

SAMUEL MERRITT COLLEGE
LEAVE OF ABSENCE Form

ATTENTION

AFTER READING THE SAMUAL MERRITT COLLEGE
LEAVE OF ABSENCE POLICIES,
PLEASE USE THE ATTACHED FORM TO APPLY FOR
THE APPROPRIATE LEAVE OF ABSENCE.
SUBMIT ALL FORMS TO HUMAN RESOURCES.

THANK YOU.

Leave of Absence CHECK LIST

Medical/Maternity Leaves:

- Department Managers signature on the back of completed LOA application.
- Physician's Statement completed.
- Submitted completed LOA application, Physician's Statement and Benefit Election form to Human Resources for approval.
- Completed and forwarded SDI and/or PFL claim form to EDD.

Personal Leaves

- Department Manager's signature on the back of completed LOA application.
- Submitted completed LOA application form to Human Resources for approval.

LEAVE OF ABSENCE POLICY AND PROCESS REMINDERS

California Short Term Disability Insurance and Paid Family Leave Payment Process

It is the responsibility of the faculty/staff member taking the leave of absence to file for State Disability Insurance (SDI) and Paid Family Leave (PFL). All faculty/staff members should contact the State (www.edd.ca.gov) directly to learn more about how the SDI and PFL benefits apply to their specific situation. However, there are some general guidelines including

- Weekly SDI benefits are available after the first seven days of disability
- SDI pays you approximately 55% of your salary, up to the weekly limit, for 6 weeks
- PDL pays you approximately 55% of your salary, up to the weekly limit, for 6 weeks
- You may not receive any other payments or benefits (e.g. unemployment or both SDI and PFL) at the time you receive this state benefit.
- You may use accrued, unused sick or vacation time to complement the state payments (e.g. 40%) but are not eligible to receive more than 100% of pay at any time

Again, please contact the State directly for forms and more information on how SDI and PFL apply to your specific Leave of Absence or disability.

Health Insurance While on a Leave of Absence

If your leave qualifies under FMLA, CFRA or PDL, the College will continue to cover your medical, dental and vision benefits as they were structured before you left for the Leave. Upon your return, you are expected to remit payment to the College for any employee-paid health care coverage contributions that you were contributing when you left for the Leave.

In the event that you voluntarily terminate your employment with the College while you are on leave, you will be required to remit the monthly costs of the insurance to Samuel Merritt College. If your leave of absence does not qualify under any of the College's Leave of Absence Policies, you will be required to pay the monthly premium in order to continue your medical, dental and vision coverage.

Newborns must be enrolled within 31 days of birth WITHOUT FAIL. Failure to complete an enrollment form past the legal plan guidelines will result in loss of access to company-sponsored coverage and denied claims. For example, if your child is born on June 1, 2001, and you do not enroll him/her in your healthcare by July 1, 2001, you will not be able to enroll your child until the next open enrollment of the following year (2002). Open enrollment is customarily scheduled during the months of October or November with an effective date of coverage of January 1st.

A “***Serious Health Condition***: means an illness, injury, impairment, physical or mental condition that involves one of the following:

1. Hospital Care

Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

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

- (1) 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
- (2) 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.

3. Pregnancy (NOTE: An employee’s own incapacity due to pregnancy is covered as a serious health condition under FMLA but not under CFRA.) Any period of incapacity due to pregnancy, or for prenatal care.

4. Chronic Conditions Requiring Treatment: A chronic condition which:

- (1) 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:
- (2) Continues over an extended period of time (including recurring episodes of a single underlying condition); and
- (3) 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, which is permanent or long-term, due to a condition for which treatment may not be effective. The employee or family member 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 there from) 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 or more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.) severe arthritis (physical therapy), kidney disease (dialysis).

Other Reminders:

- B. All Faculty/staff working a predetermined schedule of 8 hours or more per week are eligible for LOA.

- B. All requests for medical, maternity, or personal leaves must be made on the Application for Leave of Absence form and returned to the Human Resources Department located at 435 Hawthorne Ave, Oakland, Ca 94609 (510) 869-6731. For medical and maternity leaves, an appropriate Physician's Statement must be submitted before going on a LOA.

- C. All applications for LOA's require authorization and signature of the Department Managers and the Human Resources Department. In most instances this is required *before* you begin your LOA.

- D. Faculty/staff must contact Human Resources prior to returning to work to confirm their return dates and scheduled work hours. In most instances this is required at least 14 days before you return.

- E. A full and unlimited Physician's release must be submitted to Human Resources BEFORE a Faculty/staff return from medical and maternity LOA's. Faculty/staff ARE NOT allowed back to work without a release.

- F. While in a LOA status for 14 consecutive days, Faculty/staff are eligible for a limited amount, one-time only, lump-sum vacation pay out. Lump-sum pay outs cannot exceed the maximum time an employee will be off from work. FOR EXAMPLE: If an employee is requesting 180 hours for a vacation pay out and he/she is only scheduled to be out for another 2 weeks, he/she can only receive 80 hours (if employee is full time).

