University of Massachusetts Amherst

Office of Human Resources

Employee's Illness/Injury

Dear USA/MTA Sick Leave Bank Member:

Thank you for your interest in the USA/MTA Sick Leave Bank. Please refer to Article 10 of the Agreement between the University of Massachusetts' Board of Trustees and the University Staff Association (USA/MTA/NEA) which establishes a Sick Leave Bank for USA/MTA/NEA employees for information.

The Sick Leave Bank was created to provide income security in part to *Sick Leave Bank members* who:

- Are out of work on an approved leave to recover from a short term, non-work related illness or injury.
- Do not have enough accrued sick, personal, compensatory, and vacation time to secure income during the leave.
- Have a reasonable expectation of returning, and intend to return, to consistently perform the job from which they became disabled.
- Are not receiving, or eligible to receive income replacement from another source.

Please remember that you may not be absent from work without your department's approval. The University has established a standard procedure for requesting leave from your department. This process is detailed in the attached document titled Employee's Family/Medical Leave Request Checklist.

To be considered for income replacement from the Bank; a member may submit the attached Sick Leave Bank application. A completed application will consist of:

- Section One: Completed by the member.
- Section Two: Completed by the treating health care professional.
- Section Three: Completed by the member's departmental HR Representative.

The USA/MTA Bargaining Agreement states that if an application is approved by the Committee, a member may draw upon the Bank after the exhaustion of all sick leave and all but ten (10) days of total leave from personal, compensatory, and/or vacation accruals.

For questions regarding the process of applying to the Sick Leave Bank; please contact me via email at: rrgrzych@admin.umass.edu or by phone at (413) 545-1473.

Sincerely,

Randy Grzych
On behalf of the USA/MTA Sick Leave Bank

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.

University of Massachusetts Amherst

USA / MTA

SLB

Application for Income Replacement

For a Member's Illness/Injury

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

Please submit this application form and the requested information if you are applying for income replacement during an approved leave associated with your own illness/injury. The Sick Leave Bank is intended to be used for short-term and non-work related disabilities, where the employee has a reasonable expectation of returning to consistently perform the job from which he/she became disabled. It is not intended as a substitute for or supplement to other income sources (eg. long-term disability, worker's compensation)

Name: _____ Employee ID Number: _____

Home Address: _____

Home Telephone Number: _____ Work Telephone Number: _____

Email Address: _____

Job Title: _____ Department: _____

Supervisor's Name: _____

Email Address: _____ Telephone Number: _____

Department Time and Attendance Keeper: _____

Email Address: _____ Telephone Number: _____

Last Day Worked: _____ Expected Date of Return to Current Position: _____

Nature of Illness or Injury: Please describe the illness or injury for which you ae requesting income replacement from the Sick Leave Bank. How does the illness/injury prevent you from performing your job?

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Application for Income Replacement
For a Member's Illness/Injury

SECTION ONE: EMPLOYEE INFORMATION
(to be completed by applicant page 2 of 2)

Is the illness or injury that is disabling you from performing your job caused, or exacerbated, by your job?

☐ YES ☐ NO

Have you filed a Worker's Compensation Notice of Injury involving this illness/injury?

◯ YES ◯ NO

OTHER INSURANCE (this does not include the Sick Leave Bank)

Do you have insurance which may cover income replacement for this illness/injury?

◯ YES ◯ NO

If yes, please indicate:

☐ Short-term disability policy: _____
(please specify USA/MTA, Other)

☐ Long-term disability policy: _____
(please specify: USA/MTA, GIC, Other)

☐ Other Insurance: _____
(eg. auto, homeowners. Please specify company's name)

☐ Have you applied for income replacement from any of the sources indicated above?

If Yes, please specify: _____

NOTE: If you may be covered by insurance other than USA/MTA or GIC, please provide a document/letter from the insurance company outlining the waiting period and level of income replacement available.

I hereby certify that the information I provided in Section One is true and accurate. I agree to notify the Committee prior to application for income replacement from another source for the same illness/injury.

Signature: _____ **Date:** _____

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Application for Income Replacement

For a Member's Illness/Injury

SECTION TWO: MEDICAL INFORMATION (to be completed by health care professional)

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***, please specify when you anticipate the patient will be able to return the 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: _____

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

SIGNATURE OF HEALTH CARE PROVIDER: _____ **Date:** _____

Please **print** the following information:

Name of Health Care Provider: _____ Registration Number: _____

Address: _____

Telephone Number: _____ Title/Specialty: _____

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SECTION THREE: DEPARTMENTAL CONFIRMATION
(to be completed by Departmental HR Coordinator)

I have approved _____ for up to _____ hours of leave
(name)
per week from _____ until _____ due to his/her own illness.
(date) **(date)**

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 health care provider's recommendations.

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

HR Coordinator Name: _____

Campus Address: _____

Campus Telephone Number: _____

Campus Email Address: _____

HR Coordinator Signature: _____ Date: _____

Please Note: When an employee will be out of work due to a medical issue, or when requesting parental leave, the employee and his/her supervisor must follow the University's Leave and Approval Process. These checklists may be viewed at https://www.umass.edu/humres/forms. Please contact the Sick Leave Bank Administrator in the Division of Human Resources with questions or assistance.