

Family Serious Health Condition (Residents and Fellows)



Comprehensive leave guidance to help you along the way

Family Serious Health Condition

This Family Serious Health Condition leaves packet applies ONLY to resident/fellows in the following titles:

PGY 1

Title code: 002709
RESID PHYS I/NON REP
RESID PHYS I/REP

PGY 2+

Title code: 002723
RESID PHYS II-VIII/NON REP
RESID PHYS II-VIII/REP

Chief Resident

Title Code: 002738
CHIEF RESID PHYS-NON REP
CHIEF RESID PHYS-REP

ACGME Fellow

Title Code: 002736
RESID PHYS/SUBSPEC 4-8/NON REP
RESID PHYS/SUBSPEC 4-8/REP

Non-ACGME Fellow

Title Code: 002733
OTH POST-MD TRAIN 2-8/NON REP
OTH POST-MD TRAIN 2-8/REP

Med Physics Resident

Title Code: 002740
NON-PHYS CLIN TRAIN

If you are unsure of your title, click here: [Where to find your title in UC Path.](#)

PLEASE READ

FAMILY AND MEDICAL LEAVE (FML) IS JOB PROTECTION, NOT PAY.

This packet describes both your leave entitlements and income replacement options. It is important to understand these are not the same. Leave entitlements describe the types of “protected” leave to which you are entitled under University policy (incorporating federal and state laws, including FMLA, CRFA, etc.). “Protected” leaves are time you can be away from work (unpaid) and for which the University is not permitted to respond with an adverse employment action (e.g., discipline, termination, etc.). Income replacement describes the policies and procedures under University policy whereby you can continue to receive income notwithstanding that you are not working (i.e., on leave).

Pay for Family Care and Bonding (PCFB) is not applicable to residents/fellows.

Parental leave pay benefits are covered the Collective Bargaining Agreement.

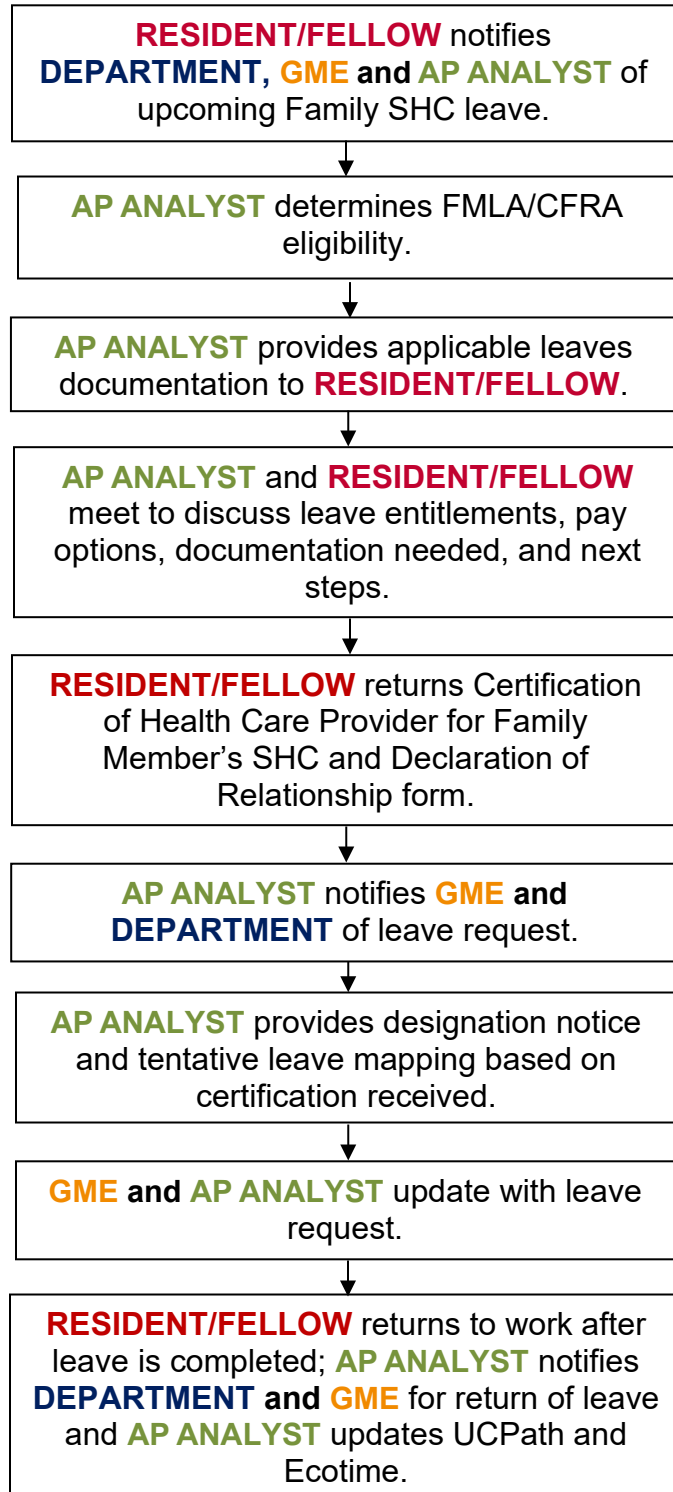
Education Training Program Extension

As a member of a Graduate Medical Education Training program, any leave of absence from your program may require a training extension, based on the duration of the leave, other absences and review of the applicable Specialty Certifying Board leave policy or applicable training program leave policy. Your program will review this with you. Please contact your Program Director and Coordinator with further questions regarding any possible extension.

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Family Serious Health Condition (SHC) Leave Process



Leave Entitlements: Family SHC

The following leave entitlement information applies to eligible Employee's Serious Health Condition leaves in academic resident/fellow titles. Compensation for this leave is discussed on the following page, Pay Options: Family Serious Health Condition.

A serious health condition is defined as an illness, injury, impairment, or physical or mental condition that involves either inpatient care or continuing treatment by a health care provider, in which the employee's family member cannot perform the essential function(s) of their job. Both physical and mental health conditions qualify for FMLA/CFRA leave.

Employees may take such leave to care for their spouse, domestic partner, designated person, child (including the child of the employee's domestic partner), parent, parent-in-law, grandparent, grandchild, or sibling.

Family and Medical Leave (FML) is a job and benefit protected leave provided under any of the following statutes:

- **Family and Medical Leave Act (FMLA, Federal entitlement)** – provides eligible employees with up to twelve (12) workweeks of unpaid, job-protected leave per calendar year for a serious health condition.

