



## **Extended Leave of Absence Resource Guide 12 Month Employees**

This guide is for Employees and Supervisors to assist employees in applying for *any type* of Extended Leave that is necessary

Family and Medical Leave (FMLA) and Shared Leave are available to employees for authorized medical, compelling family and certain military reasons that force an employee to be absent for an extended period of time, (more than three days) and for frequent intermittent absences.

For specific information about:

**Family and Medical Leave**, please refer to Personnel Information Memorandum # 9  
<http://hr.uncc.edu/family-and-medical-leave>

**Shared Leave**, please refer to Personnel Information Memorandum # 29  
<http://hr.uncc.edu/voluntary-shared-leave-program>

Please contact the Benefits Counselor at (704) 687-8134, or [Benefits@uncc.edu](mailto:Benefits@uncc.edu) should you have any additional questions.

NOTE: This guide is not intended to inform you about the various types of leave available, rather guides you through the process of applying for extended leave for determination of your eligibility and rights.

***All leave application/medical forms should be returned to:  
UNC Charlotte Benefits Office  
207 King Building  
University of North Carolina at Charlotte  
9201 University City Boulevard  
Charlotte, NC 28223-0001  
Fax: (704) 687-5254***

***All information received is confidential***

## INSTRUCTIONS FOR THE EMPLOYEE

All of the forms mentioned in the steps outlined below are included within this resource guide. The forms mentioned in steps 1 through 4 should be completed in advance of beginning leave, unless an emergency situation arises. It is your responsibility, as the employee, the one requesting leave or being asked to request leave, to ensure that all forms are completed, submitted to the UNC Charlotte Benefits Office, and approved before taking leave as well as before returning to work. Approval for the leave is determined by the Benefits Office and when a decision is made, a letter will be mailed to you, the employee, with a copy sent to your supervisor. The decision made will also be communicated via email to you, your supervisor, the Payroll Office, and Human Resources Information Systems for data entry.

- Step 1 Complete the **Family and Medical Leave/Shared Leave Application** and return it to the Benefits Office. Note: This form is used to apply for (section 1) Family and Medical Leave (FML) and/or (section 2) Shared Leave. You may apply for one or both of these programs. It is also used to validate your need for extended absences or frequent intermittent absences even if you are not eligible for Family and Medical Leave as defined in the Family and Medical Leave Act (FMLA). Return completed forms to the Benefits Office.
- Step 2 Complete Part I of the **Certification by Medical Practitioner** form. Then give the form to your healthcare provider so that he/she can complete Part II. After completion, please return it to the Benefits Office (King 207).
- Step 3 You will need to record your absences through the KRONOS system using FMLA designations for vacation leave, sick leave, bonus leave, and leave without pay when keying your leave usage while on approved FML. If possible, it is best to complete your requests for leave in KRONOS prior to starting leave of absence. Your manager should review your requests for leave as usual in KRONOS and process accordingly. If you plan on taking intermittent or reduced schedule FML, be sure that you are using leave of absence codes correctly in KRONOS so that time off for other reasons are not counted toward your 12-weeks of protected leave. The Benefits Office will record your FMLA usage from the data keyed to KRONOS for leave reporting purposes.

***NOTE:*** Failure to provide the Family and Medical Leave/Shared Leave Application and Certification by Medical Practitioner form within 15 days from receipt of the Extended Leave of Absence Guide may result in denial of job protected leave under the Family and Medical Leave Act.

- Step 4 Provide your supervisor with periodic reports on your status and intent to return to work (at least every 30 days) and prior to your expected return to work date. If your leave is extended be sure to notify the Benefits Office by providing written documentation from your physician and notify your supervisor.
- Step 5 Complete Part I of the **Fitness for Duty Certification** form. Then give the form to your healthcare provider so that he/she can complete Part II of the form. After completion, please return the form to the Benefits Office (King 207).  
**Note: This form must be completed and returned before you can return to work. If limitations are given by your medical practitioner, your supervisor will need a copy to determine if accommodations can be met.**

**REMEMBER:** It is your responsibility to ensure that all forms have been completed and submitted to the UNC Charlotte Benefits office in advance of the leave, or within 15 days following receipt of the Extended Leave of Absence Guide.

