



## **PART B - RIGHTS AND RESPONSIBILITIES FOR TAKING FMLA LEAVE**

As explained in Part A, you meet the eligibility requirements for taking FMLA leave and still have FMLA leave available in the applicable 12-month period. **However, in order for us to determine whether your absence qualifies as FMLA leave, you must return the following information to us by \_\_\_\_\_ (minimum of 15 calendar days from receipt of this notice.** If sufficient information is not provided in a timely manner, your leave may be denied.

Sufficient certification to support your request for FMLA leave. A certification form that sets forth the information necessary to support your request is enclosed.

Sufficient documentation to establish the required relationship between you and your family member.

Other information required:

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No additional information requested.

**IMPORTANT:** ASU has the right to contact your or your family member's health care provider if ASU needs to either authenticate the Certification form or clarify the handwriting or meaning of one or more responses made by the health care provider in the Certification form. In this circumstance, you will need to provide a HIPAA authorization to your health care provider to speak with ASU. If you choose not to provide a HIPAA authorization to your health care provider and you do not otherwise clarify the Certification, ASU may deny your request for FMLA leave.

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### **If your leave is approved, you will have the following responsibilities while on leave:**

- If on an unpaid leave of absence, HR Benefits Programs Management will bill you for your premiums to maintain benefits while you are on leave. You have a minimum 30-day grace period in which to make premium payments. If payment is not made timely, your benefits will be cancelled 15 calendar days after the date of your Notice of Cancellation.
- The Health Care or Limited Health Care Flexible Spending Accounts (FSAs) may be continued while on a leave (without pay) by making payments to ASU on an after-tax basis **only**. By doing this, you will have access to your account. Please contact HR to make arrangements. (Dependent Care FSAs cannot be continued while you are not in employment status.) **Upon returning to work, you must complete the FSA change form to re-enroll in the medical and/or dependent accounts otherwise this benefit will cease for the remainder of the calendar year.** <http://www.asu.edu/hr/benefits/forms/asichangeform.pdf>.
- You will be required to use your available paid sick leave. Upon exhaustion of your sick leave accruals, if you are an hourly employee with a compensatory time accrual balance, you will be required to use that time. Upon the exhaustion of any compensatory time accrual, if applicable, you may choose to use accrued vacation hours, during your FMLA absence. This means that you will receive your paid leave and the leave will also be considered protected FMLA leave and counted against your FMLA leave entitlement.

Faculty: ACD 702-02 Health-Related (Sick) Leave; and  
ACD 704-02 Vacation Leave – Fiscal Year Appointment.

Staff: SPP 701-01 Sick Leave – General Policy;  
SPP 404-04 Overtime; and  
SPP 702-01 Vacation Leave – General Policy

- While on leave you will be required to furnish us with periodic reports of your status and your intent to return to work, upon request. The frequency of the periodic reports, including updated certifications, will be stated in the Designation Notice.
- If the circumstances of your leave change and you are able to return to work earlier than the date indicated on the reverse side of this form, you will be required to notify us at least two (2) workdays prior to the date you intend to report to work.

**If your leave does qualify as FMLA leave, you will have the following rights while on FMLA leave.**

- You have a right under FMLA for up to 12 weeks of unpaid leave in a 12-month period calculated as a fixed leave year based on your anniversary date.
- Your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work.
- You must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA-protected leave. (If your leave extends beyond the end of your FMLA entitlement, you do not have return rights under FMLA.)
- 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; 2) the continuation, recurrence, or onset of a covered servicemember's serious injury or illness which would entitle you to FMLA leave, or 3) other circumstances beyond your control, you may be required to reimburse us for your share of health insurance premiums paid on your behalf during your FMLA leave.
- If you do qualify for an FMLA leave or are unable to return to work following your approved FMLA leave, you may be eligible for another leave under ASU policy. Please contact your department leaves representative for additional information.

Once we obtain the information from you as specified above, we will inform you, within 5 business days, whether your leave will be designated as FMLA leave and count towards your FMLA leave entitlement.

If you have any questions, please do not hesitate to contact your ASU leaves representative \_\_\_\_\_ at (\_\_\_\_) \_\_\_\_\_.