Eligibility - at least 12 months of cumulative University service and 1,250 hours worked in the 12 months immediately preceding the commencement of the leave. Hours worked include overtime but not holiday, vacation, sick leave, or other paid leaves.

- **California Family Rights Act (CFRA, State entitlement)** – provides eligible employees with up to twelve (12) workweeks of unpaid, job-protected leave per calendar.

Eligibility - at least 12 months of cumulative University service and 1,250 hours worked in the 12 months immediately preceding the commencement of the leave. Hours worked include overtime but not holiday, vacation, sick leave, or other paid leaves.

For Family's Serious Health Condition leaves, employees not currently eligible for FMLA/CFRA leave entitlements may work with their respective departments to coordinate the necessary time away for their Family's Serious Health Condition leave. Note: personal leaves are not protected under FMLA or CFRA.

If FMLA/CFRA eligible, FMLA/CFRA run concurrently. The start of FMLA/CFRA is dependent on the information provided by the physician on a Certification of Health Care Provider for Employee's Serious Health Condition form or comprehensive doctor's note.

Note: If a doctor's note is obtained in place of the Certification of Health Care Provider for Family Member's Serious Health Condition form, it must contain all the pertinent information that would be included on the Certification of Health Care Provider for Family Member's Serious Health Condition form. Doctor's notes with incomplete information will be returned to

the employee for an updated note which may cause a delay with the employee's FMLA/CFRA designation.

Additional information:

FMLA/CFRA protected leaves entitle eligible employees of covered employers to take unpaid, job-protected leave with continuation of group health insurance coverage under the same terms and conditions as if the employee had not taken leave.

UC Davis administers FMLA/CFRA on a calendar year basis.

- A "rolling 12-month period" will be used to calculate hours worked in determining if an employee is eligible for an FMLA/CFRA leave.
- FMLA/CFRA eligibility is re-calculated at the start of every calendar year, which includes FMLA/CFRA leaves in process.
- Any FMLA/CFRA leave used in the calendar year will decrease your total FMLA/CFRA allotment for that calendar year.
- If an employee takes less than the full amount of leave allowed, they do not need to re-qualify (regarding the number of hours worked) to take additional leave for the original reason within the 12-month period. If the additional leave is for a different reason than the original leave, the employee must re-qualify.

***Certification by a health care provider.** Under the FMLA, the definition of health care provider includes, but is not limited to the following: doctor of medicine or osteopathy, physician assistant, nurse practitioner, podiatrist, dentist, nurse-midwife, clinical psychologist, clinical social worker, optometrist, chiropractor, Christian Science practitioner, and any provider covered under the employer group health plans, including foreign countries. Other health care providers may be acceptable, please contact AP for guidance.

Leave Laws

The following is a guide regarding federal and California state disability leave laws as they relate to a family serious health condition leave. Please be advised you must confer with your Academic Personnel (AP) analyst regarding your eligibility for protected leave under the Family and Medical Leave Act (FMLA) and the California Family Rights Act (CFRA).

Type of Leave	Duration	Benefit	Eligibility Requirements and Use
Family and Medical Leave Act (FMLA)	Up to 12-weeks per calendar year	<ul style="list-style-type: none"> • Job protected leave • Eligible for benefit continuation of employer contribution for medical/dental/vision 	<p>Eligibility requirements:</p> <ol style="list-style-type: none"> 1. 12 mos. cumulative UC service 2. 1250 actual hours worked in the prior 12 mos. <p>Runs concurrently with CFRA for any period of incapacity for a family member's serious health condition.</p>
California Family Rights Act (CFRA)	Up to 12-weeks per calendar year	<ul style="list-style-type: none"> • Job protected leave • Eligible for benefit continuation of employer contribution for medical/dental/vision 	<p>Eligibility requirements:</p> <ol style="list-style-type: none"> 1. 12 mos. cumulative UC service 2. 1250 actual hours worked in the prior 12 mos. <p>If you were eligible for FMLA at the time of your leave, you will be eligible for 12 weeks of protected leave due to a family member's serious health condition.</p> <p>Runs concurrently with FMLA for any period of incapacity for a family member's serious health condition.</p>

While the Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) are unpaid entitlements during a family serious health condition leave, resident/fellows may have several options to receive compensation while on leave. The following pay option information applies to resident/fellow family serious health condition leaves.

Pay Option Benefits:

Parental Leave Pay Benefit (8 weeks pay leave) – provides 56 consecutive calendar days of full pay per pregnancy for resident/fellows only, to be used with during Pregnancy Disability Leave (PDLL), Baby Bonding time or up until the baby turns one.

Eligibility – available upon hire; granted to a resident/fellow who is a member of Graduate Medical Education (GME) program and has been certified by a health care provider that they are unable to work because of pregnancy, childbirth, recovery, and/or related medical conditions and baby bonding until the baby is 1 years old. The Parental Leave Pay benefit also applies to the non-childbearing parent. The Parental Leave pay benefit is per occurrence, available on the resident/fellow's first day of employment and is provided for the period before, during, and after childbirth.

Additional Information: The Parental Leave pay benefit is intended to substitute other benefits with partial pay, as it is the greater benefit, and therefore may not be taken in conjunction with short-term disability. It is advised to use Parental Leave as the first pay source option.

- **Vacation Pay (Vacation)** – Residents/Fellows may use the 28 days of vacation leave provided at the beginning of each academic year for full pay to cover any combination of pregnancy disability and baby bonding leave not covered by the Parental Leave benefit.
- **Sick Leave** – Resident/Fellow may use the allotted 12 days of sick leave provided at the beginning of each academic year.

Additional Information:

If a resident/fellow member has used all applicable pay options and still has protected leave available, they may choose to continue their leave without pay.

The following forms and documentation apply to Family Serious Health Condition (SHC) leaves for resident/fellow titles.

- **Notice of Eligibility and Rights & Obligations Form (AP ANALYST)**

When an employee first requests a leave for a reason that may qualify for FMLA leave/CFRA, or the department receives information of a possible qualifying event, the employer must notify the employee whether they are eligible for FMLA/CFRA leave. If the employee is eligible, the employer must notify the employee in writing about employee rights and responsibilities under the FMLA.

The Notice of Eligibility and Rights & Obligations Form should be provided to the employee **within five (5) days** of the department learning of a possible qualifying event or receipt of the leave request from the employee.

- **Certification of Health Care Provider for Family Member's Serious Health Condition Form (RESIDENT/FELLOW)**

Medical certification to support employee's request for leave to care for a family member with a serious health condition. Providing this completed form is required to obtain (or retain) the benefit of FMLA/CFRA protections for the employee's leave.

