Family and Medical Leave Act (FMLA)

The FMLA provisions are outlined in the NAPE/AFSCME and State of Nebraska Labor Contract, the SLEBC and State of Nebraska Labor Contract, the Classified System Personnel Rules and Regulations, and federal statutes and regulations. Listed below are some highlights of these sections.

FMLA leave is unpaid time off from work. An employee can use paid vacation leave, compensatory time, or sick leave (see valid reasons for using sick leave in Section 14.11 of the NAPE/AFSCME Labor Contract, Section 11.3.1 of the SLEBC labor contract, and Chapter 10, Section 005.001 of the Classified System Personnel Rules and Regulations), as part of their 12 weeks of FMLA Leave, if the employee should so choose. An employee must have at least twelve total months of service and at least 1250 hours (actual work hours) of service in the previous twelve month period to be eligible for FMLA Leave. Leaves and observed holiday time do not count toward the 1250 hours, only time worked counts. Temporary employment with the State of Nebraska counts toward an employee's eligibility.

Requests for sick leave should be approved/denied based upon your agency's application of the sick leave provisions contained in the applicable labor contracts and the Rules. The FMLA does not change the way the State administers sick leave. An employee may receive approval in advance for the intermittent use of FMLA. Approval of employee requests for vacation leave during periods of unpaid FMLA in order to receive pay for a holiday which occurs during an unpaid FMLA is not recommended but is allowed. A minimum of 30 days notice to the Agency must be provided by the employee before he/she may use FMLA Leave. Where 30 days notice is not foreseeable, notice must be given as early as possible.

Leave Entitlement.
A covered employer must grant an eligible employee up to a total of **12 workweeks** of **unpaid** leave during any 12-month period for one or more of the following reasons:

- for the birth and care of a newborn child of the employee;
- for placement with the employee of a son or daughter for adoption or foster care;
- to care for a spouse, son, daughter, or parent with a serious health condition;
- to take medical leave when the employee is unable to work because of a serious health condition;
- for qualifying exigencies arising out of the fact that the employee's spouse, son, daughter, or parent is on active duty or call to active duty status as a member of the Armed Forces, National Guard or Reserves in support of a contingency operation in a foreign country;
- A covered employer also must grant an eligible employee who is a spouse, son, daughter, parent, or next of kin of a current member of the Armed Forces, National Guard or Reserves; next of kin of a member who left the Armed Forces, National Guard or Reserves less than five years ago; with a serious injury or illness up to a total of **26 workweeks** of **unpaid** leave during a "single 12-month period" to care for the service member.

Spouses employed by the same employer are limited in the **amount of** FMLA leave they may take for the birth and care of a newborn child, placement of a child for adoption or foster care, or to care for a parent who has a serious health condition, to a combined total of 12 weeks (or 26 weeks if leave to care for a covered service member with a serious injury or illness is also used). Leave for birth and care, or placement for adoption or foster care, must conclude within 12 months of the birth or placement.

Under some circumstances, employees may take FMLA leave intermittently – taking leave in separate blocks of time for a single qualifying reason – or on a reduced leave schedule – reducing the employee's usual weekly or daily work schedule. When leave is needed for planned medical treatment, the employee must make a reasonable effort to schedule treatment so as not to unduly disrupt the employer's operation. If FMLA leave is for birth and care, or placement for adoption or foster care, use of intermittent leave is subject to the employer's approval.

Under certain conditions, employees **or** employers may choose to "substitute" (run concurrently) accrued **paid** leave (such as sick or vacation leave) to cover some or all of the FMLA leave. An employee's ability to substitute accrued paid leave is determined by the terms and conditions of the employer's normal leave policy.

"Serious health condition" means an illness, injury, impairment, or physical or mental condition that involves either:

- Inpatient care (*i.e.*, an overnight stay) in a hospital, hospice, or residential medical-care facility, including any period of incapacity (*i.e.*, inability to work, attend school, or perform other regular daily activities) or subsequent treatment in connection with such inpatient care; **or**

- Continuing treatment by a health care provider, this includes:

  (1) A period of incapacity lasting more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition that **also** includes:

    - treatment two or more times by or under the supervision of a health care provider (*i.e.*, in-person visits, the first within 7 days and both within 30 days of the first day of incapacity); **or**

    - one treatment by a health care provider (*i.e.*, an in-person visit within 7 days of the first day of incapacity) with a continuing regimen of treatment (*e.g.*, prescription medication, physical therapy); **or**

  (2) Any period of incapacity related to pregnancy or for prenatal care. A visit to the health care provider is not necessary for each absence; **or**

  (3) Any period of incapacity or treatment for a chronic serious health condition which continues over an extended period of time, requires periodic visits (at least twice a year) to a health care provider, and may involve occasional episodes of incapacity. A visit to a health care provider is not necessary for each absence; **or**

  (4) A period of incapacity that is permanent or long-term due to a condition for which treatment may not be effective. Only supervision by a health care provider is required, rather than active treatment; **or**

  (5) Any absences to receive 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.

