Dear PSU/MTA Sick Leave Bank Member,

Thank you for your inquiry regarding the Professional Staff Union/MTA/NEA Sick Leave Bank. The Sick Leave Bank was established under the provisions of the collective bargaining agreement (Article 20.2). It is intended to provide paid leave time to members who:

- Are absent from work due to a non-work related injury or illness where there is a reasonable expectation, based on medical documentation, of the member returning to the position held at the time a medical leave due to the illness or injury began. The Sick Leave Bank is not intended as a substitute for Long-Term Disability Insurance protection.
- Need paid leave time until an approved application for Long-Term Disability Insurance benefit becomes effective.
- Are absent from work due to parental leave or serious illness of a family household member.

If you are out of work for five or more days (or out regularly, intermittently due to your own health condition or in order to care for a family member with a health condition) you must submit a leave request through your local Human Resources representative (process outlined in the Employee's Family / Medical Leave Request Checklist and requiring that you submit a completed Certification of Health Care Provider form related to your leave). Departmental approval of your leave secures your job and benefits while you are on an approved leave.

While on a departmentally approved leave you may secure your income using your accrued sick, vacation and personal time. You may also apply to the PSU/MTA Sick Leave Bank for income replacement.

PSU/MTA Sick Leave Bank policy requires an employee to use all accrued sick and personal leave, and all but ten days of accrued vacation, prior to drawing from the Bank. The Sick Leave Bank Board considers applications for paid time beyond those accruals based on information provided by the employee and their health care provider(s). A PSU/MTA Sick Leave Bank application follows your consideration.

In order for your application to be considered by the Committee, please:

- Complete Section One of the application,
- Have your health care provider complete Section Two for your own illness or injury, **or provide:**
  - A completed Certification of Health Care Provider for a Family Member's Serious Health Condition in place of the Section Two for the care of a family member, or
  - Legal documents in place of Section Two for adoptions and foster child placement,
- Have your human resources representative complete Section Three, and
- Return the application to UMass Human Resources. The completed application may be mailed (University of Massachusetts Amherst, Human Resources, 325 Whitmore Administration Building, Amherst, MA 01003-9313), faxed (413.545.0483) or left at the Human Resources Information Center, room 325 Whitmore Administration Building.

Please contact me (pleasant@umass.edu / 413.545.1478) with questions regarding the Sick Leave Bank application process.

Sincerely,
Kelly Pleasant
on behalf of the PSU/MTA Sick Leave Bank Board

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, cc your departmental Human Resources representative, indicating:

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

  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.

  If you medically require accommodations in order to perform the essential functions of your job it is your responsibility to work with University's Accessible Workplace Office to secure those accommodations.

- ☐ You must provide your departmental Human Resources representative a completed Certification of Health Care Provider (HCP) form corresponding to the purpose for your leave (eg, Employee's Serious Health Condition, Family Member's Serious Health Condition, etc.) 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. If your leave is due to the birth of your child you may provide a medical note indicating the child's expected date of delivery in lieu of a Certification form. If your leave is due adoption or placement of a child in your foster care please provide corresponding legal documentation indicating the date of adoption or placement.

Voluntary: If you do not have enough accrued time to secure your income while on an approved leave you may complete and submit a completed Sick Leave Bank application to Human Resources (or AFSCME Extension of Sick Leave application). This is not applicable for work-related illness or injury that may be covered under Workers Compensation.

Required:

- ☐ If requesting an extension of your leave – follow steps above, submitting the required documents for receipt at two weeks prior to the expiration of your currently approved leave.
- ☐ During your leave you must remain in contact with the University regarding your intention to return to your University position and any changes in your anticipated return to work date.
- ☐ *Prior* to returning to your job you must provide your departmental human resources representative a written medical document releasing you to return to work and perform the essential functions of your job. If accommodations are required it is your responsibility to secure those accommodations through the University's Accessible Workplace Office prior to your return.

Note:

- ☐ If you are on approved, *unpaid* leave for two or more full payperiods and you purchase insurance through the MA Group Insurance Commission (GIC), the GIC will invoice you at home for your insurance premiums. Timely payment is required in order to secure continued coverage. If you are on an unapproved leave the Massachusetts Group Insurance Commission will invoice you for 100% of the health insurance premium.
- ☐ 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) within thirty (30) days of the child(ren)'s date of birth or adoption.

Protections under the federal Family Medical Leave Act (FMLA) run concurrent with approved time off for qualifying circumstances.