The Certification of Health Care Provider for Family Member's Serious Health Condition Form should be provided to the employer **within fifteen (15) days** of receipt of the Notice of Eligibility and Rights & Obligations Form.

- **Declaration of Relationship Form (RESIDENT/FELLOW)**

This form should be completed by the employee when the employee requests FML to care for a family member with a serious health condition. Please note: This declaration is for FML purposes only and does not establish benefits eligibility for the family member.

The Certification of Health Care Provider for Family Member's Serious Health Condition and Declaration of Relationship Form should be provided to the employer **within fifteen (15) days** of receipt of the Notice of Eligibility and Rights & Obligations Form.

- **Designation Notice Form (AP ANALYST)**

Once the employer has enough information to know whether a leave request qualifies as FMLA/CFRA leave, the employer must notify the employee in writing whether the employee's time off from work will be designated FMLA/CFRA leave, and the amount of time that will count against the employee's entitlements.

The Designation Notice Form should be provided to the employee **within five (5) days** of the employer receiving sufficient information regarding qualification of leave.

- **Family Serious Health Condition Leaves Map (AP ANALYST)**

A leave mapping offers the employer and employee a full picture glance of leave entitlements, pay, and anticipated length of leave.

- **Family and Medical Leave Benefits Fact Sheet**

This University of California fact sheet offers general guidance on how Family and Medical Leave works, eligibility requirements, how to arrange for a leave, what happens to your benefits during a leave and how to make the transition back to work.

MEDICAL, DENTAL, AND VISION BENEFITS

If you are **on pay status**, all UC-sponsored benefits continue.

CONTACT INFORMATION

UC Davis Health Benefits: HS-GMELOA@ucdavis.edu

UC Davis Health Disability Management Services (DMS): dmshelp@ucdavis.edu

Resources:

[Resident Benefits Information](#)

[GME Policy Page](#)

- * Collective Bargaining Agreement
- * UC Davis Housestaff Leaves and Accruals
- * UC Davis Housestaff Compensation Plan

Tools:

[FMLA/CFRA Eligibility Spreadsheet](#)

[Leaves Calculator](#)

Leave Timeline: Family SHC

This checklist should help you stay organized and ensure that you're taking the necessary steps for your leave of absence.

THREE MONTHS PRIOR TO LEAVE:

- Have you notified your department and AP analyst of a family serious health condition leave needed?**

- Has the AP analyst provided you with the following documents within five days of receiving notice of your leave?**
 - Notice of Eligibility and Rights and Obligations Form
 - Certification of Health Care Provider Form
 - University of California Family and Medical Leave Fact Sheet

- Have you met with your AP analyst to discuss leave entitlements and pay options?**
 - Possible leave entitlements – [FMLA](#) / [CFRA](#) (it is recommended to familiarize yourself with these federal and state entitlements prior to meeting)
 - Possible pay entitlements – applicable Health Sciences Compensation Plan member benefit (5 Annual Comp Plan Days), PFCB, Vacation, Leave Without Pay
 - Department will also provide initial leave mapping based on leaves dates discussed

TWO MONTHS PRIOR TO LEAVE:

- Have you provided your AP analyst with a completed Certification of Health Care Provider for Family Serious Health Condition form and Declaration of Relationship form?**

- Has the AP analyst provided you with the following documents within five days of receiving sufficient information regarding qualification for leave?**
 - Provides Designation Notice
 - Provides updated leave mapping if needed, based on medical certification received

ONE MONTH PRIOR TO LEAVE:

- Have you discussed/finalized your proposed leave schedule with your AP analyst and notified them of any changes/updates from your initial leave request?**
 - If yes, please provide the necessary documentation for these changes.

WHEN YOU GO OUT ON LEAVE:

- Keep in touch with your AP analyst to inform them of any changes in your approved leave schedule.**
 - Provide updated family member's medical paperwork to the department if their disability dates that require care are different from the original anticipated disability dates provided earlier in the process.
 - Note, accurate disability dates are important to ensure you receive the most comprehensive leave possible.

WHEN YOU RETURN TO WORK

- Check in with your AP analyst on the first day back to “check-in”, so they can ensure you are returned from leave in UC Path.**

The following checklist is intended to help you stay organized and ensure that you are taking the necessary steps for your faculty's leave of absence. The SHORT checklist is helpful for quick reminders of next steps. The DETAILED checklist asks the same questions as the short checklist but provides additional guidance on what is needed for each step.

SHORT

- Did the employee request leave, or did the department learn of a possible qualifying event for the employee, for one of the following reasons?
- Is the employee eligible for FMLA leave?
- Has the AP analyst provided the necessary documents to the employee within five (5) days of receipt of leave?
- Has the AP analyst and employee meet to discuss leave entitlements and pay options?
- Has the AP analyst received the applicable Certification Form within fifteen (15) days of issuance of Notice of Eligibility and Rights and Obligations form?
- Has the AP analyst notified the GME office of the leave request?
- Has the AP analyst provided the necessary documents within five (5) days of employer receiving sufficient information regarding qualification of leave?
- Has the AP analyst and GME submitted the leave in Ecotime?
- Does the department need to track this leave?
- Has the employee notified the AP analyst of any changes/updates from their initial leave request?
- Is the employee's leave ending soon?
- Has the department maintained employee's confidential leave documentation as a separate file from the employee's personnel file?

DETAILED

Did the employee request leave, or did the department learn of a possible qualifying event for the employee, for one of the following reasons?

- Employee's own serious health condition
- Serious health condition of spouse, domestic partner, child, parent, parent-in-law, grandparent, grandchild, sibling
- Birth, adoption, or foster placement of child
- Military "qualifying exigency"
- Serious Injury or illness of a covered service member

Is the employee eligible for FMLA leave?

- Has the employee worked at least 12 months for the company (need not be consecutive)?
- Has the employee worked at least 1,250 hours in the preceding 12 calendar months?
 - Hours actually worked include overtime but do not include holiday, vacation, sick leave, or other paid leaves.
- Has the employee already used FMLA leave this calendar year? If so, do they still have FMLA leave available?
- If not FMLA/CFRA eligible, does the employee have other leave options?

Has the AP analyst provided the following documents to the employee within five (5) days of receipt of leave?

- Notice of Eligibility and Rights and Obligations Form
- Declaration of Relationship Form
- University of California Family and Medical Fact Sheet

Has the AP analyst and employee met to discuss leave entitlements and pay options?

