**Contract Administration Tip – FMLA and Sick Leave**

**Please distribute to All MCCC Unit Members.**

**Please discuss this FMLA and Sick Leave Process at the chapter's first MACER meeting to ensure system-wide compliance.**

***General***

The FMLA is a federal law that requires the college to provide up to twelve (12) weeks of unpaid leave each calendar year to employees for certain family and medical reasons. The FMLA works in conjunction with other leave provisions to which employees are entitled under collective bargaining agreements, personnel policies or other laws. FMLA may be taken on an intermittent basis in increments no smaller than one hour.

***Eligibility***

A unit member must have been employed for one year and worked at least 1250 hours in the year prior to taking leave under the FMLA.

***Reasons for Taking Leave***

To care for the employee's child after birth, or placement for adoption or foster care;

To care for the employee's spouse, son, daughter, or parent, who has a serious health condition;

For a serious health condition that makes the unit member unable to perform the unit member's job duties.

***Job Benefits and Protection***

The college must maintain the unit member's health coverage during FMLA if they had coverage through the college prior to the leave. The college must return the unit member to the same or equivalent position with equivalent benefits, pay, and other terms and conditions of employment.

***Contractual Benefits***

Nothing in this Act or any amendment made by this Act shall be construed to diminish the obligation of an employer to comply with any collective bargaining agreement or any employment benefit program or plan that provides greater family or medical leave rights to employees than the rights established under this Act or any amendment made by this Act. In the present contract, MCCC unit members have the right to use paid sick leave and then, if eligible, available paid sick leave bank days; paid child care leave; and paid maternity leave. In addition, the MCCC Contract provides for unpaid family leave for up to one academic year. A unit member's rights to these benefits do not expire when the12 week FMLA leave is exhausted. If a unit member is on FMLA leave due to a serious health condition, the use of sick leave and then, if eligible, available paid sick leave bank days run concurrently.

***Negotiated FMLA and Sick Leave Forms***

The attached Request for Medical Leave was negotiated by the parties and is required at all 15 community colleges. When a unit member is in need of leave due to a serious health condition, the college's Human Resources Office is required to send this document to the unit member. The document has two sections: 1) An introduction outlining the process and the contractual requirement to provide medical certification that the unit member cannot perform the unit member's duties because the unit member is incapacitated. 2) The forms that are available to show the necessity for medical leave (Form WH-380-E, the agreed to abbreviated form - Instructions to the Health Care Provider, and the Fitness-For-Duty Certification).

# Request for Medical Leave that may be protected as FMLA or as a request for contractual sick leave

**Potential FMLA Leave** - The Human Resources Office has been informed that you have a medical need for leave that may be due to a serious health condition of an employee. Accordingly, if you believe that you may be eligible for FMLA leave designation and/or are requesting FMLA leave, Form WH-380-E is located at http://www.dol.gov/whd/forms/WH-380-E.pdf . If you would like the college to mail a copy of the form to you, please let us know. In lieu of the WH-380-E form, you may also use the attached abbreviated form entitled "Instructions to Health care Provider".

To request FMLA leave, Form WH-380-E, or the attached abbreviated form entitled "**Instructions to the Health Care Provider"** (which was agreed to as a substitute by the MCCC and the Employer) should be provided to your Health Care Provider for completion and return. You have fifteen (15) calendar days to return one of the completed forms. Your Health Care Provider will either complete one of the two forms or provide appropriate medical documentation to support any request for FMLA leave. Note there are other forms available on the Federal website for different types of leave such as that for a family member or for leave related to military service: http://www.dol.gov/whd/fmla/2013rule/militaryForms.htm

**Contractual Medical Leave Requirement** – Even if you do not believe your sick leave request would qualify as FMLA protected leave, please have your health care provider complete the attached physician's certificate entitled "**Instructions to the Health Care Provider"**, proving the necessity of such absence for the medical leave you are seeking. As set forth in Article 9.01, the certificate must be filed within seven (7) calendar days of this request, or your absence may be applied at the discretion of the College as absence without pay.

If you need additional time for your health care provider to complete the required information, please contact the Human Resources department to request an extension of time to provide the information.

Please note, the FMLA allows employers to charge your leave concurrently to sick leave under the collective bargaining agreement and to FMLA if you are entitled to the twelve-week unpaid leave allowed for certain employees under FMLA for a "serious health condition." If FMLA applies, an employee must first use all accrued sick leave and then, if eligible, available sick leave bank days, as part of their twelve-week FMLA leave prior to being placed on unpaid FMLA leave for the remainder of their 12 week FMLA leave period, if any.

