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 completed by your health care provider (both attached). Contact your department's HR/Personnel Coordinator if you work in one of the following areas:
    - Auxiliary Enterprises, see Heather Anderson, HR/Organizational Development at 918 Campus Center.
    - Facilities & Campus Services, see Ginger Thomas, HR Manager, Physical Plant.
    - Residential Life, see Ozgun Sulekoglu, HR 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.
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 Whitmore Administration Building, Amherst, MA 01003-9313
    - via facsimile: 413.545.0483
    - in person at the Human Resources Information Center, room 325 Whitmore Administration Building, open Monday-Friday, 8:30am-5:00pm.

Please contact me at rrgrzych@admin.umass.edu or (413) 545-1473 with questions about the process.

Sincerely,
Randy Grzych
On behalf of the AFSCME
Sick Leave Bank Committee

University of Massachusetts Amherst

Office of Human Resources

Employee's Family/Medical Leave Request Checklist

Required: you may not be absent from work without approval from your department.

- ☐ You must submit a written, signed, and dated request for leave to your supervisor (faculty should submit to their department chair or dean) indicating:
  1) the medical condition that prohibits you from performing your job (or if you are requesting leave to care for another person suffering from a serious health condition),
  2) the dates you anticipate being absent from work and the date you intend to return to work,
  3) be clear with your department how you are requesting that time and attendance be submitted in order to secure income if your leave is approved (e.g., sick leave, unpaid leave, etc.), and
  4) if requesting an intermittent leave, the work schedule you propose.
- ☐ The letter must be accompanied by the corresponding Certification of Health Care Provider (HCP) form completed by your HCP – or - the HCP who is treating the individual you will be caring for while on leave (parent, child, etc. The list of covered individuals differs from bargaining unit to bargaining unit). Certification of Health Care Provider forms are available at the Human Resources Employee Service Center (325 Whitmore Admin. Bldg.) and on-line at www.umass.edu/humres.

Voluntary: If you do not have enough accrued time to secure your income while on an approved leave you may

- ☐ a completed Sick Leave Bank application to Human Resources (or AFSCME Extension of Sick Leave application) if you will not have enough accrued time to secure income during your leave. Repeat as necessary. (Not applicable for Workers Compensation.)

Required:

- ☐ If requesting an extension of your leave – follow steps above, submitting the required documents to your supervisor for his/her receipt at two weeks prior to the expiration of your currently approved leave. Repeat as necessary.
- ☐ During your leave you must remain in contact with your supervisor about your medical progress and/or changes in your leave situation and intention to return to your University position.
- ☐ *Prior* to returning to your job you must provide your supervisor a written medical document releasing you to return to work and perform the essential functions of your job *and* any accommodations you are requesting in order to do so, if any.

Note:

- ☐ if you are on approved, *unpaid* leave for two or more full payperiods and you carry health insurance through your University position you must complete a Request for Continuation of Part-Cost health insurance premium form with Human Resources (545-6113). If you do not the Massachusetts Group Insurance Commission will invoice you for 100% of the health insurance premium in order to maintain coverage.
- ☐ If you are on parental leave and wish to add your child(ren) to your insurance coverages you must complete the necessary paperwork with Human Resources (HR Service Center, room 325 Whitmore Administration Building, open Monday – Friday, 8:30am – 5:00pm) within thirty (30) days of the child(ren)'s date of birth or adoption.
- ☐ Use of paid leave while on a Family Medical Leave Act-qualified leave runs concurrent with time granted under the FMLA.

Certification of Health Care Provider for Employee's Serious Health Condition (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: 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 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. Please complete Section I before giving this form to your employee. Your response is voluntary. 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 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to 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.

Employer name and contact: _____

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions: _____

_____

Check if job description is attached:

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: _____
First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. 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. Limit your responses to the condition for which the employee is seeking leave. 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). Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

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

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

   Mark below as applicable:
   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
   ___No ___Yes. If so, dates of admission:

   _____

   Date(s) you treated the patient for condition:

   _____

   Will the patient need to have treatment visits at least twice per year due to the condition? ___No ___ Yes.

   Was medication, other than over-the-counter medication, prescribed? ___No ___Yes.

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
   ____No ____Yes. If so, state the nature of such treatments and expected duration of treatment:

   _____

2. Is the medical condition pregnancy? ___No ___Yes. If so, expected delivery date: _____

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

   Is the employee unable to perform any of his/her job functions due to the condition: ____ No ____ Yes.

   If so, identify the job functions the employee is unable to perform:

   _____

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

   _____

   _____

   _____

   _____

   _____

   _____

   _____

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___No ___Yes.

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

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ___No ___Yes.

   If so, are the treatments or the reduced number of hours of work medically necessary? ___No ___Yes.

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   _____

   Estimate the part-time or reduced work schedule the employee needs, if any:

   _____ hour(s) per day; _____ days per week from _____ through _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ____No ____Yes.

   Is it medically necessary for the employee to be absent from work during the flare-ups? ____ No ____Yes. If so, explain:

   _____

   _____

   Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

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

Duration: _____ hours or ___ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

Signature of Health Care Provider **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 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 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 Ave., NW, Washington, DC 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.

(Revised 2/18/14)

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 <u>not</u> insurance.

Do you have insurance which may provide income replacement for this illness/injury? ☐ No ☐ 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: _____ Specialty: _____

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