- Leave entitlements – FMLA / CFRA
- Pay options – applicable Health Sciences Compensation Plan member benefit (5 Annual Comp Plan Days), PFCB, Vacation, Leave Without Pay
- Provide initial mapping of leave based on desired dates provided by employee

Has the AP analyst received the Declaration of Relationship form and the applicable Certification Form within fifteen (15) days of issuance of Notice of Eligibility and Rights and Obligations form?

- Have you reviewed the form for completeness?
 - For incomplete certification or if clarification is needed, retain a copy and return original certification to the employee with explanation of deficiencies and request new certification to be submitted within seven days.
- Is the leave for a qualifying reason?

Has the AP analyst notified the Department and GME of the leave request?

- Sends an email to the coordinator and GME advising of the forthcoming leave request and provides a copy of the medical certification received.

Has the AP analyst provided the following documents within five (5) days of employer receiving sufficient information regarding qualification of leave?

- Provides Designation Notice to employee
- Provides Return to Work Certification
- Provides updated leave mapping if needed, based on medical certification received.
- If intermittent leave, advise employee's manager/supervisor of approved time away due to FMLA leave.

Has the AP analyst and GME submitted the leave request in Ecotime?

- Adds leave details into Ecotime

Does the department need to track this leave?

- Departments should track intermittent leave usage.

Has the employee notified the AP analyst of any changes/updates from their initial leave request?

- If yes, has the employee provided the necessary documentation for these changes?
- Does the AP analyst need to update the existing leave in Ecotime for proper leaves tracking?
- Has the department notified appropriate personnel of these changes, if needed?

Is the employee's leave ending soon?

- Send an email 1-2 weeks in advance of anticipated leave end date to check in with the employee to:
 - Confirm return date or possible leave extension.

Has the department maintained employee's confidential medical leave documentation as a separate file from the employee's personnel file?

- Leave records should be maintained for 3 years.

Q: How do I request a Family Member's Serious Health Condition leave?

A: Contact your department coordinator and submit your request in MedHub; Contact your AP Analyst so they can provide information on your eligibility and options.

Q: What is the difference between leave entitlement and paid leave benefits?

A: Leave entitlements describe the types of "protected" leave to which you are entitled under University policy (incorporating federal and state laws, including PDLL, FMLA, CRFA, etc.). Income replacement, or paid leave benefits, describes the policies and procedures under University policy whereby you can continue to receive income notwithstanding that you are not working (i.e., on leave).

Q: Who should sign my medical documentation (e.g. disability certification, return to work certification, etc.)?

A: Medical documentation should be signed by the appropriate health care provider.

Under the FMLA, the definition of health care provider includes, but is not limited to the following: doctor of medicine or osteopathy, physician assistant, nurse practitioner, podiatrist, dentist, nurse-midwife, clinical psychologist, clinical social worker, optometrist, chiropractor, Christian Science practitioner, and any provider covered under the employer group health plans, including foreign countries. Other health care providers may be acceptable, please contact AP for guidance.

Q: Is it appropriate for an employer to contact an employee while on leave?

A: Depending on the reason for FML, it's usually fine to ask a quick question (e.g., about the status of a project or where a file might be), if you can't figure that out otherwise. It's also fine to periodically check in, provide reminders, and/or request medical documentation.

It is not acceptable to reach out to an employee to request they perform any kind of work.

When unsure, reach out to your AP Analyst.

Q: How do I return to work after my leave?

A: Employees on leave due to a Family Member's Serious Health Condition do not require a Return to Work form.

NOTICE OF ELIGIBILITY AND RIGHTS & RESPONSIBILITIES (R12/22)**Family and Medical Leave Act (FMLA), California Family Rights Act (CFRA), & California Pregnancy Disability Leave Law (PDLL)**

In general, to be eligible for Family and Medical Leave (FML), an employee must have worked for the University of California for at least 12 months and have worked at least 1,250 hours in the 12 months preceding the leave. These eligibility requirements do not apply to Pregnancy Disability Leave taken under PDLL.

Part A – NOTICE OF ELIGIBILITY

To:

Employee

Date

From:

University Representative

On _____, you informed the University that you needed leave beginning on _____ and with an anticipated end date of _____ for:

- Your own serious health condition.
- The need to care for one of the following family members due to their serious health condition:
 spouse; domestic partner; designated person; child; parent; parent-in-law;
 grandparent; grandchild; sibling.
- Pregnancy Disability Leave (PDL). This leave may be used when you are disabled by pregnancy, childbirth, or a related medical condition. It may also be used for prenatal care.
- Parental bonding leave following the birth of a child, or placement of a child with you for adoption or foster care.
- Military caregiver leave to care for a family member who is a Covered Servicemember with a serious injury or illness. You are the Covered Servicemember's:
 spouse; domestic partner; child; parent; next of kin.
- A qualifying exigency related to the following family member's active duty or call to active duty status with the Armed Forces:
 spouse; domestic partner; child; parent; parent-in-law.

This Notice is to inform you that:

- You are eligible for FML and have FML entitlement remaining and available to use for the applicable period under the following statute(s): FMLA; CFRA; PDLL. (See Part B below for Rights and Responsibilities.)
- You are eligible for FML but you have already exhausted the applicable FML leave entitlement for the applicable period.

You are **not** eligible for FML under FMLA and/or CFRA because:

- You have not met the 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately _____ months towards this requirement.
- You have not met the 1,250-hours-worked requirement.

If you have any questions, contact _____ or view the

FMLA, CFRA, and/or PDLL posters located in _____ and online, as well as applicable policies and/or collective bargaining agreement provisions.

Part B – RIGHTS AND RESPONSIBILITIES FOR TAKING FML (To be completed only if the employee is eligible and has not exhausted the applicable leave entitlement.)

As explained in Part A, you meet the eligibility requirements for taking FML and still have FML leave entitlement available in the applicable period. **However, in order for us to determine whether your absence qualifies as FML, you should return the following information to us by _____.** When certification is requested, employees have at least 15 calendar days from receipt of this notice to provide it. Under certain circumstances, additional time may be provided. If sufficient information is not provided in a timely manner, your leave may be denied.