**INSTRUCTIONS to the HEALTH CARE PROVIDER:**

Your patient _____has requested leave from _____Community College. 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(s) for which the employee is seeking leave. Please be sure to sign the form.

Provider's name: _____

Type of Practice/Medical Specialty: _____

Provider's signature:_____

Address:_____

Telephone:_____

Fax:_____

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**Approximated date condition commenced and probable duration:**_____

Overnight Admission? No___ Yes, ___If yes dates_____

Dates of treatment _____

Will patient need treatment at least twice per year?_____

Referral to other healthcare provider for evaluation or treatment? No___Yes___

If yes, nature of treatments and expected duration:_____

**Is the patient incapacitated and unable to perform the essential job functions of _____position (see attached job description and/or contractual workload requirements)** due to the condition: No____Yes___If yes identify job functions unable to perform: _____

_____.

Is medical condition pregnancy? No___ Yes___ expected delivery date:_____

Describe other relevant medical facts related to the condition for which the patient is incapacitated and seeks medical leave (diagnosis, symptoms, or any regimen of continuing treatment such as the use of specialized equipment):_____

_____

_____

_____

**Amount of Leave needed:**

Incapacitated for single continuous period? No___ Yes___Estimate beginning and ending dates_____

Follow-up treatment appointments medically necessary or part-time or reduced schedule needed for leave? No___ Yes___If yes, estimate treatment schedule including dates, length and recovery period for appointments and if leave request is for part-time or reduced schedule specify beginning and ending date and specific limitations on hours and/or days:_____

_____

**If request is for intermittent leave specify length and duration of anticipated leave:**

Will condition cause episodic flare ups preventing employee from performing job functions? No___Yes___ If yes, is it medically necessary for employee to be absent from work? No___Yes?____If yes, explain and estimate frequency and duration over next 6 months :____episodes every___week(s)___month(s) lasting ___hours or days per episode._____

**Date patient is reasonably anticipated to be able to return to the position able to perform the essential functions of his/her position with___ or without___ reasonable accommodation(s):_____** If reasonable accommodation(s) are requested, list requested accommodation(s) in order for College to dialogue with employee. For your convenience, requested accommodations may be listed on the attached Fitness-For-Duty Certification necessary to be completed prior to returning to work.

COMMONWEALTH OF MASSACHUSETTS

# FITNESS-FOR-DUTY CERTIFICATION

**DIRECTIONS TO EMPLOYER:**
1. Please attach the employee's job description to this form, including the essential functions of his/her position.
2. Give this form and the job description to the employee to obtain the requisite medical certification.

**DIRECTIONS TO EMPLOYEE:**
1. You may use this form to obtain a certification from your health care provider certifying that you are able to return to work.
2. Please have your physician fill out this form.
3. Please return this form to Human Resources before you return to work.

**TO BE COMPLETED BY EMPLOYEE: (please print or type)**

1. Name 2. Department / Agency

3 Date condition began

4. Date condition ended (or is expected to end)

5. Date set for return to work

I understand that if I do not provide a requested fitness-for-duty certification to return to work, my employer may delay restoration until I submit the certification.

Employee's Signature_____ Date:_____

**TO BE COMPLETED BY EMPLOYEE'S HEALTH CARE PROVIDER: (please print or type)**

7. I certify that I have read the job description enclosed with this form, concur with the information provided by the employee above or note any changes below, and that the above-named employee is able to meet the essential functions of the position as listed in the description **with** or **without** (please circle one) reasonable accommodation and is able to return to work on _____.

Please note that if a reasonable accommodation is requested, the Employer will also **require** certain information to show that the employee is a qualified individual with a disability and thus, entitled to a workplace accommodation and that the accommodation requested is reasonable. **This information should be included below or attached to this form and includes the following**:

- the specific nature of the employee's disability;
- signs of manifestation of the employee's disability;
- identification of all other life activities or tasks (i.e.; personal hygiene, household chores, other professional work activities, caring for family members, exercise, etc.) the employee is unable to perform or is inhibited in performing due to the employee's disability;
- identification of those essential functions of the employee's position that the employee is currently unable to perform due to the disability;
- a detailed and specific explanation of the accommodation(s) requested; and
- a reasonable assurance that the employee will be able to perform all essential functions of the position, with the requested accommodation upon the employee's return to work.

**Health Care Provider Remarks:**

_____

_____

_____

_____

_____

Signature of Health Care Provider

Date

Name of Health Care Provider (typed or printed)

Address

Telephone

Area of Practice/Specialty (if any):

Please return this form to:

FOR OFFICE USE ONLY

Confirm Return Date:

Notified Payroll On:

Initials: