



## Extended Leave of Absence Resource Guide

This guide is for Employees and Supervisors to assist employees in applying for Family Illness Leave

Family Illness Leave (FIL) and Shared Leave are available to employees for *authorized medical and compelling family reasons* that force an employee to be absent for an extended period of time, (three days or more) and for frequent intermittent absences.

For specific information about:

**Family Illness Leave**, please refer to the State Personnel Manual, Section 5; Page 27.1

[HTTP://OSHR.NC.GOV/POLICIES-FORMS/LEAVE/FAMILY-ILLNESS-LEAVE](http://OSHR.NC.GOV/POLICIES-FORMS/LEAVE/FAMILY-ILLNESS-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.

***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, to ensure that all forms are completed, approved, and submitted to the UNC Charlotte Benefits Office 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 the supervisor.*

- Step 1 Complete Part I of the **Family Illness Leave/Shared Leave Application** and return it to the Benefits Office. Note: This form is used to apply for (section 1) Family Illness Leave and/or (section 2) Shared Leave. You may apply for one or both of these programs. Return completed form to the Benefits Office.
- Step 2 Complete Part I of the **Certification by Medical Practitioner** form. Then give the form to your family members healthcare provider so that he/she can complete Part II. After completion, please return the form to the Benefits Office (King 207).
- Step 3 Process your leave requests and usage through the KRONOS system in advance of your absences when possible. You may use vacation leave, sick leave, bonus leave, shared leave – if approved, or LWOP while absent. Be sure to use the notes section when requesting Family Illness Leave (FIL). Indicate that the leave taken is for FIL. The Benefits Office will record your FIL usage from the data keyed to KRONOS for leave reporting purposes. If you will be taking intermittent leave or need to work a reduced schedule while on FIL, you will need to provide your manager with a schedule of the times you will be absent in advance.
- 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.

**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.*

## INSTRUCTIONS FOR THE SUPERVISOR

- Step 1      Confirm with your employee that the **Family Illness 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.
- Step 3      Have your employee process leave usage for any time he/she anticipates being away from work in KRONOS. Your employee needs to designate which hours are to be from accumulated compensatory time (if any), sick leave, annual leave, bonus leave, leave without pay, etc., and note that the time taken is for FIL. Please remember to use up any outstanding compensatory time first. *Also, remember that an employee cannot use shared leave until 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. By processing leave requests weekly, you can assure that the employee's leave balance will not be charged if the employee's leave ends earlier than expected.
- Step 4      Be sure to review your employee's leave entries in KRONOS. Insure that the employee has properly noted time used as FIL in the notes section when taking time off for FIL purposes.

*All Applicable Extended Leave Application Forms Follow*



**Family Illness 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:
Address:	Phone #:

Employee ID Number:	Supervisor:
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Home Phone:	Supervisor's Campus Phone:
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<p><b>1. Reason for Requested Family and Medical Leave:</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</p> <p style="padding-left: 20px;"><input type="checkbox"/> Child</p> <p style="padding-left: 20px;"><input type="checkbox"/> Spouse</p> <p style="padding-left: 20px;"><input type="checkbox"/> Parent (does not include care for in-laws)</p>	<p><b>2. Request for Shared Leave:</b></p> <p>a. I wish to apply for Voluntary Shared Leave</p> <p style="padding-left: 20px;"><input type="checkbox"/> Yes (use subject to supervisor and HR approval)</p> <p style="padding-left: 20px;"><input type="checkbox"/> No</p> <p>b. While soliciting contributions, please:</p> <p style="padding-left: 20px;"><input type="checkbox"/> Keep the nature of my leave confidential.</p> <p style="padding-left: 20px;"><input type="checkbox"/> Share the nature of my leave request.</p> <p><b>Supervisor must approve the use of shared leave</b></p>
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**3. Duration / Type of Leave:**

3a. Date Leave Begins \_\_\_\_\_ 3b. Anticipated Date of Return \_\_\_\_\_

This leave will be taken on a full-time basis 3c. Revised Date of Return \_\_\_\_\_

This leave will be taken intermittently or on a reduced schedule - *If this box is checked, the applicant must provide the supervisor with a schedule, which must be approved by the supervisor.*

**4. Terms of Leave**

- I understand that I am applying for leave that is my right to take under The Family Illness Leave (FIL) policy. I understand that the designation of this leave as Family Illness Leave may be delayed until the appropriate medical certification is received by the UNC Charlotte Benefits Office.
- If I have any sick, annual or bonus leave, I will complete the necessary leave forms designating which type of paid leave I wish to use to cover this period. 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 family member's serious health condition, I will provide medical certification from the appropriate health care provider stating that I needed to care for my spouse, child, or parent, because he/she had a serious health condition 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 different from 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 in a family member with a genetic cause) unless necessary to comply with the request:

2. Date Condition Commenced (first treated): \_\_\_\_\_ First Day of Absence from Work: \_\_\_\_\_

3. Probable Duration of Condition (calculated from the day you sign this form): \_\_\_\_\_ Is the leave continuous:   
or intermittent:

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:

\_\_\_\_\_  
**Signature of Practitioner**

\_\_\_\_\_  
**Date**



**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:	Employee ID Number:
<p>The above employee:</p> <p><input type="checkbox"/> has provided to the Benefits Office</p> <p><input type="checkbox"/> is in the process of obtaining</p> <p>satisfactory evidence to qualify for leave under the following program(s):</p> <p><input type="checkbox"/> Family Illness Leave (For a complete description of FIL, refer to State Personnel Manual Section 5, page 27.1)</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 and annual) 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:</p> <p style="text-align: right;">DATE LEAVE BEGINS: _____</p>	
<p>If you are unsure about your departmental records being accurate, please consult the Payroll Office 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 style="text-align: right;">SICK HOURS: _____</p> <p style="text-align: right;">BONUS LEAVE HOURS: _____</p> <p style="text-align: right;">ANNUAL LEAVE HOURS: _____</p>	
<p>➔ Do you support the employee's participation in the Shared Leave Program?</p> <p>(please circle)      Yes                  No</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 and annual leave in accordance with the employee's wishes.</i></p>	
_____ Supervisor's Signature	_____ Date
_____ Phone Extension	_____ Email