Family & Medical, Domestic Violence, Military And other Leaves Information Kit

The information provided in this document is applicable to qualified Classified (AFT, WFSE, Prof Tech), administrative-exempt, and faculty (RFT) employees. Human Resources (HR) provides this kit to assist with leave requests for medical and/or parental leave, domestic violence leave, or various types of military leave, for the employee and/or a family member’s event. This document does not include all the details of applicable laws, rules, policies or collective bargaining agreements (contracts). Any issues or questions that are not addressed in the guide will be administered in accordance with the aforementioned Federal, State and local documents.

This kit may be used in conjunction with Reasonable Accommodation (RA) request. However, if this request for medical leave is a Reasonable Accommodation (RA) request or part of a request, you may be requested to also complete the appropriate RA request form. The Reasonable Accommodation policy may be found in the SharePoint site under policy 4.23 – Reasonable Accommodations.

Depending on the reason for your leave, this kit will provide:

The leave request for:

- Leave for the employee’s health condition
- Leave for a family member’s health condition
- Leave for birth or placement for adoption or foster child and care of child
- Medical Leave, when the employee is not eligible for FML
- Shared Leave
- Leave for Domestic Violence
- Leave for Care of a Service Member/Veteran
- Exigency Leave

Each of the above types of leave will have a corresponding Certification Form to be completed by a health care provider, or other appropriate party. If you need help or have questions please contact Human Resources at the below information.

For assistance with this packet please contact
Sally Allen | sallen@RTC.edu | 425.235.7874 or
Lesley Hogan | lhogan@RTC.edu | 425.235.7873
Employee Rights and Responsibilities
Under the Family and Medical Leave Act

Basic Leave Entitlement
FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:
- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee’s child after birth, or placement for adoption or foster care;
- To care for the employee’s spouse, son, 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.

RTC uses a “forward rolling year” method of calculating the 12 workweeks. You may take your leave in several blocks of time, on an intermittent basis or as a reduced work schedule, if determined to be medically necessary by your attending health care provider.

Under State leave rules a mother may be eligible for FML during the pregnancy (and before delivery), based on her own medical need. The birth of the baby is then considered a separate FML qualifying event allowing for up to 12 weeks off to care/bond with newborn.

Military Family Leave Entitlements
Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12 week leave entitlement to address certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member/veteran during a single 12 month period. A covered service member/veteran is a current member of the Armed Forces, including a member of the National Guard or Reserves, has a serious injury or illness that occurred in the line of duty on active duty that may render the service member/veteran medically unfit to perform his or her duties for which the service member/veteran is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections
During FMLA leave, the employer must maintain the employee’s health coverage under any “group health plan” on the same terms as if the employee had continued to work. Failure to pay the employee portion of the premiums within 30 days of the due date could result in cancellation of coverage. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms. Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee’s leave.

Eligibility Requirements
Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition
A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee’s job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave
An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave scheduled when medically necessary.

Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer’s operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave
Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer’s normal paid leave policies.

Employee Responsibilities
Employees must provide 30 days in advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days’ notice is not possible, the employer must provide notice as soon as practicable and generally must comply with an employer’s normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave.

Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities
Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees’ rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA protected and the amount of leave counted against the employee’s leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

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
An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against the employer.

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

In addition to the Federal Family and Medical Leave Act of 1993, RTC provides leave in accordance with the State of Washington regulations, and RTC leave policies. This documentation is a summary of the aforementioned leaves and is not all inclusive. For more detailed information, please contact your HR representative. Please note: If you are not eligible for FMLA, you may still be eligible for another type of leave under the State of Washington Leave regulations, or within RTC leave policies or practices. HRS will monitor your leave request and make this determination.
Leave of Absence Checklist for Employee’s Use

- **Leave of Absence Request** – Notify your supervisor that you need to take leave for either your own health condition, that of your family member, or for the birth/placement and care of a child. You do NOT need to give confidential detail to your supervisor.

- **Family and Medical Leave Kit** – If taking leave for a possible qualifying event (i.e. medical leave, for domestic violence or military leave); please fill out appropriate paperwork from the leave kit. You can make an appointment with your HR representative to discuss any other issues.

- **Department Notification** – HR will keep in communication with you and your department regarding your leave request, return to work information, limitations/restrictions, etc.

  The following should be considered when filling out the Family and Medical Leave Request forms.

- **Worker’s Compensation** – If leave is for a work-related injury or illness, call your HR representative.

- **Medical/Dental** – Do you have leave accruals to use or will you be on full Leave without Pay (LWOP)? HR will provide information on how you can use your leave to maintain your benefit. If you will be on full Leave without Pay (LWOP), HR and Payroll will provide information regarding premiums payments in order to keep benefits active.

- **Long Term Disability Insurance (LTD)** – If the leave is for your own medical condition, apply for Long Term Disability (LTD) benefits if you will be off work longer than your waiting period and/or 90 days. Your HR representative can provide you with claim forms and provide information/assistance regarding this benefit.

