if you are not eligible for Family and Medical Leave. Return the completed form to the Benefits Office (King 226).
- Step 3 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. Please return the completed form to the Benefits Office (King 226).
- Step 4 Provide your Department Chair with periodic reports on your status and intent to return to work and prior to your expected return to work date. If you need to extend your leave, this must be approved by your Department Chair and the Provost.
- Step 5 Complete Part I of the **Fitness for Duty Certification** form if the absence is due to your own serious health condition. Then give the form to your healthcare provider so that he/she can complete Part II of the form. This should be done at the time you are released by your healthcare provider. After completion, please return the form to the Benefits Office (King 226).
Note: This form must be completed and returned before you can return to work if you were absent due to your own serious health condition. If limitations are given by your medical practitioner, your Department Chair will need a copy to determine if accommodations can be met.

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 DEPARTMENT CHAIRPERSON

- Step 1 Confirm that the form **(AA-32) – Request for Leave of Absence for a Member of the Faculty in 9-Month Appointment** has been completed and signed. The form can be located on the Academic Affairs website under forms or through the Office of Academic Affairs. Send a completed copy to the Benefits Office, King 226.
- Step 2 Confirm with your 9 month faculty member that the **Family and Medical Leave Application for Nine-Month Faculty** form has been completed and submitted to the Benefits Office (King 226).
- Step 3 Please forward a copy of the Leave Agreement signed by the faculty member, the Department Chair, Dean, and Provost to the Benefits Office, King 226.
- Step 4 Your faculty member should periodically report his/her status and intent to return to work to you. Please notify the Benefits Office as soon as possible if the leave is extended for a second semester.
- Step 5 ***Confirm that the Fitness for Duty Certification has been completed and returned to the Benefits Office before the employee returns to work if the absence was due to their own serious health condition.***

All Applicable Extended Leave Application Forms Follow



Family and Medical Leave Application
 for all Nine-Month Faculty Members of UNC Charlotte
(PART A)

(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:	Email Address Work: Email Address Home:
UNC Charlotte ID Number:	Department Chairperson:
Home Phone:	Chairperson's Campus Phone:
1. <u>Requesting Family and Medical Leave due to:</u> <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 <input type="checkbox"/> d. Care for my own serious health condition that prevents me from performing the functions of my position. <input type="checkbox"/> e. A qualifying exigency arising out of the fact that my immediate family member is on active duty or has been called to active duty status in support of a contingency operation. <input type="checkbox"/> f. Serious injury of illness of a covered service member for whom I am next of kin.	2. <u>Requesting Semester of Leave:</u> <i>(Only one can be with pay) During the Semester with pay, your salary and benefits will continue. If without pay, payment arrangements for Benefits must be made.</i> <input type="checkbox"/> Spring, (Year) _____ <input type="checkbox"/> Paid <input type="checkbox"/> Unpaid <input type="checkbox"/> Fall, (Year) _____ <input type="checkbox"/> Paid <input type="checkbox"/> Unpaid <input type="checkbox"/> Intermittently, (Attach Proposed Schedule)

You may choose to extend your leave for an additional semester without pay, but you must make arrangements to pay the full cost of your health insurance and any other elected benefits you wish to continue. Should you wish to continue the 6% contribution to your retirement plan, the University will also petition the retirement system to request approval.

Family and Medical Leave Application
for all Nine-Month Faculty Members of UNC Charlotte
(PART A)
CONTINUED

3. Terms of Leave *(By signing below, the faculty member agrees to the terms and conditions stated or referenced on this form.)*

I understand that I am applying for leave that is my right to take under The Family and Medical Leave Act (FMLA) of 1993 and 2008 amendments, or to document valid reasons for taking extended leave if I am not qualified for leave under the Family and Medical Leave Act. I understand that the designation of this leave as Family and Medical Leave may be delayed until the appropriate medical certification is received by the UNC Charlotte Benefits Office. I understand that I will be given seven days to provide missing paperwork or to correct missing or incomplete information on forms that were submitted, and that failure to supply this information can result in denial of my request for leave. Further, I understand that my physician and I must also complete a Fitness for Duty Certification before I can return to work if the reason for leave was either "a" or "d" above. I understand that if my leave is foreseeable, it is my responsibility to initiate the dialogue with my Department Chairman regarding Part C of this application, the Agreement regarding Tenure, Probation and Promotion, this is the form AA-32. If I am not capable of completing Part C due to a medical emergency, arrangements will be made in good faith. In either case, I will receive a confirmation of these arrangements.

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.

If I am unable to return to work because of my own, or my family member's serious health condition, I will provide medical certification from the appropriate health care provider stating that I am unable to perform the functions of my position on the date that my leave expired, or that I needed to care for my spouse, child, or parent, because he/she had a serious health condition, I have a qualifying exigency, or I am caregiver to a service member injured in the line of duty on the date my leave expired. I also agree that I won't commence employment for another employer while on leave.

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.

Employee Signature: _____ Date: _____



Certification by Medical Practitioner (PART B)

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:	Patient's Social Security Number: (Optional) Or Patient's Date of Birth:
Patient's Name: (if different from employee)	Practitioner's Name:
Relationship to Employee: <input type="checkbox"/> Self <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):	First Day of Absence from Work:	
3. Probable Duration of Condition (calculated from the day you sign this form):	Is the leave continuous: <input type="checkbox"/> or intermittent: <input type="checkbox"/>	
4. Regimen of 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?		
5c. <i>If patient is employee</i> , is the patient able to perform his/her own job functions as described to you?		
5d. Please state why the patient is unable to perform his/her job functions as described in the written job description if the patient is the employee (i.e. list limitations). If for a family member the reason the employee is needed as caregiver:		
6. <i>If the leave is on an intermittent basis</i> , please indicate the probable duration of this periodic, outpatient treatment:		
_____ Signature of Practitioner	_____ Date	



Fitness for Duty Certification

Required of all employees returning from a
Medical/Disability Leave of any kind.

**Employee please attach a job description listing physical
requirements of your position.**

Part I: TO BE COMPLETED BY EMPLOYEE (Please Print or Type)

Name:	Job Title:
Date Leave Begins:	Date Released for Return to Work:
Employee Signature:	
Signed: _____ Date: _____	

PART II: TO BE COMPLETED BY MEDICAL PRACTITIONER

1. I certify that I have read the job description attached to this form and that the above-named employee is physically fit to meet the physical/mental requirements listed in the description (**please check one**) with or without reasonable accommodation. **If accommodation is required, please list specific limitations to activity in remarks section (section 4).**

Signed: _____ Date: _____

2. Healthcare Provider's Name: Address: Phone:	3. Area of Practice/Specialty (if any)
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4. Please list specific restrictions to duty, if any: *(Please use extra paper if necessary.)*

5. Additional remarks:

FOR OFFICE USE ONLY:
Confirm Return Date: _____
Notified Payroll on: _____
Initials: _____

Routing: Department Supervisor