## INSTRUCTIONS FOR THE SUPERVISOR

- Step 1 Confirm with your employee that the **Family and Medical Leave/Shared Leave Application** form has been completed and submitted to the Benefits Office (King 207).
- Step 2 Complete the **Certification of Leave Balance/Approval of Shared Leave** form and return it to the Benefits Office. The form should be completed immediately following distribution of the Extended Leave of Absence Guide and be sure that you have noted the date the employee received the guide.
- Step 3 Advise your employee to complete leave requests through KRONOS for each week, he/she anticipates being away from work using FMLA designations. Your employee needs to designate which hours are to be used from accumulated compensatory time (if any) sick leave, annual leave, bonus leave, leave without pay, etc. Please remember to use up any outstanding compensatory time first. *Also, remember that an employee cannot use shared leave donations until their accumulated sick, annual, and bonus leave are exhausted.*
- Your employee should periodically (at least every 30 days) report his/her status and intent to return to work to you. By processing leave request approvals at least weekly through KRONOS, you can assure that the employee's leave balance will not be charged if recovery and return are sooner than expected.
- Please note that if your employee is taking intermittent or reduced schedule leave, you will also need to insure that time entries in KRONOS are coded correctly to insure that only hours missed related to FML are accounted for as part of the 12-weeks entitlement.
- Step 4 Review time entries in KRONOS for approval. Insure that the employee has selected the appropriate leave of absence code. (E.g. vacation leave FMLA, sick leave FMLA, bonus leave FMLA, LWOP FMLA, etc.) If the employee is unable to key their own leave usage in KRONOS, please process the employee's leave usage prior to the KRONOS cut-off dates.
- Step 5 **Confirm that the Fitness for Duty Certification has been completed and returned to the Benefits Office before the employee returns to work.** If the employee has been given work restrictions, please review the employee's work duties to determine if the restriction is considered a reasonable accommodation.

*All Applicable Extended Leave Application Forms Follow*



**Family and Medical Leave / Shared Leave Application (PART A)  
12 Month Employees**

**Return to the Benefits Office King, Room 207**

**TO BE COMPLETED BY EMPLOYEE (Please Print or Type)**  
 Complete and submit this application, with the Certification by Medical Practitioner (required before leave can be granted).

Name:	Department:
Home Address:	Email Address Work:  Email Address Home:
UNC Charlotte ID Number:	Supervisor:
Home Phone:  Cell Phone:	Supervisor's Campus Phone:
<p>1. <b>Requesting Family and Medical Leave due to:</b></p> <p><input type="checkbox"/> a. Care for Newborn Child</p> <p><input type="checkbox"/> b. Care for Adopted or Foster Child</p> <p><input type="checkbox"/> c. Care for the Serious Health Condition of my            ◇ Child            ◇ Spouse            ◇ Parent (does not include care for in-laws)</p> <p><input type="checkbox"/> d. Care for my own serious health condition that prevents me from performing the functions of my position.</p> <p><input type="checkbox"/> e. A qualifying exigency arising out of the fact that my immediate family member is on active duty or has been called to active duty status in support of a contingency operation.</p> <p><input type="checkbox"/> f. Serious injury or illness of a covered service member for whom I am next of kin.</p>	<p>2. <b>Requesting Shared Leave:</b></p> <p>a. I wish to apply for Voluntary Shared Leave           <input type="checkbox"/> Yes           <input type="checkbox"/> No</p> <p>b. While soliciting contributions, please:           <input type="checkbox"/> Keep the nature of my condition confidential.           <input type="checkbox"/> Share the nature of my condition.</p> <p><b>Supervisor must approve the use of shared leave</b></p>
<p>3. <b>Duration / Type of Leave:</b></p> <p>a. Date Leave Begins _____ b. Anticipated Date of Return _____</p> <p><input type="checkbox"/> This leave will be taken on a full-time basis c. Revised Date of Return _____</p> <p><input type="checkbox"/> This leave will be taken intermittently or on a reduced schedule *</p> <p><b>*(If this box is checked, the applicant must provide the supervisor with a schedule, which must be approved by the supervisor.)</b></p>	

**Family and Medical Leave / Shared Leave Application (PART A) Continued**  
**All 12 month employees**

**4. Terms of Leave**

I understand that I am applying for leave that is my right to take under The Family and Medical Leave Act (FMLA) of 1993 and 2008 amendments, or to document valid reasons for taking extended leave if I am not qualified for leave under The Family and Medical Leave Act. I understand that the designation of this leave as Family and Medical Leave may be delayed until the appropriate medical certification is received by the UNC Charlotte Benefits Office. I understand the designation of this leave as Family and Medical Leave may be denied if the appropriate forms are not received by the UNC Charlotte Benefits Office within 15 days of being asked to complete these forms, or my request for leave. I understand that I will be given seven days to provide missing paperwork or to correct missing or incomplete information on forms that were submitted, and that failure to supply this information can result in denial of my request for leave. Further, I understand that my physician and I must also complete a Fitness for Duty Certification before I can return to work if the reason for leave was either "a" or "d" above.

If I have any sick or annual leave, I will complete the necessary leave forms designating which type of paid leave I wish to use to cover this period, if any. I understand that I may apply for Shared Leave in accordance with Personnel Information Memorandum #29. I also understand that my supervisor must approve the use of shared leave.

I agree that while I am on leave, I will continue to pay my share of the health insurance premiums, if applicable, unless I elect to discontinue coverage. I also agree that if I fail to return to work at the end of the leave period, I will reimburse the University for the cost of University-provided health benefits during my unpaid leave, if any, unless I fail to return to work because of the continuation, recurrence or onset of a serious health condition, or because of other circumstances beyond my control.

If I am unable to return to work because of my own, or my family member's serious health condition, I will provide medical certification from the appropriate health care provider stating that I am unable to perform the functions of my position on the date that my leave expired, or that I needed to care for my spouse, child, or parent because he/she had a serious health condition, I have a qualifying exigency, or I am caregiver to a service member injured in the line of duty on the date that my leave expired. I also agree that I won't commence work for another employer while on leave.

*Finally, I understand that if I do not return to work on the date indicated above (or another date as specified by me and agreed to by the University) for reasons other than my inability to return to work due to my own serious health condition my employment may be terminated by the University as of the date my leave expired.*

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**Medical Certification (PART B)**

**Return to the Benefits Office King, Room 207**

**All items must be completed. Attach additional pages, if necessary.**

Part I: TO BE COMPLETED BY EMPLOYEE (Please Print or Type)		
Employee Name:	Patient's Social Security Number: (Optional) Or Patient's Date of Birth:	
Patient's Name: (if patient is not the employee)	Practitioner's Name:	
Relationship to Employee: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent	Practitioner's Area of Practice: (i.e. Internal Medicine)	
Practitioner's Phone Number: _____ Name of Nurse: _____	Practitioner's Address:	
PART II: TO BE COMPLETED BY MEDICAL PRACTITIONER (For patient listed in #3 above)		
1. Nature of Serious Health Condition (diagnosis). Please note that this description should not include any genetic information (including genetic tests, the genetic test results of family members, or the manifestation of a disease or disorder <u>in a family member</u> with a genetic cause) unless necessary to comply with the request:		
2. Date Condition Commenced (first treated):	First Day of Absence form Work:	
3. Probable Duration of Condition (calculated from the day you sign this form): _____ Is the leave continuous <input type="checkbox"/> OR intermittent <input type="checkbox"/>		
4. Regimen of Treatment: (i.e. your post-operative, post-partum instructions, etc. May attach clinical notes if you prefer)		
Please check "yes" or "no" as appropriate:		
	Yes	No
5a. Will the patient be hospitalized as either an in-patient or same-day surgery patient?		
5b. Does the patient require assistance for basic medical, or personal needs or safety, or for transportation?		
5c. If patient is employee, is the patient able to perform his/her own job functions as described to you?		
5d. Please state why the patient is unable to perform his/her job functions as described in the written job description if the patient is the employee (i.e. list limitations). If for a family member the reason the employee is needed as caregiver:		
6. If the leave is on an intermittent basis, please indicate the probable duration of this periodic, outpatient treatment:		
_____ <b>Signature of Practitioner</b>		_____ <b>Date</b>