In the case of a member of the Armed Forces, including the National Guard and Reserves- A **"serious injury or illness"** is one that occurs in the line of duty on active duty that may render the service member medically unfit to perform the duties of his or her office, grade, rank or rating [29 U.S.C. § 2611(18)], and in the case of a veteran, one that was incurred in the line of duty on active duty that manifested itself before or after the member became a veteran.

Health Insurance while on FMLA Leave. Employer health insurance contributions shall continue during an employee's unpaid FMLA Leave absence, provided the employee makes his/her required contribution and intends to return to work for at least 30 days following his/her FMLA leave except as specified below. Employer contributions shall be based as if the employee had continued to work his/her normal schedule. When an employee does not return from FMLA Leave for a reason other than: 1) the continuation, recurrence, or onset of a serious health condition which would entitle the employee to FMLA Leave; or, 2) other circumstances beyond the employee's control, the employee will be required to reimburse the State for the State's share of health insurance premiums paid on the employee's behalf during the FMLA Leave. Personnel Contacts should continue to coordinate questions regarding health insurance with the AS-Employee Benefits Section, (402) 471-4443.

Effect of Leave on Bonuses. Employers may disqualify employees from bonuses or other achievement payments based on job related performance goals, such as attendance or products sold, when the employee has not met the goal because they took FMLA leave, as long as the same rules apply to employees on other types of leave.

Employers Can Directly Contact the Employee's Doctor. An employer's HR administrator, leave administrator, or management official (but not the direct supervisor) may directly contact an employee's health care provider to clarify and authenticate the certification after giving the employee an opportunity to cure any deficiencies in the medical certification.

Recertification. If an employee is taking leave intermittently or is on a reduced work schedule, an employer can't require recertification before the end of the minimum period of the initial certification. The Federal Regulations at §825.308, in summary, state:

> If the minimum duration of the period of incapacity specified on a certification furnished by the health care provider is more than 30 days, the employer may not request recertification until that minimum duration has passed. For FMLA taken intermittently or on a reduced leave schedule basis, the employer may not request recertification in less than the minimum period specified on the certification as necessary for such leave (including treatment) unless one of the conditions set forth in paragraph (c) (1), (2) or (3) of Section 825.308 of the Federal Regulations is met.
>
> The exceptions listed in (c) (1), (2) or (3) include when:
>
> (1) The employee requests an extension of leave;
>
> (2) Circumstances described by the previous certification have changed significantly (e.g., the duration of the illness, the nature of the illness, complications); or
>
> (3) The employer receives information that casts doubt upon the continuing validity of the certification.

If you have any questions on the Family and Medical Leave Act, please contact William J. Wood at (402) 471-4106, Sean Davis at (402) 471-8292, or Tammy Benson at (402) 471-4104.

Family and Medical Leave Request Form
(Family and Medical Leave Act)

State of Nebraska

Employee Name: _____

Agency: _____

1. I have at least twelve months service with the State of Nebraska. **YES** **NO**
Note: *Service may be with more than one Agency -- service need not be continuous.*

2. I have been paid for at least 1,250 hours of work by the State of Nebraska in the past twelve months. (Does not include leave hours) **YES** **NO**

Go forward only if all previous Questions have been answered YES and you have not used more than twelve weeks of FMLA Leave in the past twelve months.

3. Reason for FMLA Leave:

Note: *FMLA Leave under the following circumstances must be completed no later than one year after the child's birth, adoption, or foster care placement.*

☐ I am the mother or father of a newborn child. The child's birthdate or expected birthdate is _____.

☐ I am adopting or have legally adopted a child. The date of child's placement in my home was/is _____.

☐ Placement of a foster child in my home. The date of child's placement in my home was/is _____.

☐ Personal request due to exigencies arising out of the fact my spouse, son, daughter, or parent is on active duty or call to active duty status as a member of the National Guard, Reserves, or regular duty Armed Forces personnel who are deployed to a foreign country, in support of a contingency operation.