- Sufficient certification to support your request for FML. A certification form that sets forth the information necessary to support your request is enclosed.
- Sufficient documentation to establish the required relationship between you and your family member. The required declaration form is enclosed.
- Other information needed: _____

If your leave does qualify as FML, you will have the following **responsibilities** while on leave (only checked boxes apply):

- Contact _____ at _____ to make arrangements to either (a) maintain your health benefits during your leave by continuing to make your share of the premium payments or (b) opt out of your health benefits during your leave. You have a minimum of 30 days to make premium payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse, or, at our option, we may pay your share of the premiums during your FML, and recover these payments from you upon your return to work.
- You will be required to use the following paid leave during your FML absence:
your available **sick leave**, **vacation**, and/or **other leave**.
Your entire FML absence, including any period during which you are using paid leave, will be counted against your FML leave entitlement. Note: This requirement to use paid leave does not apply to any part of an FML absence during which employees are using Pay for Family Care and Bonding (PFCB).
- While on leave you will be required to furnish us with periodic updates of your status and intent to return to work every: _____ *[Indicate interval of periodic updates, as appropriate for the particular leave situation].*
- If the circumstances of your leave change, and you are able to return to work earlier than the date indicated in Part A of this form, you need to notify your supervisor at least two workdays prior to the date you intend to report for work.

If your leave does qualify as FML, you will have the following **rights** while on leave:

- You have a right under the FMLA and/or the CFRA for up to 12 workweeks of unpaid leave in the calendar year (January-December) if you are taking leave for any FML qualifying purpose other than Military Caregiver Leave.
- You have a right under the FMLA for up to 26 workweeks of unpaid leave in a single 12-month period to care for a Covered Servicemember with a serious injury or illness (Military Caregiver Leave). This single 12-month period commenced or will commence on: _____.
- You have a right under the PDLL for up to four months of unpaid leave per pregnancy.
- Your FML leave will be designated and counted against your applicable statutory FML leave entitlement(s) and will be job-protected leave as required under the applicable statute.
- Your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work.
- If you return directly from a leave under the PDLL, you will be reinstated to the same position or, if the same position is not available, to a comparable position. (If your leave extends beyond the end of your FML leave entitlement(s), you do not have statutory return rights.)
- If you return directly from any statutory FML leave other than a leave under the PDLL, you must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your

return from FMLA-protected and/or CFRA-protected leave. (If your leave extends beyond the end of your FML leave entitlement(s), you do not have statutory return rights.)

- You may be required to reimburse the University for its share of health insurance premiums paid on your behalf during any unpaid portion of your FML if you do not return to work following FML for a reason other than: 1) the continuation, recurrence, or onset of a serious health condition that would entitle you to FML; 2) the continuation, recurrence, or onset of a Covered Servicemember's serious injury or illness which would entitle you to FML; or 3) other circumstances beyond your control.
- If we have not informed you above that you must use paid leave while taking your unpaid FML leave entitlement, you may have the right under the applicable policy or collective bargaining agreement to use Pay for Family Care and Bonding (PFCB) and/or the following paid leave during your FML absence: **sick leave, vacation leave, and/or other leave**. Applicable conditions related to the use of PFCB and paid leaves are referenced or set forth below. If you do not meet the requirements for using PFCB and/or paid leave, you remain entitled to take unpaid FML leave. Your entire FML absence, including any period during which you are using PFCB or paid leave, will be counted against your FML leave entitlement.

For conditions applicable to PFCB and sick/vacation/other leave usage please refer to _____ available at: _____

Applicable conditions for use of paid leave: _____

Once we obtain the information from you as specified above, we will inform you, within 5 business days, whether your leave will be designated as FML and count towards your FML leave entitlement. Meanwhile, WE HAVE PROVISIONALLY DESIGNATED YOUR LEAVE AS FML. If you have any questions, please do not hesitate to contact: _____ at _____

DEPARTMENT SIGNATURE

NAME (PRINT)

SIGNATURE

DATE

Fiona Fizzlepuff

Print Form

DECLARATION OF RELATIONSHIP (R12/22)

For Family and Medical Leave (FML) under the Family and Medical Leave Act (FMLA) and the California Family Rights Act (CFRA)

This form should be completed by the employee when the employee requests FML:

- to care for a family member with a serious health condition; or
- for parental bonding leave.

Please note:

- This declaration is for FML purposes only and does not establish benefits eligibility for the family member.

EMPLOYEE'S NAME (Last) Jones	(First) Joe	(Middle Initial)
EMPLOYEE'S DEPARTMENT Department Name		

FOR REQUESTS FOR LEAVE TO CARE FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION:

This leave may be taken to care for the employee's **spouse, domestic partner, designated person, child (including a child of the employee's domestic partner), parent, parent-in-law, grandparent, grandchild, or sibling.**

Please note:

- Step-relatives and relatives by virtue of adoption, foster care, and legal ward/legal guardian relationships are included on the same basis as the above-listed blood relatives.
- "In loco parentis" relationships also qualify, which means that (a) "parent" includes a person who had day-to-day responsibilities to care for the employee or financially supported the employee when the employee was a child, and (b) "child" includes a person for whom the employee has day-to-day responsibilities to provide care or for whom the employee provides financial support.
- In-laws other than parents-in-law are not included unless the employee identifies the in-law as a designated person.
- A "designated person" is any individual related by blood or whose association with the employee is the equivalent of a family relationship. Employees are limited to one designated person per calendar year for FML purposes.

I am requesting FML to care for: Janet Jones
[identify person's name]

who is my: Spouse and has a serious health condition.
[specify relationship with the employee]

If requesting FML to care for a **child**, check one of the following:

- My child is under 18 years of age or incapable of self-care due to a physical or mental disability.
- My child is 18 years of age or older and does not have a disability that renders them incapable of self-care.

If requesting FML to care for a **designated person**, please answer the following questions:

Is the designated person an individual related to you by blood or whose association with you is the equivalent of a family relationship? YES NO

Have you previously identified a designated person for FML purposes during this calendar year? YES NO

If yes, are you now requesting FML to care for that same designated person? YES NO

FOR REQUESTS FOR PARENTAL BONDING LEAVE:

This leave must be taken within 12 months of the birth or placement of the child with the employee for adoption or foster care, as applicable. If leave is being taken in connection with an adoption or foster care placement, the employee may use this leave before the actual placement if the employee's absence from work is required for the placement to proceed. Please note: If the child is not yet named, some description of the child should be included below.

I am requesting parental bonding leave to bond with my newborn child, _____
whose birth date was: _____ or is anticipated to be: _____

OR

I am requesting parental bonding leave to bond with: _____,
a child who was or will be placed with me for adoption or foster care on: _____

SIGNATURE

I Certify that the foregoing is true.

EMPLOYEE SIGNATURE

Joe Jones

DATE

04/30/2024

SAMPLE: This document was created for a FMLA/CFRA eligible resident/fellow.

