Request for Family or Medical Leave (FMLA)

Trinity Valley Community College
100 Cardinal Drive Athens, Texas 75751

Request for FMLA should be made at least 30 days prior to the date the requested leave is to begin.

Employee Section

Name_____ **Social Security #**_____
Last First Middle

I request family or medical leave for one or more of the following reasons:

( ) Birth or Adoption of a child
( ) Serious health condition of self
( ) Caring for child during Covid-19
School/Daycare child attends _____
_____

( ) Care of seriously-ill family member
( ) Other (Describe)_____
_____

Beginning date of leave_____ **Expected return date**_____

Have you taken a family or medical leave during the current fiscal year? ( ) NO ( ) YES; # of days _____

I understand and agree to the following provisions:

I have worked for my employer at least one year and at least 1,250 hours in the previous 12 months.

The 12-month period within which employees shall be eligible for 12 weeks of FMLA shall be defined as the 12-month period beginning on the first duty day of the school year. [DEC (LOCAL)].

If I fail to return to work after the leave for reasons other than the continuation, recurrence or onset of a serious health condition that would entitle me to medical leave, I will be financially responsible for the medical insurance premiums that TVCC paid while I was on leave.

This leave will be unpaid; or in the case of my own qualifying disability, payment will occur under TVCC's disability insurance plan.

I understand that I will be required to exhaust my paid vacation, personal or sick leave as part of my 12 weeks of leave, and that I will not be earning sick leave or vacation leave during my absence.

After 12 weeks of leave, if I do not return to work on the date intended, I understand that I am subject to termination.

_____ _____
Employee Signature Date

Return to your supervisor for approval process

Leave Approval - Trinity Valley Community College

_____ _____
Supervisor Signature Date

After Supervisor Approval, Return Form to Human Resources for Completion:
Employed One Year*: YES NO*
_____

Sick Days Accumulated: _____
Vacation Days Accumulated*:*

_____ _____
Director of Human Resources Date

Date Leave to Begin_____ **Expected Return Date**_____

Original to Human Resources

Trinity Valley Community College is an affirmative action/equal opportunity institution which provides educational and employment opportunities on the basis of merit and without discrimination or harassment because of race, color, religion, sex, national origin, age, or disability.

PER0029 (R11/10)

Certification of Physician or Practitioner

(Family and Medical Leave Act of 1993)

1. Employee Name_____

2. Patient Name (if different than employee)_____

3. The attached sheet describes what is meant by a "serious health condition" under the Family and Medical Leave Act. Does the patient's condition qualify under any of the categories described? If so, please check the applicable category.

___1. ___2. ___3. ___4. ___5. ___6. ___None of the above.

4. Describe the medical facts which support your certification, including a brief statement as to how the medical facts meet the criteria of one of the above categories:

_____

_____

_____

5. a. State the approximate date the condition commenced, and the probable duration of the condition (and also the probable duration of the patient's present incapacity if different):

_____

_____

b. Will it be necessary for the employee to take work only intermittently or to work on a less than full schedule as a result of the condition (including for treatment described in Item 6 below)? If yes, give the probable duration:

_____

_____

c. If the condition is a chronic condition (condition #4) or pregnancy, state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity:

_____

_____

6. a. If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments:

_____

_____

If the patient will be absent from work or other daily activities because of treatment on an intermittent or part-time basis, also provide an estimate of the probable number and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any:

_____

b. If any of these treatments will be provided by another provider of health services (e.g., physical therapist), please state the nature of the treatments:

_____

_____

(1) Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking FMLA leave.

(2) "Incapacity," for purposes of FMLA, is defined to mean inability to work, attend school, or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom.

c. If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment):

7. a. If medical leave is required for the employee's absence from work because of the employee's own condition (including absences due to pregnancy or a chronic condition), is the employee unable to perform work of any kind?

b. If able to perform some work, is the employee unable to perform any one or more of the essential functions of the employee's job (the employee or the employer should supply you with information about the essential job functions)? If yes, please list the essential functions the employee is unable to perform:

c. If neither a. nor b. applies, is it necessary for the employee to be absent from work for treatment?

8. a. If leave is required to care for a family member of the employee with a serious health condition, does the patient require assistance for basic medical or personal needs or safety, or for transportation?

b. If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery?

c. If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need:

Signature of Health Care Provider | *Date*

Printed Name of Physician or Practitioner | *Type of Practice*

Address | *Telephone Number*

TO BE COMPLETED BY THE EMPLOYEE NEEDING FAMILY LEAVE TO CARE FOR A FAMILY MEMBER:

State the care you will provide for your family member and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule:

Signature of Employee | *Date*

SERIOUS HEALTH CONDITION

A "Serious Health Condition" means an illness, injury, impairment, or physical or mental condition that involves one of the following:

1. HOSPITAL CARE

   Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

2. ABSENCE PLUS TREATMENT

   A period of incapacity of more than three (3) consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:

   (a) Treatment two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist under orders of, or on referral by, a health care provider); or

   (b) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider.

3. PREGNANCY

   Any period of incapacity due to pregnancy, or for prenatal care.

4. CHRONIC CONDITIONS REQUIRING TREATMENTS

   A chronic condition which:

   (a) Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;

   (b) Continues over an extended period of time (including recurring episodes of a single underlying condition); and

   (c) May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.)

   Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

5. PERMANENT/LONG-TERM CONDITIONS REQUIRING SUPERVISION

   A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, a severe stroke, or terminal stages of a disease.

6. MULTIPLE TREATMENTS (NON-CHRONIC CONDITIONS)

Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three (3) consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).