Edmonds College

Medical, Domestic Violence and various Military Leave Information Kit

LET US GUIDE YOU THROUGH THE PROCESS

The information provided in this document is applicable to civil service, bargaining unit covered, exempt professional, and faculty employees. Human Resources (HR) provides this kit to assist in handling leave request for medical leave, domestic violence leave, or various types of military leave, for the employee and the family member's situation. This document does not include all the details of the program discussed. Any issues that are not addressed in the guide will be administered in accordance with various Federal, State and Edmonds College Leave Regulations and Policies.

This kit may be used in conjunction with Reasonable Accommodation (RA) request. However, if this request for medical leave is a Reasonable Accommodation (RA) request or part of a request, you may be requested to also complete the appropriate RA request form. The Reasonable Accommodation policy may be found in the U:Drive.

Depending on the reason for your leave, this kit will provide:

The leave request for:

- Leave for the employee's health condition
- Leave for a family member's health condition
- Leave for birth or placement for adoption or foster child and care of child
- Medical Leave, when the employee is not eligible for FML
- Shared Leave
- Leave for Domestic Violence
- Leave for Care of a Service Member/Veteran
- Exigency Leave

Each of the above types of leave will have a corresponding Certification Form to be completed by a health care provider, or other appropriate party. If the certification form is not included with this kit it is available by calling your HR representative.

Please contact your Human Resources representative for assistance with this packet.

Employee Rights and Responsibilities
Under the Family and Medical Leave Act

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- 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; or
- For a serious health condition that makes the employee unable to perform the employee's job.

EC uses a ***"forward rolling year"*** method of calculating the 12 workweeks.

You may take your leave in several blocks of time, on an ***intermittent*** basis or as a ***reduced work schedule***, if determined to be medically necessary by your attending health care provider.

Under State leave rules a mother may be eligible for FML during the pregnancy (and before delivery), based on her own medical need. The birth of the baby is then considered a separate FML qualifying event allowing for up to 12 weeks off to care/bond with newborn.

Military Family Leave Entitlements

Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12 week leave entitlement to address certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member/veteran during a single 12 month period. A covered service member/veteran is a current member of the Armed Forces, including a member of the National Guard or Reserves, has a serious injury or illness hat occurred in the line of duty on active duty that may render the service member/veteran medically unfit to perform his or her duties for which the service member/veteran is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Failure to pay the employee portion of the premiums within 30 days of the due date could result in cancellation of coverage. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms. Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with a least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave scheduled when medically necessary.

Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days in advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave.

Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against the employer.

FMLA does not affect any Federal or State law prohibiting discriminating, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

In addition to the Federal Family and Medical Leave At of 1993, EC provides leave in accordance with the State of Washington regulations, and EC leave policies. This documentation is a summary of the aforementioned leaves and is not all inclusive. For more detailed information, please contact your HR representative. *Please note: if you are not eligible for FML, you may still be eligible for another type of leave under the State of Washington Leave regulations, or within EC leave policies or practices. HRS will monitor your leave request and make this determination.*

Leave of Absence Checklist for Employee's Use

- ☐ **Leave of Absence Request** – Notify your supervisor that you need to take leave for either your own health condition, that of your ***family member***, or for the birth/placement and care of a child
- ☐ **Family and Medical Leave Kit** – If taking leave for a possible ***qualifying event*** (i.e. medical leave, for domestic violence or military leave), please fill out appropriate paperwork from the leave kit. You can make an appointment with your HR representative to discuss any other issues.
- ☐ **Department Notification** – HR will keep in communication with you and your department regarding your leave request, return to work information, limitations/restrictions, etc.

The following should be considered when filling out the Family and Medical Leave Request forms.

- ☐ **Worker's Compensation** – If leave is for a work-related injury or illness, call your HR representative.
- ☐ **Medical/Dental** – Do you have leave accruals to use or will you be on full **Leave Without Pay** (LWOP)? HR will provide information on how you can use your leave to maintain your benefit. If you will be on full Leave Without Pay (LWOP), HR and Payroll will provide information regarding premiums payments in order to keep benefits active.
- ☐ **Long Term Disability Insurance** (LTD) – If the leave is for your own medical condition, apply for ***Long Term Disability*** (LTD) benefits if you will be off work longer than your waiting period and /or 90 days.

Your HR representative can provide you with claim forms and provide information/assistance regarding this benefit.