**CERTIFICATION OF HEALTH CARE PROVIDER
FOR FAMILY MEMBER'S SERIOUS HEALTH CONDITION (R12/22)
Family and Medical Leave Act ("FMLA") & California Family Rights Act ("CFRA")**

PURPOSE of FORM: The below-named employee of the University of California has requested a leave of absence to care for a family member with a health condition, which may qualify as a protected leave under the FMLA and/or CFRA. Employees may take such leave to care for their spouse, domestic partner, designated person, child (including the child of the employee's domestic partner), parent, parent-in-law, grandparent, grandchild, or sibling. This medical certification form will provide the University with information needed to determine if the employee's requested leave is for a qualifying reason under the FMLA and/or CFRA. Section III must be fully completed by the health care provider.

INSTRUCTIONS to EMPLOYEE: Please complete and sign Section II before giving this form to your family member or your family member's health care provider. You are required to submit a timely, complete, and sufficient medical certification to support your request for FMLA and/or CFRA leave due to your family member's serious health condition. Providing this completed form is required to obtain (or retain) the benefit of FMLA and/or CFRA protections for your leave. Failure to provide a complete and sufficient medical certification to the University may result in a delay or denial of your leave request.

This form should be completed and returned within 15 calendar days of the University's request for this information, or no later than _____.

If you cannot return the completed form within the stated deadline, please contact Fiona Fizzlepuff with the reasons for the delay and the date when the certification will be provided. You may return the form in person, by mail, or by fax. The fax number is (916) 555-5552 _____.

You should include a fax cover sheet marked "**CONFIDENTIAL**" and address your fax to:

"**ATTENTION:** Fiona Fizzlepuff."

SECTION I: To be completed by THE UNIVERSITY

Employee's Name
Joe Jones

Name of University Representative
Fiona Fizzlepuff

University Representative Department Address
1112 UC Davis Avenue, Sacramento, CA 95817

Telephone
(916) 555-5556

SECTION II – To be completed by EMPLOYEE

Name of family member for whom you will provide care:
Betty Jones

If family member is your child, date of birth:

Relationship of family member to you:
Spouse

If the child is 18 years of age or older, is the child incapable of self-care because of a mental or physical disability?

No Yes

Describe care you will provide to your family member and estimate the duration of leave needed to provide care.

Assisting with mobility, administering medication, attending medical appointments, helping with daily living activities such as bathing, dressing, and meal preparation, etc.

Are you requesting leave on an intermittent or reduced schedule basis?

No Yes

If yes, please describe the leave schedule you are requesting:

SIGNATURE

EMPLOYEE SIGNATURE

DATE

SECTION III – To be completed by HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA and/or CFRA to care for your patient. Please 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 “indefinite,” “unknown,” or “indeterminate” may not be sufficient to determine FMLA/CFRA coverage. **Limit your responses to the condition for which the patient needs the employee’s care.** Please be sure to sign and date the form on Page 3.

IMPORTANT: DO NOT DISCLOSE ANY UNDERLYING DIAGNOSIS WITHOUT THE PATIENT’S CONSENT.

THE GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA): The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. ‘Genetic information,’ as defined by GINA, includes an individual’s family medical history, the results of an individual’s or family member’s genetic tests, the fact that an individual or an individual’s family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual’s family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

THE CALIFORNIA GENETIC INFORMATION NONDISCRIMINATION ACT OF 2011 (CaGINA): The California Genetic Information Nondiscrimination Act of 2011 (CaGINA) prohibits employers and other covered entities from requesting, or requiring, genetic information of an individual or family member of the individual except as specifically allowed by law. To comply with CaGINA, we are asking that you not provide any genetic information when responding to this request for medical information. “Genetic Information,” as defined by CaGINA, includes information about the individual’s or the individual’s family member’s genetic tests, information regarding the manifestation of a disease or disorder in a family member of the individual, and includes information from genetic services or participation in clinical research that includes genetic services by an individual or any family member of the individual. “Genetic Information” does not include information about an individual’s sex or age.

PROVIDER’S NAME

Dr. Ann Tibiotic

BUSINESS ADDRESS

1234 X St, Sacramento 95817

TELEPHONE
(916) 555-5552

FAX
(916) 555-5552

PART A: MEDICAL FACTS

(1) Approximate date condition commenced:
04/29/2024

Probable duration of condition:

From: 05/01/2024 To: 06/26/2024

(2) Page 4 describes what is meant by a “[serious health condition](#)” under both the FMLA and CFRA. Does the patient’s condition qualify under any of the categories described? No Yes

If yes, which type of [serious health condition](#) listed on Page 4 applies:

1 2 3 4 5 6

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:

(1) 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:
05/01/2024-06/26/2024

During this time, does the patient’s condition warrant the participation of the employee? (In answering this question, please review the employee’s statement of care in Section II, page 1.) No Yes

(2) If the employee has requested leave on an intermittent or reduced schedule leave basis (see answer in Section II, page 1, question 2), is it medically necessary for the patient to receive care on an intermittent or reduced schedule basis, including any time for recovery? No Yes

If yes, estimate the hours the patient needs care from the employee:

Hours per Day _____

Days per Week: _____

From: _____

Through: _____

SIGNATURE

Signature of HEALTH CARE PROVIDER

Date

04/30/2024

Print Form

Serious Health Conditions

A “serious health condition” means an illness, injury (including, but not limited to, an on-the-job injury), impairment, or physical or mental condition that involves either inpatient care or continuing treatment, including, but not limited to, treatment for substance abuse.

- Inpatient Care means a stay in a hospital, hospice, or residential health care facility, any subsequent treatment in connection with such inpatient care, or any period of incapacity. A person is considered an inpatient when a health care facility formally admits them to the facility with the expectation that they will remain at least overnight and occupy a bed, even if it later develops that such person can be discharged or transferred to another facility and does not actually remain overnight.
- Incapacity means the inability to work, attend school, or perform other regular daily activities due to a serious health condition, its treatment, or the recovery that it requires.
- Continuing Treatment means ongoing medical treatment or supervision by a health care provider.

A serious health condition involves one or more of the following:

1. Inpatient Care (as defined above)

2. Absence Plus Treatment

A period of incapacity of more than three (3) consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:

- (a) Treatment two or more times by a health care provider, by a nurse or physician’s assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; OR
- (b) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider (e.g., a course of prescription medication, or therapy requiring special equipment, to resolve or alleviate the health condition). This does not include taking over-the-counter medications or activities that can be initiated without a visit to a health care provider (e.g., bed rest, exercise, drinking fluids).