Enclosures: Family Member's Health Certification Form  
Health Information Release  
ACD (for faculty) or SPP (for staff) Leave Policies

**FMLA Certification of Health Care Provider  
for Family Member's Pregnancy or Serious  
Health Condition  
(Family and Medical Leave Act)**



**Return form to:**

**Address:** \_\_\_\_\_

\_\_\_\_\_

**Telephone:** \_\_\_\_\_ **FAX:** \_\_\_\_\_

**SECTION I: Instructions for Completion by the ASU DEPARTMENT**

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. **Please complete the return address and Section I before giving this form to your employee.** Departments must maintain records and documents relating to medical certifications, re-certifications, or medical histories of employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

**IMPORTANT: Upon receipt from health care provider, fax copy of completed document to: HR Benefits & Leaves Programs Management at 480.993.0007**

Department Name and Contact Information: \_\_\_\_\_

\_\_\_\_\_

**SECTION II: Instructions for Completion by the EMPLOYEE**

Please complete Section II before giving this form to your family member or his/her medical provider. The FMLA permits Arizona State University ("ASU") to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a covered family member with a serious health condition. If requested by ASU, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). **Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. ASU must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.** These same obligations apply to any and all ASU requests for periodic re-certification.

**ENSURE YOUR HEALTH CARE PROVIDER COMPLETES & RETURNS THE FOLLOWING SECTION WITHIN 15 CALENDAR DAYS.**

Your name: \_\_\_\_\_  
First Middle Last

Name of family member for whom you will provide care: \_\_\_\_\_  
First Middle Last

Relationship of family member to you: \_\_\_\_\_

If family member is your son or daughter, date of birth: \_\_\_\_\_

Describe the care you will provide to your family member and estimate leave needed to provide care: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Employee Signature

Date

**SECTION III: Instructions for Completion by the HEALTH CARE PROVIDER**

The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the patient needs our employee to utilize FMLA leave. Page 3 provides space for additional information, should you need it. **Please be sure to sign the form on the last page.**

Provider's name and business address: \_\_\_\_\_

Type of practice / Medical specialty: \_\_\_\_\_

Telephone: ( \_\_\_\_\_ ) \_\_\_\_\_ Fax: ( \_\_\_\_\_ ) \_\_\_\_\_

**PART A: MEDICAL FACTS**

1. Approximate date condition commenced: \_ \_\_\_\_\_

Probable duration of condition: \_\_\_\_\_

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

No  Yes - If so, dates of admission: \_\_\_\_\_

Date(s) you treated the patient for condition: \_\_\_\_\_

Was medication, other than over-the-counter medication, prescribed?  No  Yes.

Will the patient need to have treatment visits at least twice per year due to the condition?  No  Yes

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?

No  Yes. If so, state the nature of such treatments and expected duration of treatment:

\_\_\_\_\_  
\_\_\_\_\_

2. Is the medical condition pregnancy?  No  Yes. If so, expected delivery date: \_\_\_\_\_

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PART B: AMOUNT OF CARE NEEDED:** When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery?

No  Yes.

Estimate the beginning and ending dates for the period of incapacity: \_\_\_\_\_

During this time, will the patient need care?  No  Yes.

Explain the care needed by the patient and why such care is medically necessary:

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5. Will the patient require follow-up treatments, including any time for recovery?  No  Yes.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

Explain the care needed by the patient, and why such care is medically necessary: \_\_\_\_\_

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6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery?

No  Yes.

Estimate the hours the patient needs care on an intermittent basis, if any:

\_\_\_\_\_ hour(s) per day; \_\_\_\_\_ days per week from \_\_\_\_\_ through \_\_\_\_\_

Explain the care needed by the patient, and why such care is medically necessary: \_\_\_\_\_

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7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities?

No  Yes.





**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**

I, \_\_\_\_\_, hereby authorize the use or disclosure of my health information for the purposes of my request for a leave of absence under ASU policy and/or the Family Medical Leave Act (FMLA).

1. I authorize the following health care provider/organization to provided this information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. I request the following information be provided (description of information):

Medical Certification

OR \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that:

- I have the right to revoke this authorization at any time by notifying Arizona State University (“ASU”) in writing. I understand that the revocation is only effective after it is received and logged the ASU. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.
- Arizona State University (“ASU”) may use or disclosure protected health information about me for purposes of my request for a leave of absence under ASU policy and/or the Family Medical Leave Act (FMLA). I request to restrict use and disclosure of protected health information concerning health care treatment, payment, or health care operations about me by the ASU in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).
- This authorization will expire when my employment with Arizona State University ends.
- I am entitled to receive a copy of this authorization.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

*Personal Representative Section:*

If a Personal Representative executes this form, that Representative warrants that he or she as authority to sign this form on the basis of the above-name employee in the following capacity \_\_\_\_\_.