Note: *In each case below, a serious health condition is defined as requiring one of the following: (1) inpatient care, (i.e. an overnight stay); (2) a period of incapacity of more than three consecutive calendar days, and treatment two or more times by a health care provider, or 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) incapacity due to pregnancy or prenatal condition (4) a chronic condition requiring at least two visits per year for treatment by a health care provider; or (5) a permanent/long-term condition requiring supervision* *This does not include voluntary or cosmetic treatments unless inpatient hospital care is required.*

Note: *In each case below, a* ***Health Care Provider's Certification Form*** *must be completed and returned within 15 calendar days of submission of this form.*

☐ Care for my seriously ill mother or father. *(if not your biological or adoptive parent, you must present satisfactory evidence of parental relationship -- care for a mother-in-law or father-in-law does not qualify for FMLA Leave)*

☐ Care for my seriously ill spouse. *(must be legal spouse; unmarried domestic partners do not qualify for FMLA Leave)*

☐ Care for my seriously ill child. *(If not your biological, adoptive, foster, or step-child, you must present documentation of parent-child relationship)*

☐ Personal request due to my serious health condition or injury *(would include recovery from childbirth or extended pre-natal care).*

Note: *In the cases below, a* ***Serious Injury or Illness of a Current Service Member Certification Form*** *or* ***a Serious Injury or Illness of a Veteran for Military Caregiver Leave Certification Form*** *must be completed and returned within 15 calendar days of submission of this form.*

☐ I am the next of kin of a current service member who has a serious illness or injury incurred in the line of duty, while on active duty.
☐ I am the next of kin of a Veteran who has a serious illness or injury that was incurred or aggravated when the covered veteran was a member of the Armed Forces.

4. I understand that FMLA Leave is strictly unpaid leave that is used at the employee's discretion for qualifying events. Accrued paid leave may be used as part of the 12 weeks, under the conditions noted previously, at the employee's discretion.

5. I understand that in cases where FMLA Leave is foreseeable, I must apply, for FMLA Leave a minimum of 30 days in advance. In cases where FMLA Leave is not foreseeable, I understand it is my responsibility to apply for FMLA Leave as early as possible and practicable, either before or after the FMLA Leave event.

Note: *In all circumstances, employees are required to complete this form.*

6. My first day of absence from work will be _____, and I will return to work on _____. If exact dates are unknown, please enter approximate dates.

Note: *Total absence may not exceed twelve weeks or twenty-six weeks for service member caregiver leave. In cases of childbirth, adoption, or foster child placement, the employer may require the leave to be taken in a single continuous period. In cases of serious health condition, leave may be taken intermittently for medical reasons, according to a schedule approved by the health care provider (attach leave schedule to the Health Care Provider's Certification Form).*

7. I understand that FMLA Leave is strictly unpaid leave. Requests for sick and vacation leave and/or compensatory time will be processed according to applicable labor contracts or Personnel Rules. Use of sick leave, vacation leave and compensatory time **may** be counted towards my twelve weeks of FMLA Leave.

8. I understand that sick and vacation leave will not accrue and holidays will not be compensated during non-paid absences.

9. I understand that my service date will be adjusted if my unpaid absence exceeds fourteen consecutive calendar days.

10. I understand that I must complete the ***Insurance Coverage Continuation Form***.

11. I understand that if the absence from work was due to my personal health condition, I must submit a "Release for Duty" report from my Health Care Provider prior to my return to work.

12. I understand that when I return to work, I will be returned to the same job I left or an equivalent job and that a failure to return to work at the end of my leave period may be treated as a resignation unless an extension has been agreed upon and approved in writing.

Employee Signature: _____ Date: _____

☐ ***Approved***

☐ ***Denied*** (employee requests may not be denied without prior notification to AS-Employee Relations Division)

Agency Authorized Signature: _____ Date: _____

If you need help using this form, please contact your agency Personnel Office or AS Employee Relations at (402) 471-8292 - TDD (402) 471-4693

YOUR RIGHTS AS A NEBRASKA STATE EMPLOYEE

Under the

FAMILY AND MEDICAL LEAVE ACT (FMLA) OF 1993

FMLA requires the State of Nebraska to provide up to 12 weeks of unpaid, job protected leave to "eligible" employees for certain family and medical reasons. The employee may use other paid leaves, such as vacation leave, sick leave, or comp time as part of the 12 weeks if he/she meets the criteria for such leave, has accrued leave or compensatory time, and receives advanced supervisory approval.