3. Pregnancy (which is covered as a serious health condition under FMLA but not under CFRA)

A period of incapacity due to pregnancy, childbirth, or related medical conditions. This includes severe morning sickness and prenatal care.

4. Chronic Conditions Requiring Treatment

A chronic condition that:

- (a) Requires periodic visits for treatment by a health care provider, or by a nurse or physician’s assistant under direct supervision of a health care provider;
- (b) Continues over an extended period of time (including recurring episodes of a single underlying condition); and
- (c) May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

5. Permanent/Long-Term Conditions Requiring Supervision

A period of incapacity that is permanent or long-term due to a condition for which treatment may not be effective. The person must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer’s, a severe stroke, or the terminal stages of a disease.

6. Multiple Treatments (Non-Chronic Conditions)

Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three (3) consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), or kidney disease (dialysis).

DESIGNATION NOTICE (R12/22)**FAMILY AND MEDICAL LEAVE ACT (FMLA), CALIFORNIA FAMILY RIGHTS ACT (CFRA),
AND CALIFORNIA PREGNANCY DISABILITY LEAVE LAW (PDLL)**

To: _____ Date: _____

We have reviewed your request for Family and Medical Leave (FML) and any supporting documentation that you have provided.

We received your most recent information on _____ and decided:

PART A: To Be Completed if FML Request is Approved.

Your FML request for the following reason(s) is approved:

- Your own serious health condition.
- The need to care for one of the following family members due to their serious health condition:
 spouse; domestic partner; designated person: _____; child;
 parent; parent-in-law; grandparent; grandchild; sibling.
- Pregnancy Disability Leave (PDL). This leave may be used when you are disabled by pregnancy, childbirth, or a related medical condition. It may also be used for prenatal care.
- Parental bonding leave following the birth of a child, or placement of a child with you for adoption or foster care.
- Military caregiver leave to care for a family member who is a Covered Servicemember with a serious injury or illness. You are the Covered Servicemember's:
 spouse; domestic partner; child; parent; next of kin.
- A qualifying exigency related to the following family member's active duty or call to active duty status with the Armed Forces:
 spouse; domestic partner; child; parent; parent-in-law.

All leave taken for the above reason(s) will be designated as FML and counted against your entitlement under the following statute(s) until exhausted: FMLA; CFRA; PDLL.**For block leaves:**

Start date: _____ Anticipated End Date: _____ Return to Work Date: _____

For Reduced schedule leaves or leaves on an intermittent basis:

Start date: _____ Anticipated End Date: _____

You are required to notify the University as soon as practicable if the dates of your scheduled leave change or are extended. If there was no firm end date for your leave, you should notify the University as soon as practicable when a firm end date is established. Based on the information you have provided to date, we are providing the following information about the amount of time that will be counted against your FML leave entitlement:

- Provided there is no deviation from your anticipated leave schedule, the following number of hours, days, or weeks will be counted against your FML leave entitlement under the following statute(s):
- FMLA _____ Weeks _____ Days _____ Hours.
- CFRA _____ Weeks _____ Days _____ Hours.
- PDLL _____ Weeks _____ Days _____ Hours.

- Because the leave you will need will be unscheduled, it is not possible to provide the hours, days, or weeks that will be counted against your FML leave entitlement at this time. You have the right to request this information once in a 30-day period (if leave was taken in the 30-day period).

If more than one statute is checked above, please note:

- For an FML leave other than Pregnancy Disability Leave: If both the FMLA and CFRA boxes are checked above, you will be concurrently using your entitlements under those statutes until you have either completed your leave or exhausted one or both of those entitlements.
- For a Pregnancy Disability Leave (whether or not immediately followed by Parental Bonding Leave): During the first 12 workweeks of your Pregnancy Disability Leave, you will be concurrently using your PDLL and FMLA entitlements until you have either completed your Pregnancy Disability Leave or exhausted your FMLA entitlement. If your Pregnancy Disability Leave continues after that point, you will only be using your PDLL entitlement until you have either completed your Pregnancy Disability Leave or exhausted your PDLL entitlement. If you take Parental Bonding Leave immediately following Pregnancy Disability Leave and you have not yet exhausted both your FMLA and CFRA entitlements, you will be concurrently using your FMLA and CFRA entitlements during your Parental Bonding Leave until you have either completed your leave or exhausted one or both of those entitlements.

Please be advised (check if applicable):

- You have requested to use paid leave during your FML. Your entire FML absence, including any period during which you are using paid leave, will count against your FML leave entitlement.
- You have requested to use Pay for Family Care and Bonding (PFCB) during your FML. If your leave qualifies for the PFCB option and you have PFCB entitlement available, your entire FML absence, including any period during which you are using PFCB, will count against your FML leave entitlement.
- We are requiring you to use paid leave during some or all of your FML. Your entire FML absence, including any period during which you are using paid leave, will count against your FML leave entitlement.
- You will be required to provide the enclosed Return to Work certification to be restored to employment. If such certification is not timely received, your return to work may be delayed until certification is provided. If the job description is attached, the Return to Work certification must address your ability to perform those essential functions that you were unable to perform as a result of your serious health condition.
- A job description listing the essential functions of your position is attached to the Return to Work Certification.

PART B: To Be Completed if FML Request Is Not Approved

Your FML request is **Not Approved** because:

- Your leave is not for an FML-qualifying reason.
- You have not provided the necessary information to support your request for FML.
- You have exhausted your FML leave entitlement for the applicable period.

DEPARTMENT SIGNATURE

NAME (PRINT)