- G. FURTHER, while you're in a paid status, your pension contributions will continue. When you go into an unpaid/LOA status, these contributions will terminate until you return to work. Since pension contributions are made on all earnings, if you receive a one-time vacation pay out, contributions will be made on that pay out.

LOA PACKETS CAN BE PICKED UP FROM THE HUMAN RESOURCES LOCATED AT THE ADDRESS LISTED ABOVE.

**SAMUEL MERRITT COLLEGE
APPLICATION FOR LEAVE OF ABSENCE**

Faculty/Staff NAME: _____

I hereby request a leave of Absence for the following time period:

FROM: _____ TO: _____

I expect to return to work on _____

(If this is a maternity leave, please indicate expected delivery date: _____)

This leave is requested for the following specific reason(s):

Address and Phone Number during Leave of Absences:

I UNDERSTAND that when this Leave of Absence becomes unpaid, I will have no employment benefits such as wages, or benefit accruals such as sick leave, holiday pay, etc. An adjustment to the amount of time employed may affect the time of my eligibility for vacation, sick leave, retirement, and tenure.

I UNDERSTAND that the College cannot ensure the availability of a position if, during the period of Leave of Absence, (a) the position is eliminated, or (b) the position is affected by a lay-off. I UNDERSTAND that I will be placed in a job as close as possible to the same area, shift, and content as occupied prior to the Leave of Absence, but that re-employment in the same precise job cannot be guaranteed. I UNDERSTAND that, the College will continue to pay for my Medical, Dental and Vision coverage while I am on a leave that qualifies under FMLA and if I voluntarily terminate my employment with the College during my leave of absence, I will be required to remit payment for the cost of this benefit to the College.

I FURTHER UNDERSTAND, if I am not available for work on the date indicated above, I may jeopardize my employment status. REQUEST FOR EXTENSION of Leave of Absence must be made in advance of the termination of the leave. Circumstances may prevent approval of extension of the leave in some instances. FAILURE TO REQUEST an extension before the end of the authorized leave may jeopardize employment status. RETURNING TO WORK PRIOR TO THE EXPIRATION of the authorized Leave of Absence requires approval of the Department Head and Human Resources Department.

EMPLOYEE'S SIGNATURE: _____ DATE: _____

RECOMMENDATION OF THE DEPARTMENT HEAD: _____

DEPT. HEAD'S SIGNATURE: _____ DATE: _____

CERTIFICATIUN OF HEALTH CARE PROVIDER

**Applies to Family Medical Leave Act (FMLA), Pregnancy Disability Leave (PDL)
and the California Family Rights Act of 1993 (CFRA)**

1. Employee's Name: _____

2. Patient's Name (If other than employee): _____

3. Date medical condition or need for treatment commenced _____
(NOTE: THE HEALTH CARE PROVIDER IS NOT TO DISCLOSE THE
UNDERLYING DIAGNOSIS WITHOUT THE CONSENT OF THE PATIENT)

4. Probable duration of medical condition or need for treatment _____

5. The attached sheet describes what is meant by a "serious health condition" under both the Federal Family and Medical Leave Act (FMLA) and the California Family Rights Act (CFRA). Does the patient's condition qualify under any of the categories described? If so, please check the appropriate category.

(1)_____ (2)_____ (3)_____ (4)_____ (5)_____ (6)_____

6. If the certification is for the serious health condition of the employee, please answer the following:

Yes No

Is employee able to perform work of any kind?
(If "No", skip next question.)

Is employee unable to perform any one or more of the essential functions?
of employee's position? (Answer after reviewing statement from
employer of essential functions of employee's position, or, if none
provided, aster discussing with employee.)

7. If the certification is for the care of the employee's family member, please answer the following:

Yes No

Does (or will) the patient require assistance for basic medical, hygiene,
nutritional needs, safety or transportation?

After review of the employee's signed statement (See Item 10 below),
does the condition warrant the participation of the employee? (This
participation may include psychological comfort and/or arranging for
third-party care for the family member.)

8. Estimate the period of time care needed for during which the employee's presence
would be beneficial: _____

9. Please answer the following question only if the employee is asking for intermittent leave or a reduced work schedule.

Yes No

- Is it medically necessary for the employee to be off work on an intermittent basis or to work less than employee's normal work schedule in order to deal with the serious health condition of the employee or family member?

If the answer to 9 is Yes, please indicated the estimated number of doctor's visits, and/or estimated duration of medical treatment, either by the health care practitioner or another provider of health services. Upon referral from the health care provider.

ITEM 10 IS TO BE COMPLETED BY THE EMPLOYEE NEEDING FAMILY LEAVE.

*****TO BE PROVIDED TO THE HEALTH CARE PROVIDER UNDER SEPARATE COVER.**

10. When family care leave is needed to care for a seriously-ill family member, the employee shall state the care he/she will provide and an estimate of the time period during which this care will be provided, including a schedule if leave is to be taken intermittently or on a reduced work schedule:

11. Signature of health care provider: _____

Date: _____
Please Print Name

Address City Sate Zip

12. Signature of Employee: _____

Date: _____
Please Print Name

Address City Sate Zip