- **Shared Leave** – If leave is due to severe or life threatening circumstances, you may be eligible for Shared Leave. Contact your HR representative. NOTE: Eligibility for Worker’s Compensation or LTD benefits will impact eligibility for shared leave.

- **Leave Request Form** – After reviewing the above topics, determine how you will use your leave and complete the Leave Request Form. Do not hesitate to contact HR if you have questions.

- **Certification Form** – You will be responsible for providing the appropriate certification form to the appropriate medical provider or individual and ensuring they provide the documentation to RTC-HR. Important – this information should not be provided to your supervisor or your department, but submitted directly to HR.

- **Call in Requirements** – Plan with your supervisor and/or HR as to how often you should contact RTC while you are on leave.

  Other Important information of which to be aware:

- **Leave Without Pay (LWOP) – Loss of Benefits**
  At the end of an FML period, or if you are on full LWOP for a non-FML event, you will lose eligibility for employer-paid benefits. Employees maintain eligibility for employer-paid benefits if in paid status 8 or more hours in a month, but are still responsible for their portion of the premiums, which 8 hours of pay may not cover. Contact HR for the criteria/limitations of how the 8 hours may be used.

  The Public Employee Benefits Board will send a self-pay packet to the employee offering the option to continue benefit coverage on a self-pay basis.

  If you lose employer-paid coverage, contact HR Benefits upon return to work to re-activate benefits.

- **Release to Return to Work**
  If you have been off work for your own medical condition, you may be required to submit to HR a Work Assessment Form completed by your doctor prior to work. If the Work Assessment Form shows that you are unable to return to work on a full-time basis, or if you need temporary modified duties, HR will coordinate a Return-to-Work Plan with your department.

- **Reasonable Accommodation (RA)**
  If your leave goes beyond the FML you may be able to have extended medical leave as a Reasonable Accommodation. Additionally, if the Work Assessment Form shows you may have limitations/restrictions when released to work, a RA may also be pursued.

- **Life Insurance Premium Waiver**
  If you are or know you will be off work for more than 6 months for your own medical condition, contact HR Benefits for information regarding the Life Insurance Premium Waiver. A life waiver allows an eligible employee to keep the life insurance coverage, but have the premiums waived during the period of disability.

- **Disability Separation/Retirement**
  If circumstances dictate that you are unable to work, a disability separation or disability retirement may be pursued. Your HR representative will assist you in this matter.
Who is responsible for what?

**Employee**
- Notifying supervisor of need for leave
- Working with HR to fill out appropriate paperwork
- Submitting time and leave reporting each pay period electronically (TLR) or via paper time sheets / leave forms
- Communicating with supervisor based on agreed upon “Call In Requirements”
- Providing the *Work Assessment Form* when requested and necessary for return to work

**Department**
- Referring request for medical leave to HR
- Ensuring that payroll documents (PAF, Leave slips) are properly filled out, and submitted on a timely basis while employee is on leave
- Contacting HR with any questions about the leave or return to work process

**Human Resources**
- Counsel and advise employee and departments about medical leave and return to work processes
- Communicate with employing department regarding request and status of leave
- Assist with paperwork
- Monitor process and paperwork for accuracy and timeliness
- Coordinate efforts with Payroll
Renton Technical College

Extended Leave Request Form for any of the following:

Family Medical Leave, Family Care Leave, Disability Leave, Parental Leave, Service Member/Veteran Caregiver Leave, Exigency Leave,
Military Spouse Leave, Military Leave, Domestic Violence Leave, and State of Emergency Leave

<table>
<thead>
<tr>
<th>Employee: Please complete (consult HR for assistance)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee:</td>
</tr>
<tr>
<td>Department:</td>
</tr>
<tr>
<td>Supervisor’s Name:</td>
</tr>
<tr>
<td>Home Mailing Address:</td>
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<tr>
<td>Home Phone Number:</td>
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</tbody>
</table>

Please check reason(s) for leave of absence: Additional Certification Documentation will be required to support leave request.

- Own health condition (not work related)
- Work-related condition (contact Benefit Services)
- Pregnancy disability (prior to birth of child)
- Applying for Shared Leave (See Shared Leave application)
- Care for newborn/placed child
- Care for parent/spouse/child w/serious health condition
- Parental Leave
- Leave for Domestic Violence, Sexual Assault or Stalking
- Military Leave
- Service Member/Veteran Caregiver Leave
- Exigency Leave due to family members call to duty
- Military Spouse Leave
- State of Emergency Leave
- Other

Request Start Date: Anticipated Return to Work Date:

Intermittent or reduced work schedule (describe):

- Please submit leave slip for your anticipating time for your extended leave. Specify the leave you wish to use, the dates, on which to apply it and the total leave hours of each type of leave. Forward to supervisor prior to the start of your leave.
- The FML Act permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FML/Modern leave due to your own serious health condition or to care for a covered family member with a serious health condition. Failure to provide a complete and sufficient medical certification may result in denial of your FML request.
- In requesting leave, I understand that if my request for leave is incomplete or insufficient, HR will give me 7 days to provide the requested information. I also understand and release appropriate HR professionals (i.e. official HR personnel only – not my supervisor or department management) to contact my HCP to authenticate (confirm signature) or clarify the information provided (understand handwriting or meaning of response). If I refuse to provide this release, I understand that RTC can deny my request for leave.

