WELLESLEY COLLEGE
REQUEST FOR FAMILY OR MEDICAL LEAVE

Employee's Name: _____

Reason for Leave: **Check One:**

1. Employee's own serious health condition _____
2. Serious health condition of your:
   - Child_____(Name) _____
   - Spouse_____(Name) _____
   - Parent_____(Name) _____
3. Birth of child _____
4. Adopting or placement of a child for foster care _____

Anticipated Date of Leave: _____

Anticipated Date of Return: _____ (Employee to complete)

Certification:
If your need for leave is due to either your serous health condition or the need to care for a seriously ill child, spouse, or parent, you must provide medical certification by a health care provider before or at the commencement of your leave stating:

1. the date on which the condition commenced;
2. the probably duration; and
3. medical facts surrounding the condition

The form for medical certification will be available form Human Resources. For your own medical leave the certification must also include a statement by your health care provider that you are or will be unable to perform your job functions.

For family medical leave, the medical certification should include an estimate of the amount of time you will be needed to care for your child, spouse, or parent.

The Company may require periodic recertification during the leave, and may request a second medical opinion at Company expense. If the first and second opinions differ, the Company may require the opinion of a third health care provider (approved by both the Company and you) whose opinion will be binding.

If the need for leave does not allow for time to present prior medical certification, certification should be provided as soon as possible after the commencement of the leave.

Employee Acknowledgments:

1. My qualified health care provider currently anticipates (and has documented in writing) that I will be physically/mentally able to return to work on the first day following the date my FMLA leave ends.
2. I currently intend to return to work on the first day following the date my FMLA leave ends, if my qualified health care provider gives me medical clearance.
3. If I accept employment elsewhere or become self-employed during my FMLA leave, I understand that my employment may be terminated automatically.
4. CHECK "A", "B", **OR** "C" below

   (A) During my FMLA leave of absence, I want my group health insurance coverage to remain in effect, and I understand that in order for my group health insurance coverage to remain in effect, I agree I will pay the current amount of my contribution (if any) to the insurance premium in advance or weekly, and I also hereby authorize the Company to deduct the current amount of my contribution to the insurance premium from any paychecks which I receive from the Company, if necessary. **If you select choice "A" check here:**_____

   (B) I do not want my group health insurance coverage to remain in effect during my FMLA leave. **If you select choice "B", check here:**_____

   (C) I do not have group health insurance coverage through the company. **If you select choice "C", check here:**_____

5. I understand I am eligible to receive holiday pay or accrue vacation, sick, or personal time during my FMLA leave.
6. I understand my accrued, but unused vacation, sick or personal time (if any) may be applied to my FMLA leave at its commencement, unless my leave runs concurrently with a worker's compensation leave.
7. If my absence is the result of a workplace injury which is covered by worker's compensation, the fact that my FMLA leave will run concurrently with my worker's compensation leave will not negatively impact or affect my rights under worker's compensation laws.

_____ _____

Employee Signature Date

_____ _____

Supervisor's Signature Date

Forms to be returned to: Wellesley College
106 Central Street
Wellesley, MA 02481

Faculty: return form to the attention of Ruth Frommer, Office of the Provost
Staff (admin. & union): return form to the attention of JoAnne O'Beirne, Human Resources

Certification of Health Care Provider for Employee's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT

OMB Control Number: 1235-0003
Expires: 8/31/2021

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees 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, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: _____

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

Employee's essential job functions: _____

_____

Check if job description is attached:

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, 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. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: _____
First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. 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 FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b). 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:

   _____

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

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

Signature of Health Care Provider **Date**

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**

Your Rights
under the
Family and Medical Leave Act of 1993

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to "eligible" employees for certain family and medical reasons. Employees are eligible if they have worked for their employer for at least one year, and for 1,250 hours over the previous 12 months, and if there are at least 50 employees within 75 miles. The FMLA permits employees to take leave on an intermittent basis or to work a reduced schedule under certain circumstances.

Reasons for Taking Leave:

Unpaid leave must be granted for *any* of the following reasons:

- to care for the employee's child after birth, or placement for adoption or foster care;
- to care for the employee's spouse, son or daughter, or parent who has a serious health condition; or
- for a serious health condition that makes the employee unable to perform the employee's job.

At the employee's or employer's option, certain kinds of *paid* leave may be substituted for unpaid leave.

Advance Notice and Medical Certification:

The employee may be required to provide advance leave notice and medical certification. Taking of leave may be denied if requirements are not met.

- The employee ordinarily must provide 30 days advance notice when the leave is "foreseeable."
- An employer may require medical certification to support a request for leave because of a serious health condition, and may require second or third opinions (at the employer's expense) and a fitness for duty report to return to work.

Job Benefits and Protection:

- For the duration of FMLA leave, the employer must maintain the employee's health coverage under any "group health plan."
- Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.
- The use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Unlawful Acts by Employers:

FMLA makes it unlawful for any employer to:

- interfere with, restrain, or deny the exercise of any right provided under FMLA:
- discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement:

- The U.S. Department of Labor is authorized to investigate and resolve complaints of violations.
- An eligible employee may bring a civil action against an employer for violations.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

For Additional Information:

If you have access to the Internet visit our FMLA website: **http://www.dol.gov/esa/whd/fmla.** To locate your nearest Wage-Hour Office, telephone our Wage-Hour toll-free information and help line at 1-866-4USWAGE (1-866-487-9243): a customer service representative is available to assist you with referral information from 8am to 5pm **in your time zone;** or log onto our Home Page at **http://www.wagehour.dol.gov**.