ELIGIBILITY FOR FMLA LEAVE: An employee is eligible if he/she has worked for at least one year, has been paid for more than 1250 hours of work over the previous 12 months, and has not used more that 12 weeks of FMLA Leave in the previous 12 months. When an employee and their spouse are both working for the State of Nebraska, each will be eligible for 12 weeks of FMLA Leave, except in the case of a birth, or the adoption or placement of a foster child with the employee in which case they are eligible for a combined total of 12 weeks.

REASONS FOR TAKING LEAVE: FMLA Leave must be granted for the following reasons:

- To care for the employee's child after birth, or the adoption or placement of a foster child with the employee;
- To care for the employee's spouse, son or daughter, or parent, who has a serious health condition;
- For a serious health condition that makes the employee unable to perform his/her job;
- For an exigency caused by the call to active duty of a member of the Armed Forces in a foreign country;
- To care for a spouse, child, parent or next of kin who is a service member and is injured or has become seriously ill while on active duty or within five years of leaving the armed forces if related to an injury or illness suffered while on active duty, or aggravated while on active duty (up to 26 weeks of leave is allowed during a 12 month period).

UNPAID LEAVE: FMLA Leave is unpaid leave.

- Sick Leave, Vacation Leave and/or Compensatory Time may be retained or used according to applicable labor contract provisions or Classified System Personnel Rules and Regulations. Sick Leave, Vacation Leave or Compensatory Time will be counted toward the 12 week FMLA Leave allotment if the employee so chooses and meets the requirements to use such leave.

ADVANCE NOTICE AND MEDICAL CERTIFICATION: The employee may be required to provide medical certification and advance leave notice when the reason for the leave is foreseeable. FMLA Leave may be denied if these requirements are not met:

- The employee ordinarily must provide at least 30 days advance notice when the leave is "foreseeable."
- The employer may require medical certification to support a request for FMLA Leave because of a serious health condition. (Second or third opinions may be required at the employer's expense.) The employee is required to provide a fitness for duty report prior to returning to work. The need for a fitness for duty certification must be communicated to the employee at the same time as notice of eligibility for FMLA leave is given.

JOB BENEFITS AND PROTECTION:

- During FMLA Leave, the State's contribution toward the employee's health coverage will continue, provided that the employee continues his/her health coverage contribution and intends to return to work for at least 30 days after the FMLA Leave ends.

- Upon return from FMLA Leave, the employee will be restored to his/her original or equivalent position 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: The FMLA Leave law makes it unlawful for the employer to interfere with, restrain, discriminate, discharge, or otherwise deny an employee his/her rights provided under the FMLA.

ADDITIONAL INFORMATION AND ENFORCEMENT:

- See your agency Personnel Officer if you have questions.

- AS-Employee Relations is your State Government FMLA Leave resource. (402) 471-8292, (402) 471-4106, (402) 471-4104; TDD (402) 471-4693.

- The U.S. Department of Labor investigates and resolves complaints of violations. The FMLA coordinator for the Midwest Region (including Nebraska) can be reached by telephone at: 312-596-7189. The Wage and Hour Division also provides information from a toll-free number: 1-866-487-9243.

- An eligible employee may bring a civil action against an employer for violations.

Revised 3/10

Insurance Coverage Continuation Form *(during Family and Medical Leave)*

Name: _____ S.S.# _____ Empl. ID: _____ Date of Leave: _____

Current Coverage:	***Continue?*** **YES / NO**		Option or Type	Premium Employer	Premium Employee
***Health**	_____	_____	_____	_____	_____
Dental	_____	_____	_____	_____	_____
Life	_____	_____	_____	_____	_____
Vision	_____	_____	_____	_____	_____
Flexible Spending Accounts	_____	_____	_____	_____	_____
Long Term Disability	_____	_____	_____	_____	_____

Employee's Total: _____

Circle one: Bi-Weekly /Monthly /Other

1. ***I understand that my Agency will continue to pay for the State's contribution of my health coverage during my absence. I understand my Agency's obligation to continue to contribute to my health coverage ends when:

a. I choose not to retain health coverage during my FMLA Leave absence as I have indicated above; or

b. I fail to return from leave upon schedule, or I inform my Agency of my intent not to return.

(Upon separation from employment, COBRA insurance continuation provisions may apply.)