- ☐ **Shared Leave** – If leave is due to severe or life threatening circumstances, you may be eligible for ***Shared Leave***. Contact your HR representative. NOTE: Eligibility for Worker's Compensation or LTD benefits will impact eligibility for shared leave.
- ☐ **Leave Request Form** – After reviewing the above topics, determine how you will use your leave and complete the Leave Request Form. Do not hesitate to contact HR if you have questions.
- ☐ **Certification Form** – You will be responsible for providing the appropriate certification form to the appropriate medical provider or individual and ensuring they provide the documentation to EC-HR. **Important – this information should not be provided to your supervisor or your department, but submitted directly to HR.**
- ☐ **Call in Requirements** – Plan with your supervisor and/or HR as to how often you should contact EC while you are on leave.

Other Important information of which to be aware:

- ☐ **Leave Without Pay (LWOP) – Loss of Benefits**

At the end of an FML period, or if you are on full LWOP for a non-FML event, you will lose eligibility ***for employer-paid benefits***. Employees maintain eligibility for employer-paid benefits if in paid status 8 or more hours in a month, but are still responsible for their portion of the premiums, which 8 hours of pay may not cover. Contact HR for the criteria/limitations of how the 8 hours may be used. The Public Employee Benefits Board will send a ***self-pay packet*** to the employee offering the option to continue benefit coverage on a self-pay basis.

If you lose employer-paid coverage, contact HR Benefits upon return to work to re-activate benefits.

- ☐ **Release to Return to Work**

If you have been off work **for your own medical condition**, you may be required to submit to HR a *Work Assessment Form* completed by your doctor prior to work. If the *Work Assessment Form* shows that you are unable to return to work on a full-time basis, or if you need temporary modified duties, HR will coordinate a Return-to-Work Plan with your department.

- ☐ **Reasonable Accommodation (RA)**

If your leave goes beyond the FML you may be able to have extended medical leave as a Reasonable Accommodation. Additionally, if the *Work Assessment Form* shows you may have limitations/restrictions when released to work, a RA may also be pursued.

- ☐ **Life Insurance Premium Waiver**

If you are or know you will be off work for more than 6 months for your own medical condition, contact HR Benefits for information regarding the ***Life Insurance Premium Wavier***. A life waiver allows an eligible employee to keep the life insurance coverage, but have the premiums waived during the period of disability.

- ☐ **Disability Separation/Retirement**

If circumstances dictate that you are unable to work, a ***disability separation*** or ***disability retirement*** may be pursued. HR Benefits personnel will assist you in this matter.

Denise Olson | denise.olson@edmonds.edu | 425.640.1069

Who is responsible for what?

Employee

- Notifying supervisor of need for leave
- Working with HR to fill out appropriate paperwork
- Communicating with supervisor based on agreed upon "Call In Requirements"
- Providing the *Work Assessment Form* when requested and necessary for return to work

Department

- Referring request for medical leave to HR
- Ensuring that payroll documents (PAF, Leave slips) are properly filled out, and submitted on a timely basis while employee is on leave
- Contacting HR with any questions about the leave or return to work process

Human Resources

- Counsel and advise employee and departments about medical leave and return to work processes
- Communicate with employing department regarding request and status of leave
- Assist with paperwork
- Monitor process and paperwork for accuracy and timeliness
- Coordinate efforts within HR and Payroll

Edmonds College

Extended Leave Request Form (> 5 days) for any of the following:

Family Medical Leave, Family Care Leave, Disability Leave, Parental Leave, Service Member/Veteran Caregiver Leave, Exigency Leave, Military Spouse Leave, Military Leave, Domestic Violence Leave, and State of Emergency Leave

Employee : Please complete (consult HR for assistance)

Employee:		Employee ID:
Department:		Campus Ext.:
Supervisor's Name:	Supervisor's Ext:	Employee Type: ☐ Classified ☐ Exempt ☐ FT/PT Faculty
Home Mailing Address:		City State Zip
Home Phone Number:	Personal Email Address:	Work Email Address:

Please check reason(s) for leave of absence: Additional Certification Documentation will be required to support leave request.

