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. 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 _____ 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.

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: _____

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.

Certification of Health Care Provider for Family Member'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 to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. 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' family members, 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: _____

_____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your family member or his/her 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 to care for a covered family member with a 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 to your employer. 29 C.F.R. § 825.305.

Your name: _____
First Middle Last

Name of family member for whom you will provide care:_____
First Middle Last

Relationship of family member to you: _____

If family member is your son or daughter, date of birth:_____

Describe care you will provide to your family member and estimate leave needed to provide care:

_____

_____

_____

_____ ____ _____
Employee Signature Date

CONTINUED ON NEXT PAGE

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. 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 patient needs leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e). Page 3 provides space for additional information, should you need it. 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: _____

   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: _____

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

   Will the patient need to have treatment visits at least twice per year due to the condition? ___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. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

_____

_____

_____

_____

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ___No ___Yes.

   Estimate the beginning and ending dates for the period of incapacity: _____

   During this time, will the patient need care? __ No __ Yes.

   Explain the care needed by the patient and why such care is medically necessary:

   _____

   _____

   _____

   _____

   _____

5. Will the patient require follow-up treatments, including any time for recovery? ___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:

   _____

   Explain the care needed by the patient, and why such care is medically necessary: _____

   _____

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? __ No __ Yes.

   Estimate the hours the patient needs care on an intermittent basis, if any:

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

   Explain the care needed by the patient, and why such care is medically necessary:

   _____

   _____

   _____

   _____

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ____No ____Yes.

   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

   Does the patient need care during these flare-ups? ____ No ____ Yes.

   Explain the care needed by the patient, and why such care is medically necessary: _____

_____

_____

_____

_____

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.