2. I understand that if I choose to continue my insurance as indicated above, my premium is due by the first of the month for the month of coverage (check made out for the above specified total to the Department of Administrative Services, and delivered to my Agency's Personnel Officer). If my premium is not remitted by the first calendar day of the month, my coverage will be suspended until my payment is received. If my payment is not received by the last calendar day of the month, my coverage will be terminated permanently until my return to work.

3. I understand that while on leave, I will have the same opportunities as other employees to change coverage, plans or benefits (open enrollment opportunities, for example).

4. I understand the State may recover the State contributions made on my behalf should I fail to return to work after my FMLA Leave entitlement expires, unless the reason I fail to return is due to:

(a) a continuation, recurrence, or onset of a serious health condition which would entitle me to leave under the Family and Medical Leave Act; or

(b) other circumstances beyond my control as defined in the Family and Medical Leave Act.

Employee Signature: _____ Date: _____

Certification of Qualifying Exigency For Military Family Leave (Family and Medical Leave Act)

U.S. Department of Labor

Wage and Hour Division

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 leave due to a qualifying exigency to submit a certification. Please complete Section I before giving this form to your employee. Your response is voluntary, and 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 CFR 825.309.

Employer name: _____

Contact Information: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II fully and completely. The FMLA permits an employer to require that you submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a qualifying exigency. Several questions in this section seek a response as to the frequency or duration of the qualifying exigency. Be as specific as you can; terms such as "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Your response is required to obtain a benefit. 29 CFR 825.310. While you are not required to provide this information, failure to do so may result in a denial of your request for FMLA leave. Your employer must give you at least 15 calendar days to return this form to your employer.

Your Name: _____
First Middle Last

Name of military member on covered active duty or call to covered active duty status:

_____
First Middle Last

Relationship of military member to you: _____

Period of military member's covered active duty: _____

A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes written documentation confirming a military member's covered active duty or call to covered active duty status. Please check one of the following and attach the indicated document to support that the military member is on covered active duty or call to covered active duty status.

A copy of the military member's covered active duty orders is attached.

Other documentation from the military certifying that the military member is on covered active duty (or has been notified of an impending call to covered active duty) is attached.

I have previously provided my employer with sufficient written documentation confirming the military member's covered active duty or call to covered active duty status.

PART A: QUALIFYING REASON FOR LEAVE

1. Describe the reason you are requesting FMLA leave due to a qualifying exigency (including the specific reason you are requesting leave):

_____

_____

_____

_____

2. A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes any available written documentation which supports the need for leave; such documentation may include a copy of a meeting announcement for informational briefings sponsored by the military; a document confirming the military member's Rest and Recuperation leave; a document confirming an appointment with a third party, such as a counselor or school official, or staff at a care facility; or a copy of a bill for services for the handling of legal or financial affairs. Available written documentation supporting this request for leave is attached.

Yes ☐ No ☐ None Available ☐

PART B: AMOUNT OF LEAVE NEEDED

1. Approximate date exigency commenced: _____

Probable duration of exigency: _____

2. Will you need to be absent from work for a single continuous period of time due to the qualifying exigency?

Yes☐ No☐

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

_____

3. Will you need to be absent from work periodically to address this qualifying exigency? Yes☐ No☐

Estimate schedule of leave, including the dates of any scheduled meetings or appointments:

_____

_____

_____

Estimate the frequency and duration of each appointment, meeting, or leave event, including any travel time (i.e., 1 deployment-related meeting every month lasting 4 hours):

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

Duration: _____ hours ___ day(s) per event.

PART C:

If leave is requested to meet with a third party (such as to arrange for childcare or parental care, to attend counseling, to attend meetings with school, childcare or parental care providers, to make financial or legal arrangements, to act as the military member's representative before a federal, state, or local agency for purposes of obtaining, arranging or appealing military service benefits, or to attend any event sponsored by the military or military service organizations), a complete and sufficient certification includes the name, address, and appropriate contact information of the individual or entity with whom you are meeting (i.e., either the telephone or fax number or email address of the individual or entity). This information may be used by your employer to verify that the information contained on this form is accurate.

Name of Individual: _____ Title: _____

Organization: _____

Address: _____

Telephone: (_____) _____ Fax: (_____) _____

Email: _____

Describe nature of meeting: _____

_____

_____

_____

_____

_____

_____

_____

PART D:

I certify that the information I provided above is true and correct.

Signature of Employee _____ 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 CFR 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 AV, NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE EMPLOYER.**