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.
    - Residential Life, contact Kathryn Coach/HR (413-577-6159) 325 Berkshire House.
    - 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: www.umass.edu/humres/employee-service-center).

Please contact me at ecurry@umass.edu with questions about the process.

Sincerely,
Elizabeth Curry
On behalf of the AFSCME
Sick Leave Bank Committee

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

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.

Certification of Health Care Provider for Employee's Serious Health Condition under the Family and Medical Leave Act

U.S. Department of Labor
Wage and Hour Division

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR.
RETURN TO THE PATIENT.

OMB Control Number: 1235-0003
Expires: 6/30/2023

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. 29 U.S.C. §§ 2613, 2614(c)(3); 29 C.F.R. § 825.305. The employer must give the employee **at least 15 calendar days** to provide the certification. If the employee fails to provide complete and sufficient medical certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

SECTION I – EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, this form asks the health care provider for the information necessary for a complete and sufficient medical certification, which is set out at 29 C.F.R. § 825.306. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308.** Additionally, you **may not** request a certification for FMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care.

Employers must generally maintain records and documents relating to medical information, medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

(1) Employee name: ____
First *Middle* *Last*

(2) Employer name: ______________________________ Date: ______________ *(mm/dd/yyyy)*
(List date certification requested)

(3) The medical certification must be returned by ______________________________ *(mm/dd/yyyy)*
(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee's diligent, good faith efforts.)

(4) Employee's job title: ______________________________ Job description (☐ is / ☐ is not) attached.
Employee's regular work schedule: ______________________________
Statement of the employee's essential job functions: ______________________________
____
(The essential functions of the employee's position are determined with reference to the position the employee held at the time the employee notified the employer of the need for leave or the leave started, whichever is earlier.)

SECTION II - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form. Your patient has requested leave under the FMLA. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of the employee. For FMLA purposes, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves *inpatient care* or *continuing treatment by a health care provider*. For more information about the definitions of a serious health condition under the FMLA, see the chart on page 4.

You may, but are **not required** to, provide other appropriate medical facts including symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment. Please note that some state or local laws may not allow disclosure of private medical information about the patient's serious health condition, such as providing the diagnosis and/or course of treatment.

Employee Name: ____

Health Care Provider's name: *(Print)* ____

Health Care Provider's business address: ____

Type of practice / Medical specialty: ____

Telephone: (___) ______________ Fax: (___) ______________ E-mail: ______________________________

PART A: Medical Information

Limit your response to the medical condition(s) for which the employee is seeking FMLA leave. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. **After completing Part A, complete Part B to provide information about the amount of leave needed.** Note: For FMLA purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

(1) State the approximate date the condition started or will start: ______________________ *(mm/dd/yyyy)*

(2) Provide your **best estimate** of how long the condition lasted or will last: ______________________

(3) Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

- ☐ **Inpatient Care**: The patient (☐ has been / ☐ is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): ______________________

- ☐ **Incapacity plus Treatment**: *(e.g. outpatient surgery, strep throat)*
  Due to the condition, the patient (☐ has been / ☐ is expected to be) incapacitated for *more than* three consecutive, full calendar days from ______________ *(mm/dd/yyyy)* to ______________ *(mm/dd/yyyy)*.

  The patient (☐ was / ☐ will be) seen on the following date(s): ______________________

  ____

  The condition (☐ has / ☐ has not) also resulted in a course of continuing treatment under the supervision of a health care provider *(e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment)*

- ☐ **Pregnancy**: The condition is pregnancy. List the expected delivery date: ______________ *(mm/dd/yyyy)*.

- ☐ **Chronic Conditions**: *(e.g. asthma, migraine headaches)* Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

- ☐ **Permanent or Long Term Conditions**: *(e.g. Alzheimer's, terminal stages of cancer)* Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

- ☐ **Conditions requiring Multiple Treatments**: (*e.g. chemotherapy treatments, restorative surgery)* Due to the condition, it is medically necessary for the patient to receive multiple treatments.

- ☐ **None of the above**: If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed. Go to page 4 to sign and date the form.

Employee Name: ____

(4) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. *(e.g., use of nebulizer, dialysis)* ____

____

PART B: Amount of Leave Needed

For the medical condition(s) checked in Part A, complete all that apply. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage.

(5) Due to the condition, the patient (☐ had / ☐ will have) **planned medical treatment(s)** (scheduled medical visits) *(e.g. psychotherapy, prenatal appointments)* on the following date(s): ______________________________

____

(6) Due to the condition, the patient (☐ was / ☐ will be) **referred to other health care provider(s)** for evaluation or treatment(s).

State the nature of such treatments: *(e.g. cardiologist, physical therapy)* ______________________________

Provide your **best estimate** of the beginning date ________________ *(mm/dd/yyyy)* and end date ________________ *(mm/dd/yyyy)* for the treatment(s).

Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery *(e.g. 3 days/week)*

____

(7) Due to the condition, it is medically necessary for the employee to work a **reduced schedule**.

Provide your **best estimate** of the reduced schedule the employee is able to work. From ____________________ *(mm/dd/yyyy)* to __________________ *(mm/dd/yyyy)* the employee is able to work: *(e.g., 5 hours/day, up to 25 hours a week)*

____

(8) Due to the condition, the patient (☐ was / ☐ will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.

Provide your **best estimate** of the beginning date ___________________ *(mm/dd/yyyy)* and end date ________________ *(mm/dd/yyyy)* for the period of incapacity.

(9) Due to the condition, it (☐ was / ☐ is / ☐ will be) medically necessary for the employee to be absent from work on an **intermittent basis** (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, episodes of incapacity are estimated to occur ___________________________ times per (☐ day / ☐ week / ☐ month) and are likely to last approximately ______________ (☐ hours / ☐ days) per episode.

Employee Name: ____

PART C: Essential Job Functions

If provided, the information in Section I question #4 may be used to answer this question. If the employer fails to provide a statement of the employee's essential functions or a job description, answer these questions based upon the employee's own description of the essential job functions. An employee who must be absent from work to receive medical treatment(s), such as scheduled medical visits, for a serious health condition is considered to be *not able* to perform the essential job functions of the position during the absence for treatment(s).

(10) Due to the condition, the employee (☐ was not able / ☐ is not able / ☐ will not be able) to perform *one or more* of the essential job function(s). Identify at least one essential job function the employee is not able to perform:

____

____

Signature of
Health Care Provider ___________________________ **Date** _______________ *(mm/dd/yyyy)*

Definitions of a Serious Health Condition *(See 29 C.F.R. §§ 825.113-.115)*
Inpatient Care
• An overnight stay in a hospital, hospice, or residential medical care facility. • Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.
Continuing Treatment by a Health Care Provider (any one or more of the following)
Incapacity Plus Treatment: A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either: ○ Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or, ○ At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.
Pregnancy: Any period of incapacity due to pregnancy or for prenatal care.
Chronic Conditions: Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.
Permanent or Long-term Conditions: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.
Conditions Requiring Multiple Treatments: Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.

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 C.F.R. § 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 15 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 Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR. RETURN TO THE PATIENT.

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.

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: ________________________________

Thank you for taking the time to complete this form.

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: ______________________________ Specialty: ______________________________

Thank you for taking the time to complete this form.

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, Heather Anderson, Human Resources/Org Dev at 918 Campus Center**
- **Facilities & Campus Services, Ginger Thomas, Human Resources Manager, Physical Plant**
- **Residential Life, Ozgun Sulekoglu, Human Resources Coordinator, 325 Berkshire House**
- **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

Thank you for taking the time to complete this form.