



ASU LEAVE NOTICE OF ELIGIBILITY WITH RIGHTS & RESPONSIBILITY FOR BIRTH/ADOPTION/ FOSTER CARE OR EMPLOYEE MEDICAL

TO: _____
Employee

DATE: _____

FROM: _____
<College or Department Name>

DATE OF HIRE: _____

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

PART A - NOTICE OF ELIGIBILITY

On _____, you informed us that you needed leave beginning on _____ for:

	Birth / Adoption / Foster Care
	Employee Medical - Your own serious health condition.
	Family – You are needed to care for your <input type="checkbox"/> spouse, <input type="checkbox"/> child, or <input type="checkbox"/> parent due to his/her serious health condition.
	Personal Reasons

This Notice is to inform you that you are eligible for leave (See Rights and Responsibilities), conditioned on your timely submission of supporting documentation discussed in Part B, below.

However, you are not eligible for leave under the Family Medical Leave Act (FMLA), because:

- You have not met the FMLA’s 12-month length of service requirement. As of the first date of requested leave, you will have to work approximately _____ months towards this requirement.
- You have not met the FMLA’s requirement of 1,250 hours-worked within the 12 months immediately preceding the start of the requested leave.
- You have already used the 12 weeks of leave available in the applicable 12 month period.

If you have any questions, contact your ASU leaves representative _____ at (____) _____ or view the FMLA poster located on the HR Leaves Management website www.asu.edu/hr/benefits/leavesmanagementFAQ.html.

PART B - RIGHTS AND RESPONSIBILITIES FOR TAKING LEAVE UNDER ASU POLICY

As explained in Part A, you meet the eligibility requirements for taking either Leave without Pay (ACD 707 for faculty) or Extended Leave (SPP 705-01 for staff). **However, in order for us to determine whether your absence qualifies as leave under Arizona State University policies, 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 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 needed:
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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 leave of absence.

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

- If on an unpaid leave of absence, HR Benefits & Leaves 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.
- A birth, adoption, or placement of a child in your household is considered a qualified life event for purposes of making mid-year changes to your insurance benefits. You have **31 days only** from the qualified life event to submit benefits changes by completing the ***Declaration for Benefits Change*** form located in the HR Forms section of the Human Resources website. Please contact HR at (480) 965-2701 or (480) 727-9900 if you have questions.
- 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 may use your available paid sick, compensatory, or vacation leave in accordance with the policies referenced below:

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 Leave 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.

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: ACD (for faculty) or SPP (for staff) Leave Policies

For Pregnancy or Employee Medical reasons:

- Employee Health Certification Form with essential functions
- Health Information Release
- Health Care Provider Release to Return to Work

**Certification of Health Care Provider for
Employee's Birth or Serious Health Condition
(ASU Leave of Absence policy)**



Return form to:

Address: _____

Telephone: _____ **FAX:** _____

SECTION I: Instructions for Completion by the ASU DEPARTMENT

Please complete the above 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 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 Management at 480.993.0007

Department name and contact: _____

Employee's job title: _____ Regular work schedule: _____

(MUST BE PROVIDED) Employee's essential job functions: _____

Check if job description with essential functions is attached:

SECTION II: Instructions for Completion by the EMPLOYEE

Please complete Section II before giving this form to your medical provider. Arizona State University ("ASU") requires that you submit a complete and sufficient medical certification to support a request for leave due to your health condition within 15 calendar days. **Failure to provide a complete and sufficient medical certification within 15 calendar days may result in a denial of your leave request.** 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

SECTION III: Instructions for Completion by the HEALTH CARE PROVIDER

Your patient has requested leave under Arizona State University policy. Answer, fully and completely, all applicable parts. 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 coverage. Limit your responses to the condition for which the employee is seeking leave. 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: _____

Mark below as applicable:

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:

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

Was medication, other than over-the-counter medication, prescribed? 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. **Use the information provided by the employer in Section I to answer this question.** If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition: No Yes - If so, identify the job functions the employee is unable to perform (*provide additional information on last page if needed*).

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4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment)

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? No Yes.

If so, estimate the beginning and ending dates for the period of incapacity: _____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? No Yes.

If so, are the treatments or the reduced number of hours of work medically necessary? 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:

Estimate the part-time or reduced work schedule the employee needs, if any:

_____ hour(s) per day; _____ days per week from _____ through _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions?
 No Yes.

Is it medically necessary for the employee to be absent from work during the flare-ups? No Yes. If so, explain:

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or _____ day(s) per episode



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 _____.

**ASU Leave Designation Notice
(Employee Medical)**



DATE OF HIRE (Anniversary): _____

TO: _____
Employee

DATE: _____

FROM: _____
Department

We have reviewed your request for leave and any supporting documentation that you have provided. We received your most recent information on _____ and decided:

Your Leave without Pay (ACD 707 for faculty) or Extended Leave (SPP 705-02 for staff) request is approved, effective _____.

The leave policy requires that you notify us as soon as practicable if dates of scheduled leave change or are extended, or were initially unknown.

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

The certification you have provided is not complete and sufficient to determine whether you qualify for a leave. 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 leave of absence has been denied.

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 available, you may use paid sick, compensatory, and/or vacation leave.

If on an unpaid leave of absence, OHR Benefits & Leaves 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.

You will be required to present a Release to Return to Work to be restored to employment (required only where employee has given birth). If such certification is not timely received, your return to work may be delayed until certification is provided. A list of the essential functions of your position is attached. The Release to Return to Work must address your ability to perform these functions.



Health Care Provider
Release to Return to Work
Certificate of Illness

Thank you for evaluating our employee, _____

ASU ID (10 Digit Number): _____

Was this a work-related injury or illness? Yes [] No []

Date of Illness or Injury: _____
MM/DD/YYYY

1) This employee may return to full duties without restrictions on _____
MM/DD/YYYY

OR

2) If, in your medical opinion this employee is not capable of performing essential functions (attached), every effort will be made to place this employee in a job that will accommodate the restriction(s) you find medically necessary due to the injury/illness of _____.
MM/DD/YYYY

Is employee able to return to fulltime or part-time work? Full-time [] Part-time []

Please indicate restriction(s) below and whether it is a permanent restriction.

Are these restrictions permanent? Yes [] No []

Duration of Restrictions: Beginning _____ Ending _____
MM/DD/YYYY MM/DD/YYYY

- Lifting _____ Bending _____
Kneeling _____ Stooping _____
Twisting _____ Standing _____
Walking _____ Sitting _____
Climbing _____ Reaching _____
Other _____ Repetitive Motion _____

Anticipated date employee can return to full unrestricted duty. _____
MM/DD/YYYY

Comments: (DO NOT PROVIDE ANY CONFIDENTIAL MEDICAL INFORMATION)

Print Health Care Provider Name Health Care Provider Signature Date Signed (MM/DD/YYYY)

Address

Telephone Number Fax Number

Return completed form to: Arizona State University, HR Benefits Design & Management
P.O. Box 875612, Tempe, Arizona 85287-5612 OR Fax to (480) 993-0007
For further information, please call (480) 727-9900.

Give copy to Employee: Required to provide a copy of this Release to the Department and/or Supervisor.



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: