The Family & Medical Leave Act

General Provisions:

If you are temporarily unable to work because of a serious health condition or because you need to care for a newborn or newly adopted child or seriously ill spouse, child, or parent, and you have exhausted available paid leave, such as vacation, short term disability and sick time you may be granted an unpaid job protected leave of absence. When you are able to return from an approved unpaid leave of absence, you will be returned to your former position, another comparable position for which you qualify, or you will be treated the same as any other similarly situated employee who did not take leave.

A request for FMLA must be made in writing to your Supervisor and the Human Resources Department and must include your expected date of return. If possible, your request must be made at least thirty (30) days in advance of the date you wish your leave to begin. You must maintain regular contact with your Supervisor during an approved FMLA. If you do not return to work on your expected date of return, and do not contact your Supervisor, you will be considered to have voluntarily abounded your position and will not be eligible for rehire.

The maximum leave time which may be requested or which will be approved in any twelve-month period is 12 weeks, or the maximum time permitted by state laws, whichever is greater. This time period includes the use and exhaustion of available paid leave.

Time spent on FMLA is not included in the computation of time necessary to earn benefits, nor are benefits earned/accrued during an approved leave. However, no prior service time is lost for purposes of benefits eligibility when you take an approved leave. In addition, group health benefits will continue to be provided for up to twelve weeks during an approved leave at the same level and under the same conditions as if no leave had been taken.

Employees that contribute to a portion of their health/dental benefits will be responsible to make timely payments or make payment arrangements before the leave begins. If you do not return to work at the expiration of your leave, you may be required to repay the cost of any group health/dental insurance provided to you during your leave.

Moore College of Art & Design
20th Street & The Parkway
Philadelphia, PA 19103-1179
(215) 965-4025

Family Medical Leave Act Application

Part I: Certification of Physician

Please type of print the information requested below

1. Employee's Name:_____
2. Patient's Name (if other than employee):_____
3. Diagnosis:_____

_____

_____

_____

4. Date condition commenced: _____
5. Probable duration of condition: _____
6. Regimen of treatment to be prescribed (indicate number of visits, general nature and duration of treatment, including referral to other provider of health services. Include schedule of visits or treatment if it is medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal schedule of hours per day or days per week.):

   a. By Physician or Practitioner:

   _____

   _____

   b. By another provider of health services, if referred by Physician or Practitioner:

   _____

   _____

IF THIS CERTIFICATION RELATES TO CARE FOR THE EMPLOYEE'S SERIOUSLY-ILL FAMILY MEMBER, SKIP ITEMS 7, 8 AND 9 AND PROCEED TO ITEMS 10 THRU 20 ON REVERSE SIDE. OTHERWISE, CONTINUE BELOW.

Check Yes or No below, as appropriate.

	Yes	No	
7.	☐	☐	Is inpatient hospitalization of the employee required?
8.	☐	☐	Is employee able to perform work of any kind? (If "NO" skip item 9)
9.	☐	☐	Is employee able to perform the functions of employee's position? (Answer after reviewing statement from employer of essential functions of employee's position, or if non provided, after discussing with employee.)

FOR CERTIFICATION RELATING TO CARE FOR THE EMPLOYEE'S SERIOUSLY-ILL FAMILY MEMBER, COMPLETE ITEMS 10 THR 13 BELOW AS THEY APPLY TO THE FAMILY MEMBER AND PROCEED TO ITEM 14.

10.	☐	☐	Is inpatient hospitalization of the family member (patient) required?
11.	☐	☐	Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation?
12.	☐	☐	Is the employee's presence necessary or would it be beneficial for the care to the patient? (This may include psychological comfort).

13. Estimate the period of time is needed or the employee's presence would be beneficial.

---

14. Name of Physician: _____

15. Address of Physician: _____

---

16. Phone Number of Physician: _____

17. Name of contact at Physician's office if Employer has questions:

---

18. Type of practice (Field of Specialization, if any): _____

---

19. Signature of Physician: _____

20: Date: _____

PART II: EMPLOYEE CERTIFICATION

Please type or print the information requested below:

1. Employee Name: _____

2. Department: _____ Job Title: _____

3. Hire Date: _____

4. Reason for requesting leave:

   ☐ the birth of a child
   ☐ the placement of a child for adoption or foster care
   ☐ your own serious health condition
   ☐ a serious health condition affecting your
      ☐ spouse
      ☐ child
      ☐ parent (for which you provide care).

5. Are you requesting:
   [ ] Intermittent leave (a day or week at a time as needed)

   [ ] extended leave (up to 12 weeks)

6. If family leave is needed to care for a seriously ill family member, please state below the care you will provided and an estimate of the time period using which this care will be provided, including a schedule if leave is to be taken intermittently or on a reduced leave schedule. _____

   _____

7. If Family Leave is needed for your own health or for the birth or adoption of a child, please state below when you anticipate returning to work.

_____ on a part time basis
(Date)

_____ on a full time basis
(Date)

8. Employee Certification:

Please note the following:

a. You are required to used accrued vacation benefits if the leave is being taken to care for a seriously ill family member, the adoption of a child or your own illness if you are not eligible for short-term disability benefits or you exhaust your short-term disability benefits. For your own illness all accrued sick time must be used.

b. If you normally contribute to your health insurance premiums, you are required to continue to do so. Monthly payments must be forwarded to the Human Resources Office by the 15th of each month you are absent.

   You have a 30 (thirty) day grace period in which to make payment. If payment has not been made timely, your group health insurance may be cancelled.

c. You are required to furnish us with periodic reports of your status and intent to return to work every 30 (thirty) days while on leave of absence. You must contact the Human Resources office with this information.

   You may also be required to provide updated physician's certification.

d. You are required to present a fitness for duty certification prior to being restored to employment if your leave is being taken for your own serious health condition.

   If such certification is not received, your return to work will be delayed until it is provided.

I have read and understand the above. I attest that the information I have given here is true.

Employee Signature: _____

Date: _____-