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division
Washington, D.C. 20210

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FREQUENTLY ASKED QUESTIONS ABOUT FMLA (Family and Medical Leave Act)

Although Wellesley College's leave policies were generally more generous than the Family and Medical Leave Act of 1993, the College nonetheless must comply with the documentation requirements of the Act. To help explain the impact of the FMLA on the College's leave policies we are providing the following Frequently Asked Question (FAQ) section.

What is the Family and Medical Leave Act ("FMLA")?
The Family and Medical Leave Act of 1993 generally took effect on August 5, 1993. It provides that eligible employees who have worked for the College at least 1,250 hours during the 12 months immediately prior to the request may be granted up to 12 weeks of unpaid leave during the following 12-month period. An employee must use any accumulated unused sick leave during his or her FMLA leave.

What are the reasons to take a FMLA leave?
- to care for the employee's newborn child or child placed with the employee for adoption or foster care;
- to care for the employee's spouse, domestic partner, son or daughter, or employee's parent who has a serious health condition; or,
- for a serious health condition that makes the employee unable to perform the employee's job.

What is a "serious health condition"?
A "serious health condition" is an illness, injury, or physical or mental condition involving inpatient care or continuing treatment by a health care provider for a period that includes incapacity. Absences for short-term illnesses and routine healthcare are not covered under the FMLA.

How are health benefits provided during the leave?
For the duration of FMLA leave the College maintains the employee's health coverage at the group rate provided that the employee continues to co-pay health premiums timely while on leave.

Do I need to provide a medical certification?
The College requires medical certification of the condition necessitating FMLA leave and its estimated duration. This is the case whether the leave is to care for the employee's own medical condition or that of a family member. The College also requires that an employee present a medical certification from his or her physician that he or she is able to return to work.

When and how do I apply for a FMLA leave?
The College expects employees to provide 30 days' advance notice for leaves that are foreseeable. If illness or injury strikes unexpectedly, the notice should be provided at the first available opportunity. The necessary application forms and medical forms are available in the Human Resources Office and can be obtained by calling x2231. (Faculty should contact the Office of the Dean of the College.)

Is FMLA only unpaid leave?
The College requires that employees substitute any accrued, unused sick time. Leave **may also** be covered by accrued vacation or personal time, or STD, depending upon the reason for and the length of the leave. If there is no accrued time available the leave will be unpaid.

[Wellesley College provides a benefit of six weeks of paid parental leave for a woman who gives birth or an administrative staff member who takes primary responsibility for the care of a biological or newly adopted child. Union employees are eligible for Parental Leave as described in the College-Union Agreement. Faculty Parental Leave is administered by the Office of the Dean of the College and is described in the Faculty Handbook.]

What is my responsibility as a manager when an employee asks for leave or is out of work for five consecutive days?

As a Manager it is your responsibility to inform Human Resources when an employee is out of work for 5 consecutive days or requests a leave of absence. The Manager is also responsible for informing Human Resources if the dates of the leave change in any way.

What is my responsibility as a manager during an employee's leave?

1. **Documentation**

   The manager is responsible for directing the employee to Human Resources **prior** to the start of a leave to obtain a medical certification and leave application.

2. **Payroll**

   a. If your employee is on an **intermittent leave** (a leave schedule that reduces the usual number of hours per workweek, or hours per workday, of an employee for a limited period), then the manager must assure the appropriate time off is reflected on Web Time Entry.

   b. If your employee is on a **full leave**, payroll of the employee is handled by Human Resources on a weekly or monthly basis.

What is my responsibility as a manager when an employee Returns to Work following a leave?

As a manager it is your responsibility to direct the employee to forward their medical clearance to Human Resources prior to their return to work date. Human Resources will then notify the manager of the expected return to work date.

January 2007

Lactation Support Program

Wellesley College provides a private lactation area on campus to support women balancing work with their needs as mothers of young children. The area provides a secure environment free from intrusion.

Reasonable unpaid break time will be provided each day to an employee who needs to express breast milk for her infant child. The break time shall, if possible, run concurrently with any break time already provided to the employee. Supervisors should attempt to provide as much flexibility as reasonably possible to accommodate the nursing mother's need.

Nursing mothers will need to provide their own breast pumps and plan for storage and cooling.

To ensure privacy, the space can be utilized only by those with access authorization to the room. A request form must be completed and submitted. Please respect the privacy of other users by knocking before access to the room.

Access to the lactation rooms, Green Hall Room 140 and Science Building, Room S125A, are available by contacting Sandra Murga, email: smurgazu@wellesley.edu Room 141 Green Hall.

WELLESLEY COLLEGE

HUMAN RESOURCES

Request for Lactation Room Access
Green Hall, Room 140
Science Building, Room S125A

Date of Request _____

Employee Name _____

Department _____

Daytime Contact Phone _____ Email Address _____

_____

Length of Time Needed

Start Date_____ End Date_____

Would you be interested in being contacted by other new moms for networking?

- o Yes
- o No

Please send completed form via email or in person to:
Sandra Murga, Room 141 Green Hall
E-mail: smurgazu@wellesley.edu

Please note room access expires after end date or one year, whichever comes first. Resubmit request to reapply if necessary.

5/5/11