Employee’s Signature ___________________________ Date ___________________________

FOR HR USE ONLY:

<table>
<thead>
<tr>
<th>Has employee worked for the state for at least 1250 hours w/in the last 12 months &amp; been employed at last 12 months?</th>
<th>□ YES</th>
<th>□ NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the reason for this request an FMLA-qualifying event?</td>
<td>□ YES</td>
<td>□ NO</td>
</tr>
<tr>
<td>Is this leave designated as covered by FMLA?</td>
<td>□ YES</td>
<td>□ NO</td>
</tr>
</tbody>
</table>
EMPLOYEE:
Please complete the following information and have the family member’s licensed health care provider complete the physicians section.

RTC Employee:

Name of family member for whom you will provide medical care: ____________________________________________

Relationship of family member to you: ________________________________________________________________

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

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

Employee Signature: _______________________________ Date _______________________________

HEALTH CARE PROVIDER: Please fill out completely.
Please address any of the following that are applicable to your patient, who is identified above as the family member. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Be as specific as you can; terms such as “lifetime,” “unknown,” or “as tolerated,” may not be sufficient to determine FMLA coverage.

Medical facts: Describe relevant medical facts, if any, related to the patient’s condition for which the RTC employee is seeking leave (such medical facts may include symptoms, diagnosis, of any regimen of continuing treatment such as the use of specialized equipment.)

Please identify any of the following that are applicable to your patient:

1. Inpatient care (i.e. hospital stay) including period of incapacity of subsequent treatment.

   If yes, dates of admission: ____________________________________________

   Continuing treatment by a health care provider (HCP), which includes any one or more of the following:

2. Incapacity of more than 3 days plus,

   Two or more treatments by HCP; with the first visit being within 7 days of the incapacity, and the second visit occurring within 30 days of the incapacity or
   One treatment by HCP within 7 days and continuing regimen under supervision of HCP.


4. Incapacity due to Chronic Serious Health Condition (SHC). A chronic SHC is one which:
   A. Requires periodic visits or treatments (at least twice per year) by HCP
   B. Continues over an extended period of time; i.e. physical therapy; and
   C. May cause episodic absences rather than continued incapacity (asthma, diabetes, epilepsy, etc.)

5. Permanent or Long –Term Conditions (Alzheimer’s, severe stroke, terminal stages of a disease, etc.)

6. Multiple Treatments for restorative surgery or for a condition that would likely result in a period of incapacity of more than three days if not treated.
Renton Technical College
Medical Leave Certification FOR FMLA and Family Care Leave

**AMOUNT OF CARE NEEDED:** When answering these questions please 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.

<table>
<thead>
<tr>
<th>Question</th>
<th>No</th>
<th>Yes</th>
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<tbody>
<tr>
<td>Will the patient be medically incapacitated for a single period of time, which requires the care of the RTC employee?</td>
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<tr>
<td>If so, begin date on condition requires care: __________________________</td>
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<tr>
<td>Date when care will no longer be needed, if known: ______________________</td>
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<tr>
<th>Question</th>
<th>No</th>
<th>Yes</th>
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<tr>
<td>Will the patient need care on a part-time or intermittent basis?</td>
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<tr>
<td>If so, estimate the part-time or reduced work schedule the RTC employee will need to provide care, if any:</td>
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<tr>
<td><em><strong><strong>hour(s) per day;<em><strong><strong><strong><strong>days per week from</strong></strong></strong></strong></em></strong></strong></em>__________ through ______________________</td>
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<td>Explain the care needed by the patient why such care is medically necessary:</td>
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<tr>
<th>Question</th>
<th>No</th>
<th>Yes</th>
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<tbody>
<tr>
<td>Will the condition cause episodic flare-ups periodically requiring the care of the RTC employee for your patient?</td>
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<td>If so, based upon the patient’s medical history and your knowledge of their 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):</td>
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<td>Frequency: _____times per______week(s)______month(s)</td>
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<tr>
<td>Duration: _____hours(s) per_____day(s) per episode</td>
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<tr>
<td>Explain the care needed by the patient why such care is medically necessary:</td>
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</table>

**When is the next scheduled appointment to re-evaluate?**

<table>
<thead>
<tr>
<th>Name of Licensed Health Care Providers:</th>
<th>Specialty:</th>
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<tbody>
<tr>
<td>Signature of Licensed Health Care Providers:</td>
<td>Date:</td>
</tr>
<tr>
<td>Address:</td>
<td>Phone:</td>
</tr>
</tbody>
</table>

**Return this form to:**

<table>
<thead>
<tr>
<th>Employee/Patient:</th>
<th>Renton Technical College - HR</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>3000 NE 4th Street</td>
</tr>
<tr>
<td></td>
<td>Renton, WA 98056-4123</td>
</tr>
<tr>
<td></td>
<td>Fax: 425.235.2567</td>
</tr>
</tbody>
</table>