

# GRCC Memorandum

TO: GRCC Employee  
FROM: Human Resources  
SUBJECT: Family Medical Leave Act (FMLA) Information

Attached is information on the **Family and Medical Leave Act of 1993**. Employees are eligible if they have worked for Grand Rapids Community College at least 12 months, and have worked at least 1,250 hours over the past 12 months. Various medical conditions are appropriate for Family and Medical Leave, such as continuing treatment for chronic or long-term medical conditions.

If FMLA leave is appropriate for you, please complete the **Family and Medical Leave Request** form before you begin your leave. This form needs to be complete with your signature and the signature of your supervisor. Return to the Human Resources coordinator for Adjunct Faculty and FMLA.

Also, complete the top portion of the front page of the **Certification of Health Care Provider** form. Include the employee's name and department, or if applicable, the patient's name and relationship to the employee. The attending physician must complete the remainder of the form. Once this form is completed by your physician, please return to the Human Resources coordinator for Adjunct Faculty and FMLA. Your physician may fax the form to Human Resources.

Attached you will find the GRCC policy on Family and Medical Leave, Information on FMLA, the **Family and Medical Leave Request form**, and the **Certification of Health Care Provider form**.

If you have any questions regarding payroll deductions while on FMLA, please call (616) 234-4038.

Human Resources  
Phone: (616) 234-3904  
Fax: (616) 234-3907  
hr@grcc.edu

# GRCC Family Medical Leave (FMLA) Policy

## Family Medical Leave Policy (FMLA)

### I. Policy Section

6.0 Personnel

### II. Policy Subsection

6.14 Family Medical Leave Policy

### III. Policy Statement

Grand Rapids Community College will abide by all regulations set forth under the Family Medical Leave Act and will grant up to 12 weeks of job-protected leave in a 12 month period for qualified medical reasons.

### VI. Reason for Policy

FMLA requires covered employers (employers with 50 or more employees) to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- A. Incapacity due to pregnancy, prenatal medical care or child birth
- B. To care for the employee's child after birth, or placement for adoption or foster care
- C. To care for the employee's spouse\*, son, daughter or parent, who has a serious health condition or
- D. A serious health condition that makes the employee unable to perform the employee's job
- E. Qualifying exigency leave for military service
- F. Military caregiver leave to care for an injured or ill service member or veteran

\* Note: As of March 27, 2015, workers in legal, same-sex marriages, regardless of where they live, have the same rights as those in opposite-sex marriages to federal job-protected leave under the FMLA to care for a spouse with a serious health condition.

### V. Entities Affected by this Policy

All eligible GRCC Employees that have worked 1250 hours during the past 365 days

### VI. Who Should Read this Policy

All GRCC Staff and Faculty

### VII. Related Documents

[www.grcc.edu/fmla](http://www.grcc.edu/fmla)

### VIII. Contacts

Policy Owner: Human Resources Coordinator for Adjunct Faculty & FMLA Executive Director of Human Resources  
Human Resources Generalists

### IX. Definitions

- A. FMLA: Family and Medical Leave Act is a Federal law that provides "eligible" employees of a covered employer the right to take up to 12 workweeks of unpaid, job-protected leave, during any 12 months. Eligible employees must have worked at least 1,250 hours over the previous 12 months.
- B. Serious Health Condition(s): Serious health condition means an illness, injury, impairment, or physical or mental condition that involves either:
  1. Inpatient care (i.e., an overnight stay) in a hospital.
  2. Continuing treatment by a health care provider.
    - i. Any period of incapacity related to pregnancy or for prenatal care. A visit to the health care provider is not necessary for each absence.
    - ii. Any period of incapacity or treatment for a chronic serious health condition which continues over an extended period of time, requires periodic visits (at least twice a year) to a health care provider, and may involve occasional episodes of incapacity. A visit to a health care provider is not necessary for each absence.
    - iii. A period of incapacity that is permanent or long-term due to a condition for which treatment may not be effective. Only supervision by a health care provider is required, rather than active treatment.
    - iv. Any absences to receive multiple treatments for restorative surgery or for a condition that would likely result in a period of incapacity of more than three days if not treated.