**FMLA Leave Designation Notice  
(For Qualified Family Members)**



DATE OF HIRE (Anniversary):

\_\_\_\_\_

TO: \_\_\_\_\_ DATE: \_\_\_\_\_  
Employee

FROM: \_\_\_\_\_  
Department

**CC: HR Benefits & Leaves Programs Management -- Fax to 480.993.0007**

We have reviewed your request for leave under the Family and Medical Leave Act (FMLA) and any supporting documentation that you have provided. We received your most recent information on \_\_\_\_\_ and decided:

**Your FMLA Leave request is approved, effective \_\_\_\_\_.** All leave taken for this reason will be designated as FMLA leave, not to exceed the number of weeks that remain available in the applicable 12-month period.

The FMLA requires that you notify us as soon as practicable if dates of scheduled leave change or are extended or were initially unknown. Based on the information you have provided to date, we are providing the following information about the amount of time that will be counted against your leave entitlement.

Provided there is no deviation from your anticipated leave schedule, the following number of hours, days, or weeks will be counted against your FMLA leave entitlement \_\_\_\_\_ for the  serious health condition of a family member (maximum 12 weeks);  serious illness/injury of a covered service member or veteran (maximum of 26 weeks); or  qualifying exigency arising out of military service (maximum of 12 weeks). If applicable, you have already used \_\_\_\_\_ weeks of FMLA Leave in the current 12-month period.

Because the leave you will need will be unscheduled, it is not possible to provide the hours, days or weeks that will be counted against your FMLA entitlement at this time. You have the right to request this information one in a 30-day period (if leave was taken in the 30-day period).

Please be advised (check if applicable):

If available, we are requiring you to substitute or use paid sick leave during your FMLA leave.

If you are an hourly employee and have accrued compensatory time hours, we are requiring you to use compensatory time hours once you have exhausted your sick leave accrual during your FMLA leave.

You have requested to use paid vacation leave during your FMLA leave upon your sick hour accrual becoming exhausted. Any paid leave taken for this reason will count against your FMLA leave entitlement.

**Additional information is needed to determine if your FMLA leave request can be approved:**

The certification you have provided is not complete and sufficient to determine whether the FMLA applies to your leave request. You must provide the following information no later than \_\_\_\_\_, *(provide at least seven calendar days)* unless it is not practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied. *(Specify information needed to make the certification complete and sufficient)* \_\_\_\_\_

\_\_\_\_\_

We are exercising our right to have you obtain a second or third opinion medical certification at our expense, and we will provide further details at a later time.

**Your FMLA Leave request is not approved.**

**The FMLA does not apply to your leave request.**

**You have exhausted your FMLA leave entitlement in the applicable 12-month period.**

Please be advised (check if applicable):

You will be required to provide ASU with a re-certification from your treating Health Care Provider once every \_\_\_\_\_ days or \_\_\_\_\_ weeks or \_\_\_\_\_ months

If on an unpaid leave of absence, OHR Benefits Programs Management will bill you for your premiums to maintain benefits while you are on leave. You have a minimum 30-day grace period in which to make premium payments. If payment is not made timely, your benefits will be cancelled 15 calendar days after the date of your Notice of Cancellation.

# Leave of Absence Status Change Form

(for Department Use Only)



Employee Name \_\_\_\_\_ Date: \_\_\_\_\_

Employee Number: \_\_\_\_\_ (10 digits) Dept. Name : \_\_\_\_\_ Dept. No.: \_\_\_\_\_

## **CHANGE LEAVE DATES**

From: \_\_\_\_\_ To: \_\_\_\_\_  
(first day of leave) (proposed or revised return to work date)

## **CHANGE LEAVE TYPE**

**EFFECTIVE DATE OF LEAVE CHANGE:** \_\_\_\_\_

From FMLA to:  
 Extended Leave (Staff) or  Leave Without Pay (Faculty)

From Extended Leave (Staff) or Leave Without Pay (Faculty) to:  
 FMLA

From Parental Leave to:  
 FMLA or  Leave Without Pay (Faculty)

## **CHANGE PAY STATUS**

**EFFECTIVE DATE OF CHANGE:** \_\_\_\_\_

Paid  Unpaid

## **RETURN FROM LEAVE**

FMLA  Parental  Extended or Leave Without Pay  Military  Sabbatical or Fellowship  Hold

### **Return To Work Details:**

Return from LOA or Hold to Active Status Effective Date \_\_\_\_\_ Salary \_\_\_\_\_ Pay Frequency \_\_\_\_\_

### **Returning To:**

Original Dept  New Dept  Other (explain) \_\_\_\_\_

Total Weekly Scheduled Hours \_\_\_\_\_

\_\_\_\_\_  
Supervisor/Designee Name (Print)

\_\_\_\_\_  
Supervisor/ Designee Approval (Signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
(If department monetary impact) Budgetary Approval (Signature of VP, Dean or Designee)

\_\_\_\_\_  
Date

**Send to:**