University of Massachusetts Amherst

Office of Human Resources

Dear AFSCME Sick Leave Bank Member:

Thank you for your interest in the AFSCME Union Local 1776 Sick Leave Bank (SLB). The Bank was established to maintain income for SLB members who are on an approved medical leave for more than ten (10) working days where there is a reasonable expectation that the member will return to perform the essential functions of his/her job. The SLB does not provide income replacement for periods which may be covered by an insurance policy (workers' compensation, motor vehicle insurance, etc.).

The SLB can secure income after a SLB application is approved and the member has:

- Been out of work for ten (10) work days.
- Exhausted all accrued sick and personal time, and all but ten days of accrued vacation time.
- Been placed on a departmentally approved leave.

To apply for income security from the AFSCME Sick Leave Bank you must:

1. Submit a written request for leave to your departmental Human Resources (HR) representative. The process is outlined in the attached Employee Family/Medical Leave Request Checklist and requires a Certification of Health Care Provider form for an Employee's Serious Health Condition completed byyour health care provider (both attached). Contact your department's HR/Personnel Coordinator if you work in one of the following areas:
   - Auxiliary Enterprises, contact Katty Calderon, HR/Organizational Developmentat 918 Campus Center.
   - Facilities & Campus Services, Ozgun Sulekoglu (413-545-6452) or Kris Moriarty (413-577-0473), HR/Physical Plant.
   - If you do not work in one of the above areas, please contact your department's HR representative or manager for guidance.
2. Complete Section One of the SLB application, and
3. Have your health care provider complete Section Two of the SLB application
4. Have your department's Human Resources representative complete Section Three of the SLB application; and
5. return the application to Human Resources:
   - Via mail: University of Massachusetts Amherst, Human Resources, 325 WhitmoreAdministration Building, Amherst, MA 01003-9313
   - Via facsimile: 413.545.0483
   - In person at the Human Resources Information Center, room 325 Whitmore Administration Building (hours of operation posted online: Employee Service Center).

Please contact me at via AskHR online from www.umass.edu/hr with questions about the process.

Sincerely,
Kelly Pleasant
On behalf of the AFSCME
Sick Leave Bank Committee

University of Massachusetts Amherst

Office of Human Resources

Employee's Family / Medical Leave Request Checklist

#1 At least 30 calendar days prior to your leave* (or if medically unable, as soon as practicable), submit a written, signed, and dated request to your supervisor, cc your Human Resources representative, indicating:

1) That you are requesting a family / medical leave,

2) The anticipated dates of your leave (including the date you intend to return to work)
If requesting an intermittent leave, the work schedule you propose.

3) How you are requesting to secure income. Eg, if leave is approved are you asking your department to submit your sick time? Vacation time? Personal time? Are you requesting unpaid leave?

#2 Concurrently or within 15 calendar days thereafter provide your Human Resources representative supporting documentation. What is that documentation? If your need leave due to:

- Parental Leave*
  - Prepare for birth of a child or to bond/care for child within 12 months following birth: provide a medical note or birth certificate establishing relationship and child's date of birth
  - Adoption/placement of a child in foster care with you, or bond with/care for a child within 12 months following adoption/placement): legal document establishing date of adoption by/placement with you.
- Your own illness/injury:
  Certification of Health Care Provider form for an Employee's Serious Health Condition
- Care for a family member with an illness/injury:
  Certification of Health Care Provider form for a Family Member's Serious Health Condition
- Care for a family member whose illness/injury results from active US Military service:
  Certification for Serious Injury or Illness of a Veteran for Military Caregiver Leave
- Your family member being on, or called to, active duty in the US Military:
  Certification for Military Family Leave for Qualifying Exigency

If you encounter challenges opening Certification forms using the links above all forms are available on the Department of Labor website: www.dol.gov/agencies/whd/fmla/forms

All forms are available from your Human Resources representative, on the UMass Amherst Human Resources website (www.umass.edu/humres/hr-library) and from the Human Resources Employee Service Center (325 Whitmore Admin. Bldg.).

* Birth/adoption/placement of a child is a qualifying event to make changes to your health & dental insurances and enroll/change a Health Care Flexible Spending Account / Dependent Care Assistance Plan. These changes must be completed within 60 days of birth/adoption/placement. You may also wish to review your tax withholdings and life insurance/retirement beneficiaries. Consult the Human Resources website or a UMass Human Resources Employee Service Center (room 325 Whitmore Administration Building) representative for more information.

AFSCME UNION LOCAL 1776
SICK LEAVE BANK APPLICATION

A.F.S.C.M.E.

SECTION ONE: EMPLOYEE INFORMATION
(To be completed by the applicant - Page 1 of 2)

The AFSCME Sick Leave Bank (SLB) was established to secure income for members who are on an approved medical leave for more than ten (10) work days where there is a reasonable expectation that the member will return to perform the essential functions of his/her job. The SLB does not provide income replacement for periods which may be covered by an insurance policy (e.g. workers' compensation, motor vehicle insurance, etc.)

Name_____ Employee ID# _____

Home Address _____

Home Telephone #_____ Work Telephone # _____

Email Address _____

Job Title_____ Department _____

Supervisor's Name _____

Telephone # _____

Email Address _____

Last Day Worked_____ Expected Date of Return to Current Position _____

Nature of Illness or Injury: Please describe the illness or injury for which you are requesting income replacement from the SLB. How does the illness or injury prevent you from performing your job?