- v. Any continuing treatment by a health care provider which includes a period of incapacity of more than three consecutive calendar days that results in a regimen of continuing treatment under the supervision of a health care provider (e.g., a course of prescription drugs, physical therapy). Unless complications arise, the common cold, flu, upset stomach, headaches, routine dental problems and cosmetic treatments do not meet the definition of a "serious health condition."
- C. Qualifying Exigency Leave: This leave applies to employees that are members of the National Guard or Reserves or of a regular component of the Armed Forces when the covered military member is on covered active duty or called to covered active duty. The qualifying exigency must be one of the following:
  - 1. Short-notice deployment
  - 2. Military events and activities
  - 3. Child care and school activities
  - 4. Financial and legal arrangements
  - 5. Counseling
  - 6. Rest and recuperation
  - 7. Post-deployment activities and
  - 8. Additional activities that arise out of active duty, provided that the employer and employee agree, including agreement on timing and duration of the leave.
- D. Covered active duty: A member of the Armed Forces (including a member of the National Guard or Reserves) who is undergoing recuperation for a serious injury or illness; or, a veteran who is undergoing recuperation for a serious injury or illness and who was a member of the Armed Forces (including a member of the National Guard or Reserves) at any time during the preceding period of five years.
- E. Military Caregiver Leave: MCL also known as covered service member leave are leaves to care for an injured or ill service member or veteran. These leaves may extend up to 26 weeks in a 12 month period.
- F. 12-Month Period Method: The College will measure the 12-month period as a fixed 12-month period measured at the beginning of each fiscal year (July 1st– June 30th) each time an employee uses any leave under this policy. Eligible employees may take up to twelve (12) weeks of leave during the 12-month Fiscal Year (July 1 through June 30) period for a purpose that qualifies for a leave under the FMLA Policy. For military caregiver leaves, the 12 month period is not defined by the employer under a calendar or fixed or rolling year, but rather is defined as a rolling year beginning on the first day of leave. FMLA leave already taken for other FMLA circumstances will be deducted from the total of 26 weeks available.

## X. Procedures

- A. All employees requesting FMLA leave must provide verbal or written notice of the need for the leave to Human Resources. Within five business days after the employee has provided this notice, Human Resources will complete and provide the employee with the appropriate written notice of eligibility.
- B. When the need for the leave is foreseeable, the employee must provide Human Resources with at least 30 days' notice. When an employee becomes aware of a need for FMLA leave less than 30 days in advance, the employee must provide notice of the need for the leave either the same day or the next business day. When the need for FMLA leave is not foreseeable, the employee must comply with GRCC's usual and customary notice and procedural requirements for requesting leave, absent unusual circumstances. Within five business days after the employee has submitted the appropriate certification form, the employee will be provided with a written response regarding their request for FMLA leave.
- C. Employee Status and Benefits during Leave:
  - 1. While an employee is on leave, the College will continue the employee's health benefits during the leave period at the same level and under the same conditions as if the employee had continued to work.
  - 2. If the employee chooses not to return to work for reasons other than a continued serious health condition of the employee or the employee's family member or a circumstance beyond the employee's control, the College will require the employee to reimburse the amount it paid for the employee's health insurance premium during the leave period.
  - 3. Under current College policy, the employee pays a portion of the health care premium. While on paid leave, the employer will continue to make payroll deductions to collect the employee's share of the premium.
  - 4. While on unpaid leave, the employee must continue to make this payment, either in person or by mail. It is the employees' responsibility to submit timely monthly payments directly to the Benefits office in order to continue coverage while on an unpaid leave. If the payment is more than 30 days late, the employee's health care coverage may be dropped for the duration of the leave. The College will provide 15 days' notification prior to the employee's loss of coverage.
  - 5. If the employee contributes to a life insurance or disability plan, the employer will continue making payroll deductions while the employee is on paid leave. While the employee is on unpaid leave, the employee may request continuation of such benefits and pay his or her portion of the premiums, or the College may elect to maintain such benefits during the leave and pay the employee's share of the premium payments. If the employee does not continue these payments, the College may discontinue coverage during the leave. If the College maintains coverage, we may recover the costs incurred for paying the employee's share of any premiums, whether or not the employee returns to work.

