University of Houston
FMLA/Parental Leave Application

Employee Information

Name: Empl ID: _____

Employee's Email Address:* _____ Telephone # _____

Home Address: State Zip _____

Department: Campus: _____

Supervisor Name Telephone # _____

Pay Type: ☐ Monthly ☐ Biweekly

Normal months worked per year: ☐ 12 months ☐ 9 months ☐ Other

Request for: ☐ Family and Medical Leave -or- ☐ Parental Leave

*** All communications from HR regarding your FML will be made via this Email address**

Leave Request Summary

Is this a joint application with a spouse who is also a UH employee? ☐ Yes ☐ No

Is the qualifying condition due to the birth or placement of a child with you for adoption or foster care? ☐ Yes ☐ No

Please indicate: □ Birth -or- □ Adoption -or- □ Foster Care Anticipated birth/placement date: _____

Is the qualifying event due to Military Leave:_____Active Duty Leave_____Military caregiver leave? ☐ Yes ☐ No

Active duty: Qualifying exigency Relationship: Active duty Paid Vacation? ☐ Yes ☐ No

Military caregiver: Certification of health care provider: ☐ Yes ☐ No Certification for next of kin? ☐ Yes ☐ No

Is the qualifying condition due to the serious health condition of a child, parent, or spouse of the employee? ☐ Yes ☐ No

If leave is requested for a serious health condition of a dependent, please provide the following information:

Name: Relationship: DOB (if child) _____

Is the qualifying condition due to the serious health condition of the employee? ☐ Yes ☐ No

Date of event or onset of condition: _____/_____/_____ Duration: Last Day Worked: _____/_____/_____

Are you requesting intermittent leave? ☐ Yes ☐ No

If yes, please provide: Work/leave schedule: Duration of leave:

NOTE: Recertification is required every 6 months for intermittent leave.

Provisions

I understand and agree to the following provisions. ***M denotes Military Leave acknowledgement***

_____I certify that I have received the Health Care Provider Certification and must return it within 15 calendar days or my FML will be denied.

_____I understand I will be given state premium sharing toward the cost of health insurance while on FML. I will be billed (or the amount will be deducted from any sick leave or vacation pay) for additional premiums in excess of the state premium sharing. Should I fail to pay the additional premiums, the health coverage will be changed to the Employee Only level and optional coveages will be terminated.

***M*____Continuation of group insurance is subject to the conditions and policies of the 'Employees Retirement System of Texas" relating to coveages while on leave without pay.**

***M*___I will report periodically during the leave *(at least once per week)* to my supervisor on my leave status and intention to return to work.**

- I must exhaust all sick, vacation, or other paid leave accumulations while taking FMLA leave. Once my paid leave is exhausted, I will be placed on leave without pay.
- After 12 weeks or the amount of approved leave, if I do not return to work or contact my supervisor or manager on or before that date intended, it will be considered that I abandoned my job.
- I will receive the state credit for health insurance during the Family or Medical or Parental leave and will be billed for any additional insurance premiums due. Should I fail to pay the additional premiums, my health insurance coverage will be changed to employee only level and optional coverages will be canceled. Continuation of group insurance is subject to the conditions and policies of ERS relating to coverage while on leave without pay.
- I must provide a release to return to work from my physician following my leave. Should I fail to do so, my department may deny restoration of my employment.

Employee Signature: Date: _____

Fax this form to 713-743-4830

Employee Section

Employee Section

YOUR RIGHTS UNDER THE FAMILY AND MEDICAL LEAVE ACT OF 1993

The Family Medical Leave Act (FMLA) requires covered employers to provide up to 12 weeks (up to 26 weeks for military caregiver leave) of unpaid, job-protected leave to "eligible" employees for certain family and medical reasons. Employees are eligible if they have worked for a covered 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.

ADVANCE NOTICE AND MEDICAL CERTIFICATION

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

- The employee must provide 30 days' notice when the leave is "foreseeable"
- The University of Houston requires medical certification to support a request for leave because of a serious health condition, may require a second or third opinion (at the university's expense), and requires certification of fitness to return to work.

JOB BENEFITS AND PROTECTION

For the duration of FMLA leave, the University of Houston must allow the employee to 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.

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 the employer for violations.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective.

HR Only

This Section To Be Completed By Human Resources

Employee's Job Title: FTE: Hire Date: / /_____

Vacation Balance: Sick Leave Balance: _____

HR Service Center Signature: Date: _____

_____

_____

_____

_____

NOTE:

- HR will report any changes in the approved leave immediately to the Department
- HR will prepare an ePAR to change the employee's status from active to paid or unpaid leave.
- HR may request leave records, if necessary, for processing benefits, including but not limited to disability applications, workers compensation claims, and death claims.

Fax this form to 713-743-4830

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UNIVERSITY of HOUSTON

HUMAN RESOURCES

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FML PHYSICIAN'S INFORMATION RELEASE

TO: _____
(Attending Physician)

RE: _____
(Printed Name of Patient)

This is an authorization to release all information pertaining to my condition to the University of Houston, Office of Human Resources. Please return the original with the Certification of Health Care Provider form and retain a copy with your records.

I understand that this authorization can be revoked at any time by me in writing, but it will not be retroactive for information previously released in good faith.

Patient Signature: _____

Date Signed: _____

FML Employee Responsibilities

1. It is the immediate responsibility of the employee to inform their departments that they are applying for FML including what dates they anticipate being out on FML.

2. Be aware the FML process is a 15 day/2.5 week period that will be denied if the certification is not received.

3. Once you are out on FML, you must contact your department/supervisor at least once a week during the duration of your leave.

4. Provide an Email that you check regularly as this will be the communication method for HR when sending you any FML notifications including approval or denial.

5. If you are on FML and are in an unpaid status, it is your responsibility to pay your premiums to ERS directly or you will lose those benefits.