**Supervisor Certification (PART C)**

**Return to the Benefits Office King, Room 207**

TO BE COMPLETED BY SUPERVISOR (Please Print or Type)	
Supervisor:	Department:
Employee Requesting Leave:	UNC Charlotte ID Number:
<p>The above employee: <input type="checkbox"/> has provided to the Benefits Office <input type="checkbox"/> is in the process of obtaining satisfactory evidence to qualify for leave under the following program(s):</p> <p><input type="checkbox"/> Family and Medical Leave Act (For a complete description of FMLA, refer to PIM-09)</p> <p><input type="checkbox"/> Shared Leave (For a complete description of Shared Leave, refer to PIM-29)</p>	
<p>In order for the Benefits Office to apply paid leave (sick, annual, and bonus) appropriately, we must have accurate starting balances from which to draw paid leave until it is exhausted. Please provide the balances as of the following date:      DATE LEAVE BEGINS: _____</p>	
<p>If you are unsure about your departmental records being accurate, <i>please consult the Payroll Office</i> to verify leave balances. Remember to deduct any leave not reflected in the monthly report last received from the Payroll Office, as well as to credit any current accruals earned as of the date above.</p> <p>SICK HOURS: _____</p> <p>BONUS LEAVE HOURS: _____</p> <p>ANNUAL LEAVE HOURS: _____</p>	
<p>➔ Do you support the employee's participation in the Shared Leave Program? (please circle)      Yes      No</p>	
<p>Please provide the date the employee made you aware of a need for extended leave and you provided the employee with the Extended Leave of Absence Guide, or the date you asked the employee to complete the Extended Leave of Absence Guide to determine eligibility of benefits under University leave policies.      DATE: _____</p>	
<p><i>I certify that the leave balances provided are accurate to the best of my knowledge, and that while the employee is out I will furnish the Payroll Office and Benefits Office with leave slips reflecting the usage of sick, annual, bonus leave or leave without pay in accordance with the employee's wishes</i></p>	
_____ Supervisor's Signature	_____ Date
_____ Phone Extension	



**Fitness for Duty Certification**

Required of all employees returning from a Medical/Disability Leave of any kind.

**Return to the Benefits Office King, Room 207**

<b>Part I: TO BE COMPLETED BY EMPLOYEE (Please Print or Type)</b>	
<i>Please attach a job description listing physical requirements of your position to this form</i>	
Name:	Job Title:
Date Leave Begins:	University ID #:
Employee Signature: _____ Date: _____	
<b>PART II: TO BE COMPLETED BY MEDICAL PRACTITIONER</b>	
1. I certify that I have read the employee's job description attached to this form and that the above-named employee is physically fit to meet the physical/mental requirements listed in the description <b>(please check one)</b> with <input type="checkbox"/> or without <input type="checkbox"/> reasonable accommodation. <b>If accommodation is required, please list specific limitations to activity in remarks section (section 4).</b>	
Signed: _____ Date: _____	
2. Healthcare Provider's Name:  Address:  Phone:	3. Area of Practice/Specialty (if any)
4. Please list specific restrictions to duty, if any: <i>(Please use extra paper if necessary.)</i>	
5. Additional remarks:	
6. Date Released to Return to Work.	

FOR OFFICE USE ONLY:

Confirm Return Date: \_\_\_\_\_

Notified Payroll on: \_\_\_\_\_

Initials: \_\_\_\_\_

Routing: Department Supervisor