- ☐ Own health condition (not work related)
- ☐ Work-related condition (contact Benefit Services)
- ☐ Pregnancy disability (prior to birth of child)
- ☐ Applying for Shared Leave (See Shared Leave application)
- ☐ Care for newborn/placed child
- ☐ Care for parent/spouse/child w/serious health condition
- ☐ Parental Leave
- ☐ Leave for Domestic Violence, Sexual Assault or Stalking
- ☐ Military Leave
- ☐ Service Member/Veteran Caregiver Leave
- ☐ Exigency Leave due to family members call to duty
- ☐ Military Spouse Leave
- ☐ State of Emergency Leave
- ☐ Other

Request Start Date:	Anticipated Return to Work Date:

Intermittent or reduced work schedule (describe):

- I have read HR 5.04 pr - Procedure for Reporting of Leave, Overtime, and Compensatory Time: General Requirements for Eligible Employees (accessible at https://www.employees.edmonds.edu/hr/ under the drop-down menu titled, "Special Information and Links," click the link to, "College Policies and Procedures") and understand which procedure details are applicable to my situation.
- I understand FMLA permits an employer to require that I submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to my own serious health condition or to care for a covered family member with a serious health condition. I understand failure to provide a complete and sufficient medical certification may result in denial of my FMLA request.
- In requesting leave, I understand that if my request for leave is incomplete or insufficient, HR will give me 7 days to provide the requested information. I also understand and release appropriate HR professionals (i.e. official HR personnel only – not my supervisor or department management) to contact my HCP to authenticate (confirm signature) or clarify the information provided (understand handwriting or meaning of response). If I refuse to provide this release, I understand that EdC can deny my request for leave.

Employee's Signature ______________________ **Date** ____________

For HR use only:

Has employee worked for the state for at least 1250 hours w/in the last 12 months & been employed at last 12 months?	◯ Yes ◯ No	Date medical certification received	________
Is the reason for this request an FMLA-qualifying event?	◯ Yes ◯ No	Date notification sent	________
Is this leave designated as covered by FMLA?	◯ Yes ◯ No	Cc to employee & supervisor	________

Certification of Health Care Provider for employee's Serious Health Condition under the Family and Medical Leave Act

---

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. • 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: ○ 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, ○ 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.

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 15 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 Avenue, N.W., Washington, D.C. 20210.

Please send completed forms to:
Edmonds College/Benefits Manager
20000 68th Ave W, Lynnwood, WA 98036
Fax: 425.640.1195
Head Start Fax: 425.290.3693 (Head Start employees only)

Edmonds College

Application for Shared Leave

(Not eligible for those who are off work due to work-related injury or illness)

Please check reason for requesting shared leave: Reasons for requesting shared leave will also be processed accordingly for Family Medical Leave or other federal, state or college leave provision.

- ☐ Own health condition (not work related)
- ☐ Pregnancy disability (prior to birth of child)
- ☐ Care for relative/household member

Employee or Employer Representative: Please complete	
Name of Employee:	Employee SID:
Name of person with medical condition:	Relationship to Employee:

If request for Shared Leave is for medical reasons, in order to qualify for Shard Leave an employee must be suffering from, or have a relative or household member suffering from an extraordinary or severe illness or injury. Extraordinary or severe illness or injury is defined as a serious or extreme and/or life-threatening injury or illness.

☐ I certify that I meet all of these requirements. I have attached the *Medical Leave Certification* form from a licensed health care provider which describes the illness, injury, impairment, or physical or mental condition.

☐ In addition to applying for shared leave, I understand that I also must have applied for:

- ☐ FML or Medical Leave
- ☐ Long Term Disability (LTD), if applicable

Announcement of Shared Leave (if request is approved)

I consent to the publication of my name in an EdC Announcement notifying my need for shared leave donations.

- ☐ I do consent
- ☐ I do not consent

Employee Signature & Date: ______________________________

To be completed by Human Resources	
Date - Initials	**Shared Leave Application Review and Certification**
	Certification of Leave Status via copy of time/leave report (attach to request). Employee's leave balance will expire on
	Optional Long Term Disability Waiting Period If approved, employee is granted Shared Leave through
	Employee's shared leave is approved.
	Employee's request of shared leave is denied for the following reasons: Not a shared leave qualifying event has enough Lv to satisfy LTD waiting period has filed a worker comp claim
	Shared leave request has been entered onto database. Spreadsheet sent to BUDGET for approval.

HR Representative Signature & Date: ______________________________

Original - Shared Leave File
Copies - Recipient, Supervisor