- D. Employee Status After Leave: An employee who takes leave under this policy will be asked to provide a fitness for duty (FFD) clearance from the health care provider. This requirement will be included in the employer's response to the FMLA request. Generally, an employee who takes FMLA leave will be able to return to the same position or a position with equivalent status, pay, benefits and other employment terms. GRCC may choose to exempt certain key employees from this requirement and not return them to the same or similar position.
- E. Use of Paid and Unpaid Leave:
1. An employee who is taking FMLA leave because of the employee's own serious health condition, leave for the birth of the child, workers' compensation leave (to the extent that it qualifies), or the serious health condition of a family member is required to use accrued but unused sick days to cover this period of absence. If the employee's FMLA leave continues after they have exhausted their available sick days, the remainder of the leave will be unpaid or they have the option to use accrued but unused vacation, personal business or compensatory time. Sick leave may be run concurrently with FMLA leave if the reason for the FMLA leave is covered by the established sick leave policy.
  2. An employee who is taking leave for the birth of a child beyond the disability, adoption or foster care of a child may use all paid vacation, personal or family leave prior to being eligible for unpaid leave.
  3. An employee who is using military FMLA leave for a qualifying exigency must use all paid vacation and personal leave prior to being eligible for unpaid leave. An employee using FMLA military caregiver leave must also use all paid vacation, personal leave or sick leave (as long as the reason for the absence is covered by GRCC's sick leave policy) prior to being eligible for unpaid leave.
- F. Intermittent Leave or a Reduced Work Schedule
1. The employee may take FMLA leave in 12 consecutive weeks, may use the leave intermittently (take a day periodically when needed over the year) or, under certain circumstances, may use the leave to reduce the workweek or workday, resulting in a reduced hour schedule. In all cases, the leave may not exceed a total of 12 workweeks (or 26 workweeks to care for an injured or ill service member over a 12-month period).
  2. The College may temporarily transfer an employee to an available alternative position with equivalent pay and benefits if the alternative position would better accommodate the intermittent or reduced schedule, in instances when leave for the employee or employee's family member is foreseeable and for planned medical treatment, including recovery from a serious health condition or to care for a child after birth, or placement for adoption or foster care.
  3. For the birth, adoption or foster care of a child, the College and the employee must mutually agree to the schedule before the employee may take the leave intermittently or work a reduced hour schedule. Leave for birth, adoption or foster care of a child must be taken within one year of the birth or placement of the child.
  4. If the employee is taking leave for a serious health condition or because of the serious health condition of a family member, the employee should try to reach an agreement with the College before taking intermittent leave or working a reduced hour schedule. If this is not possible, then the employee must prove that the use of the leave is medically necessary.
- G. Intent to Return to Work from FMLA Leave: The College may require an employee on FMLA leave to report periodically on the employee's status and intent to return to work.

#### XI. Forms

GRCC FMLA Request Form  
Department of Labor Certification of Health Care Provider Form  
FMLA Family Form  
FMLA Employee Rights and Responsibilities  
Department of Labor Employee Guide

#### XII. Effective Date

July 1994

#### XIII. Policy History

This policy was updated June 2013 to ensure compliance with state and federal laws related to FMLA

#### XIV. Next Review/Revision Date

June 2017

# GRCC Family and Medical Leave (FMLA) Request

## PERSONAL INFORMATION (Please print.)

Employee's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: (\_\_\_\_\_) \_\_\_\_\_

## WORK-RELATED INFORMATION

Department: \_\_\_\_\_ Employee's ID Number: \_\_\_\_\_  
 GRCC Email Address: \_\_\_\_\_  
 Date of Hire: \_\_\_\_\_ Normal Work Hours Per Week: \_\_\_\_\_  
 Anticipated Begin Date of Leave: \_\_\_\_\_ Anticipated Return to Work Date: \_\_\_\_\_  
 Supervisor's Name: \_\_\_\_\_ Phone Number: (\_\_\_\_\_) \_\_\_\_\_  
 Employee Group:  
 APSS  
 Adjunct Faculty  
 Campus Police  
 CEBA  
 Faculty  
 Meet and Confer

## REASONS FOR REQUEST

- Birth and/or care of a child of the employee
- Placement of a child into the employee's family by adoption or by a foster care arrangement
- In order to care for the employee's spouse, child or parent who has a serious health condition
- Spouse
- Child
- Parent
- A serious health condition which renders the employee unable to perform the functions of the employees position

## REQUIRED SIGNATURE

- I acknowledge that I have received the policy and/or rules relative to the Family and Medical Leave Act.

Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## SUPERVISOR AND HUMAN RESOURCE SECTION

Leave has been:

- Approved
- Denied

Supervisor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Human Resource's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Certification of Health Care Provider for  
Family Member's Serious Health Condition  
(Family and Medical Leave Act)

U.S. Department of Labor  
Wage and Hour Division



DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.

OMB Control Number: 1235-0003  
Expires: 5/31/2018

**SECTION I: For Completion by the EMPLOYER**

**INSTRUCTIONS to the EMPLOYER:** The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees' family members, 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.

Employer name and contact:

**SECTION II: For Completion by the EMPLOYEE**

**INSTRUCTIONS to the EMPLOYEE:** Please complete Section II before giving this form to your family member or his/her medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a covered family member with a serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Your name: \_\_\_\_\_  
First Middle Last

Name of family member for whom you will provide care: \_\_\_\_\_  
First Middle Last

Relationship of family member to you: \_\_\_\_\_

If family member is your son or daughter, date of birth: \_\_\_\_\_

Describe care you will provide to your family member and estimate leave needed to provide care:

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

**SECTION III: For Completion by the HEALTH CARE PROVIDER**

**INSTRUCTIONS to the HEALTH CARE PROVIDER:** The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. 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 for which the patient needs leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e). Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider’s name and business address: \_\_\_\_\_

Type of practice / Medical specialty: \_\_\_\_\_

Telephone: ( \_\_\_\_\_ ) \_\_\_\_\_ Fax:( \_\_\_\_\_ ) \_\_\_\_\_

**PART A: MEDICAL FACTS**

1. Approximate date condition commenced: \_\_\_\_\_

Probable duration of condition: \_\_\_\_\_

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?  
\_\_\_ No \_\_\_ Yes. If so, dates of admission: \_\_\_\_\_

Date(s) you treated the patient for condition: \_\_\_\_\_

Was medication, other than over-the-counter medication, prescribed? \_\_\_ No \_\_\_ Yes.

Will the patient need to have treatment visits at least twice per year due to the condition? \_\_\_ No \_\_\_ Yes

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?  
\_\_\_ No \_\_\_ Yes. If so, state the nature of such treatments and expected duration of treatment:

2. Is the medical condition pregnancy? \_\_\_ No \_\_\_ Yes. If so, expected delivery date: \_\_\_\_\_

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

**PART B: AMOUNT OF CARE NEEDED:** When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery?  No  Yes.

Estimate the beginning and ending dates for the period of incapacity: \_\_\_\_\_

During this time, will the patient need care?  No  Yes.

Explain the care needed by the patient and why such care is medically necessary:

5. Will the patient require follow-up treatments, including any time for recovery?  No  Yes.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

Explain the care needed by the patient, and why such care is medically necessary:

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery?  
No  Yes .

Estimate the hours the patient needs care on an intermittent basis, if any:

\_\_\_\_\_ hour(s) per day; \_\_\_\_\_ days per week from \_\_\_\_\_ through \_\_\_\_\_

Explain the care needed by the patient, and why such care is medically necessary:



7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? \_\_\_No \_\_\_Yes.

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: \_\_\_ times per \_\_\_ week(s) \_\_\_ month(s)

Duration: \_\_\_ hours or \_\_\_ day(s) per episode

Does the patient need care during these flare-ups? \_\_\_ No \_\_\_ Yes.

Explain the care needed by the patient, and why such care is medically necessary:

**ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.**

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**Signature of Health Care Provider**

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**Date**

**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 20 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 Ave., NW, Washington, DC 20210.

**DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**