**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**

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.<br>• 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:<br>o 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,<br>o 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. |



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

University of Massachusetts Amherst

# SICK LEAVE BANK APPLICATION

PSU

The items you must provide to apply for income from the PSU/MTA Sick Leave Bank differs based on the nature of your leave:

| | Nature of Sick Leave Bank Application Request | Complete & Submit Sections |
|---|---|---|
| ☐ | Your own serious health condition. | 1, 2 & 3 |
| ☐ | The birth of a child, or placement of a child with you for adoption or foster care. | 1, 2 & 3. Doctor should indicate due date on Section 2.<br>If adoption or placement of a child in foster care – please provide legal documentation *in lieu* of Section 2. |
| ☐ | You are needed to care for your ☐ spouse; ☐ domestic partner; ☐ child; ☐ parent; ☐ sibling; ☐ grandchild; ☐ grandparent; ☐ relative living in household; due to his/her serious health condition. | 1, 3 & Certification of Health Care Provider form for Family Member's Serious Health Condition. |

## SECTION ONE: EMPLOYEE INFORMATION - (to be completed by the applicant)

Name sdsd Employee ID# _____

Home Address _____ Home Phone # _____

Job Title _____ Work Phone # _____

Department _____

Name of Supervisor/Dept. Head: _____

Name of Dept Time & Attendance Keeper _____

Last Day of Work _____ Expected Date of Return to Work _____

Please describe the illness or injury for which you are requesting time from the Sick Leave Bank. How does the illness or injury prevent you from performing your job?

Signature _____ Date _____

**PSU/MTA Sick Leave Bank • contact: Human Resources • phone 413-545-0380 • fax 413-545-0483**

Thank you for taking the time to complete this form.

# Please Submit The Following Section 2 Of The Application If You Are Applying For Income Replacement During An Approved Leave For Your Own Serious Health Condition

(to be completed by a health care professional)

University of Massachusetts Amherst

# SICK LEAVE BANK APPLICATION

PSU

**SECTION TWO: MEDICAL INFORMATION – (to be completed by physician)**

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

Patient's name: _____

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

_____

_____

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

_____

_____

3. Please describe your treatment plan and prognosis for this patient: _____

_____

_____

_____

**4.** Do you believe the patient will be able to perform the duties of their current position in the future? □ **Yes** □ **No**

If **yes**, specify when you anticipate the patient will be able to return to work and perform the duties of their current position: _____

If **yes** 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: _____

**5.** Do you anticipate the patient will be able to return to work earlier on a modified work schedule? □ **Yes** □ **No**

If **yes**, please specify the date on which the employee can return with modifications _____

Required Work Modifications _____

_____

_____

Specify the date when the employee will be able to return to work without modifications _____

6. 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 _____

7. Please **print** the following information:

Name of Physician: _____

Address: _____

Telephone number: _____ Specialty: _____

# Please Submit The Following Certification Of Health Care Provider Form For A Family Member's Serious Health Condition

## If You Are Seeking Income Replacement During An Approved Leave To Care For A Qualified Family Member

(to be completed by a health care professional)

University of Massachusetts Amherst

# SICK LEAVE BANK APPLICATION

PSU

## SECTION THREE: SUPERVISORY CONFIRMATION
**(to be completed by applicant's supervisor)**

_____ (employee name) has notified me of his/her intention to apply to the PSU/MTA Sick Leave Bank for up to_____hours of paid leave time per week from _____ (date) until_____(date) due to:

- ☐ his/her own illness.
- ☐ parental leave for the care of a child in the event of birth, adoption, or foster placement.
- ☐ a serious illness of a family or household member.

If the paid 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.

_____ Supervisor's Signature

_____ Date

_____ Supervisor's name (printed)

_____ Campus Address

_____ Campus Telephone Number

**PLEASE NOTE** THAT WHEN AN EMPLOYEE WILL BE OUT OF WORK FOR ANY OF THE ABOVE REASONS THE EMPLOYEE AND HIS/HER SUPERVISOR MUST FOLLOW THE UNIVERSITY'S LEAVE APPLICATION AND APPROVAL PROCESS. CORRESPONDING SUPERVISORY AND EMPLOYEE CHECKLISTS ARE ATTACHED. CHECKLISTS AND CORRESPONDING FORMS ARE ALSO AVAILABLE ON THE HR WEBSITE WWW.UMASS.EDU/HUMRES. PLEASE CONTACT THE PSU/MTA SICK LEAVE BANK ADMINISTRATOR IN HUMAN RESOURCES WITH QUESTIONS & FOR ASSISTANCE.