Thank you for taking the time to complete this form.

(Revised 08/11/23

University of Massachusetts Amherst

AFSCME UNION LOCAL 1776
SICK LEAVE BANK APPLICATION

A.F.S.C.M.E.

SECTION ONE: EMPLOYEE INFORMATION
(To be completed by the applicant - Page 2 of 2)

OTHER INSURANCE: The Sick Leave Bank is not insurance.

Do you have insurance which may provide income replacement for this illness/injury? ☐ Yes

☐ Short-term disability policy_____
(please specify insurance company name)

☐ Long-term disability policy _____
(please specify GIC or other insurance company name)

☐ Other insurance ___
(e.g. auto, homeowners. Please specify type of plan and company name)

Have you applied for income replacement? ☐ *Yes ☐ No

*If yes, please specify type of policy and status of claim: _____

NOTE: If you are covered by an insurance plan not provided through AFSCME or the GIC, please provide a document / letter from that insurance company outlining the waiting period and level of income replacement available.

I agree to notify the Committee prior to application for income replacement from another source for the same illness/injury.

I hereby certify that the information I provided in Section One is true and accurate and I understand that all information I provide will be reviewed by the Sick Leave Bank Committee as well as its administrator.

Signature: _____ Date: _____

AFSCME UNION LOCAL 1776
SICK LEAVE BANK APPLICATION

A.F.S.C.M.E.

SECTION TWO: MEDICAL INFORMATION - <u>to be completed by physician</u>

Please answer the following questions as completely as possible. Attach additional sheets as necessary.

1. Patient's name: _____

2. General statement of this patient's condition, diagnosis, and date of onset: _____

_____

3. How long have you been treating this patient for this condition (include dates of first and most recent visits)?

_____

4. Please describe your treatment plan for this patient:

Plan (e.g. surgery, medication, test(s), therapy, etc.): _____

If therapy, please note type of therapy and frequency (i.e. daily, weekly, etc.): _____

Expected therapy/treatment end date: _____

Prognosis: _____

Please describe the medical progress made to-date (if applicable): _____

_____

5. What is medically preventing this patient from performing his/her job? _____

_____

6. Do you believe this patient will be able to perform the duties of his/her current position in the future? ☐**Yes** ☐**No**

If **<u>yes</u>**, specify the date (mm/dd/yy) you anticipate this patient will be able to return to work and perform the duties of his/her current position: _____

If **<u>yes</u>,** and you are unable to determine a return to work date at this time, when will you be able to provide a return to work date: _____

7. Do you anticipate this patient will be able to return to work earlier on a modified work schedule? ☐ **Yes** ☐ **No**

If **<u>yes</u>**, please specify the date on which the employee can return with accommodations: _____

Required work accommodations (e.g. reduced hours, physical limitations, etc.) _____

_____

Specify the date when the employee will be able to return to work <u>without</u> accommodations: _____

8. I hereby certify that I have examined the above-named patient and that the information provided is true based upon my knowledge and belief.

Signature of Physician _____ Date _____

9. Please **print legibly** the following information:

Name of Physician: _____ Registration Number: _____

Address: _____

Telephone Number: _____ <u>Specialty</u>: _____

AFSCME UNION LOCAL 1776
SICK LEAVE BANK APPLICATION

A.F.S.C.M.E.

SECTION THREE: DEPARTMENT CONFIRMATION

Please see your department's HR/Personnel Coordinator.

If you work in one of the following areas, please have Section Three completed by individual below:

- **Auxiliary Enterprises, Katty Calderon-Marks, Human Resources/Org Dev at 918 Campus Center**
- **Facilities & Campus Services, Ozgun Sulekoglu (413-545-6452) or Kris Moriarty (413-577-0473), HR/Physical Plant.**
- **If you do not work in one of the above areas, please contact your department's HR representative or manager for guidance.**

PLEASE NOTE THAT WHEN AN EMPLOYEE IS/WILL BE OUT OF WORK DUE TO A MEDICAL ISSUE, THE EMPLOYEE AND HIS/HER HR PERSONNEL COORDINATOR MUST FOLLOW THE UNIVERSITY'S LEAVE APPLICATION AND APPROVAL PROCESS (ATTACHED). PLEASE CONTACT THE AFSCME SICK LEAVE BANK ADMINISTRATOR IN HUMAN RESOURCES WITH QUESTIONS AND FOR ASSISTANCE.

Department Time and Attendance Keeper _____

Telephone # _____

Email Address _____

_____ is on an approved leave for up to _____ hours of leave time
(employee name)

per **week** from _____ until _____ due to his/her own illness.
(first day out of work) (last day out of work)

If the leave request is part-time, the employee and I have agreed to **the attached work schedule**, which meets both the needs of the department and the physician's recommendations.

Based on the information available to me, this leave does not result from a work-related illness or injury.

_____ _____
Dept. HR Personnel Coordinator's Signature Date

_____ _____
Dept. HR Personnel Coordinator's Name (printed) Campus Address

_____ _____
Campus Telephone Number Campus Email Address