SIGNATURE

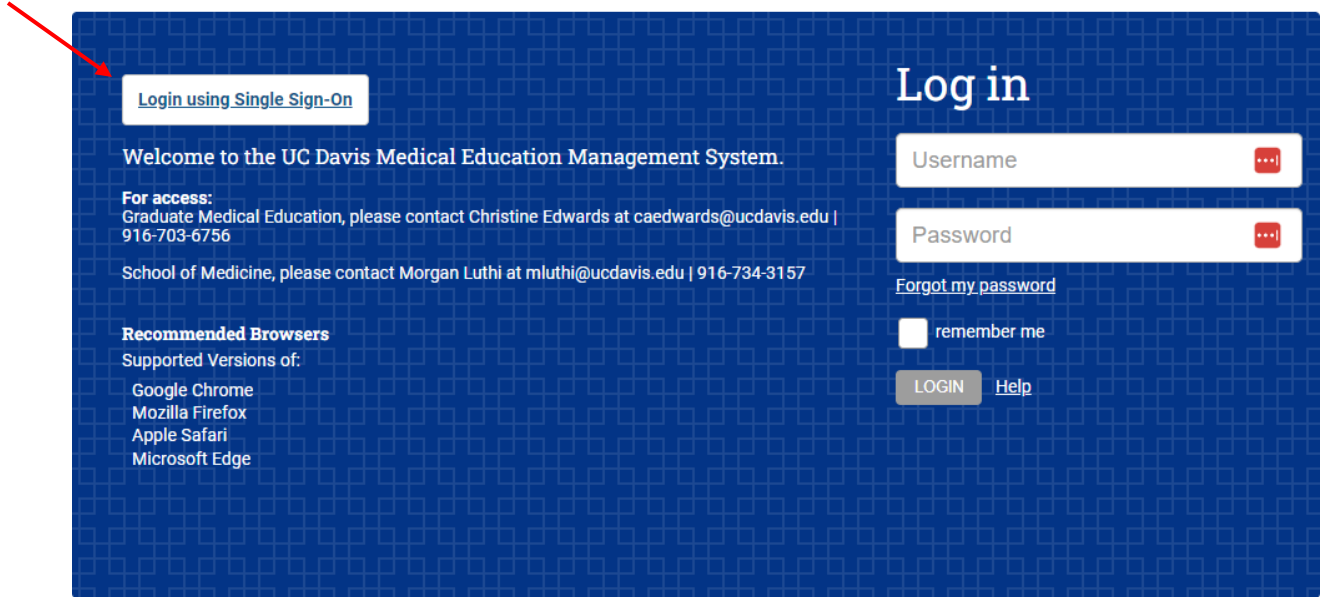
Fiona Fizzlepuff

DATE

HOW-TO REQUEST AN LOA

1. Log into MedHub at <https://ucdavis.medhub.com/index.mh>

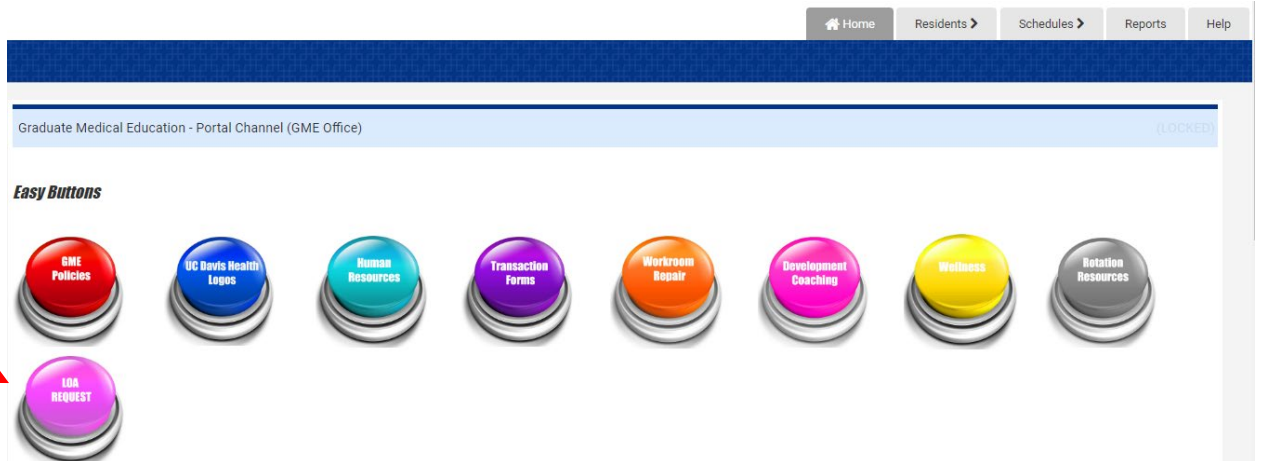
UCDAVIS
HEALTH



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2. On the home screen, click the pink colored 'LOA REQUEST' Easy Button



3. Read the statement about LOAs and GME training extensions, then click the arrow.



Please provide the following information to initiate your Leave of Absence.

[A Leave of Absence is for absences related to Family Leave, Medical Leave, Personal Leave, Parental Leave and Pregnancy Disability Leave.](#)

Please contact your Program Coordinator regarding instructions to request standard Vacation, Sick or Away Conference absences. Please do not enter them here.

- You will be contacted by Holly Singleteary, HR Business Partner, to initiate your leave, determine leave type eligibility.
- GME will work with your program and HR to determine your available entitlements (pay source) and potential extension.
- Your program will review with you and make any adjustments.
- Once complete the *LOA Time Off - Extension Mapping Acknowledgement* form will be sent for signatures via DocuSign.

Please be sure that your vacation and sick time are accurately recorded in MedHub. This will be used to calculate your available entitlements (pay sources) for your leave. Any over usage of entitlements will be required to be paid back to the University.

As a member of a Graduate Medical Education Training program, any leave of absence from your program may require a training extension, based on the duration of the leave, other absences and review of the applicable Specialty Certifying Board leave policy or applicable training program leave policy. Your program will review this with you. Please contact your Program Director and Coordinator with further questions regarding any possible extension.



4. Complete all sections of the questionnaire and click the arrow at the bottom of the page.



Full Name

Program

Email

Contact Phone Number

Are you (trainee) on a J1 Visa?

Yes

No

Program Director

Program Director Email (please confirm this is an accurate email address)

Program Coordinator

Program Coordinator Email (please confirm this is an accurate email address)

Acknowledgement:

As a member of a Graduate Medical Education Training program, any leave of absence from your program may require a training extension, based on the duration of the leave, other absences and review of the applicable Specialty Certifying Board leave policy or applicable training program leave policy. Your program will review this with you. Please contact your Program Director and Coordinator with further questions regarding any possible extension.

By typing your name in the box below, you acknowledge that you understand that any leave beyond the four (4) weeks of vacation per year MAY impact your program completion date.

What are your requested/anticipated Leave dates (MM-DD-YYYY) from start to end?

Start Date

End Date

HR requires a Medical Certification for any FML qualified, Medical Leave or Pregnancy related leave. We know your dates may change.

Have you requested your Medical Certification from your medical provider?

Please email (hrsingleteary@ucdavis.edu) or fax (916.734.8829) the Medical Certification within 15 days of this request.

Yes

No

Does not apply to this request

Type of Leave Request

Parental Leave

Medical Leave - Self

Personal Leave

Medical Leave - Family Care

Other

Description (Optional)

Please use this space to provide any known details (such as dates) or prompt any questions.





We thank you for your time spent taking this survey.
Your response has been recorded.

5. Request is routed to the GME Office and AP Analyst for processing.