

What You Need To Know About...	MEDICAL OR PERSONAL LEAVE OF ABSENCE WITHOUT PAY
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PURPOSE

Leaves of absence without pay may be granted for medical reasons, personal need, or in compliance with the West Virginia Parental Leave Act and the Federal Family Medical Leave Act.

ELIGIBILITY

In order to meet eligibility requirements, an employee must be a full-time regular employee.

PROCEDURE

Employees must send a written request to the President to seek approval for a leave of absence without pay, whether it is for medical reasons or for personal reasons. Employees must also submit a Medical Leave Verification form completed by an appropriately licensed treating health care provider if the leave without pay request is for medical reasons. The physician's signature is required on the form (as opposed to the signature of a member of the physician's staff).

PROCESS

The President, at his or her discretion, may require the written approval of the supervisor and/or head of the department before accepting the written request of an employee for a leave of absence without pay. The President shall determine if the purpose for which such leave is requested is proper and within sound administrative policy.

DURATION

Approved leave of absence without pay may not exceed a period of one year.

APPLICATION OF PAID LEAVE

All sick and annual leave must be exhausted before a medical or personal leave of absence will be approved.

All annual leave must be exhausted before the West Virginia Parental Leave Act can be applied.

Concurrent with the Family Medical Leave Act (FMLA) all sick leave must be exhausted before the employee goes off the payroll.

INSURANCE

Employees on approved *personal* leave of absence without pay may continue their group health insurance provided they pay the full premium costs (both the employee and employer's share) of such health insurance. Employees on approved *medical* leave of absence without pay may continue their group health insurance provided they pay the employee's share of such health insurance. (Source: Shepherd University Board of Governor's Policy 10)

Arrangements must be made through the Payroll Office for these insurance premium payments.

HOURLY PAYROLL

Employees who are on a leave of absence without pay may be transferred to the hourly payroll when they deplete their leave, at least until they have accrued five days of leave upon their return. Employees may not routinely take leave without pay when they have annual and sick leave accrued.

RETURN TO WORK

Before employees return to work, they must present to the Human Resources Office or to their supervisor a Medical Release to Return to Work form signed by the treating physician to the Human Resources Office. If the form is presented to the supervisor, then the supervisor must forward the release to the Human Resources Office.

At the expiration of a leave of absence without pay the employee shall be reinstated without the loss of any rights to the employee's position or a comparable position. Failure of the employee to report promptly at the expiration of an approved leave of absence without pay, except for satisfactory reasons submitted and approved in advance, shall be cause for termination of employment by the institution.

Shepherd University Medical Leave Verification

Employee's Name: _____

Home Address: _____

Home Phone Number: _____

Physician's Statement (if leave is being requested for Employee):

Medical Condition of Employee: _____

Diagnosis: _____

Prognosis: _____

Duration and Treatment Plan: _____

Employee needs to be off work from _____ through and including _____

Physician's Statement (if leave is being requested for a family member):

Medical Condition of Patient (Family Member): _____

Diagnosis: _____

Prognosis: _____

Duration and Treatment Plan: _____

Relationship of Patient to Employee: _____

Employee needs to be off work consecutively from _____ through and including _____
AND/OR

Employee needs to be off work intermittently from _____ through and including _____

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.

Physician's Signature (Must be signed by physician, not staff)

Date

Name of Physician (please print)

Physician's Phone Number

I hereby grant permission for my medical records to be released to the Human Resources Office, Shepherd University, PO Box 5000, Shepherdstown, WV, 25443. (Phone 304-876-5299; Fax 304-876-5197)

Employee's Signature

Date

Shepherd University Medical Release to Return to Work

Patient's Name: _____ is released to return to work on _____ with the following restrictions:

_____ No restrictions required

_____ Restricted hours per day: This specified limit _____

_____ Restricted days per week: This specified limit _____

_____ Restricted weight lifting: No greater than: 50 lbs. 20 lbs. 10 lbs. 5 lbs. Other _____

Restrictions during a work shift

Bending/Stooping 0 hours 1-3 hours 4-5 hours 6-8+ hours No restriction

Pulling/Pushing 0 hours 1-3 hours 4-5 hours 6-8+ hours No restriction

Overhead Reaching 0 hours 1-3 hours 4-5 hours 6-8+ hours No restriction

Sitting 0 hours 1-3 hours 4-5 hours 6-8+ hours No restriction

Standing 0 hours 1-3 hours 4-5 hours 6-8+ hours No restriction

If other limitations please specify: _____

These restrictions are to be in effect starting _____ through and including _____

These limitations are: **Permanent** **Temporary**

May resume regular duties on _____ **OR** will be re-evaluated on _____

Physician's Signature (Must be signed by physician, not staff)

Date

Name of Physician (please print)

Physician's Phone Number

I hereby grant permission for my medical records to be released to the Human Resources Office, Shepherd University, PO Box 5000, Shepherdstown, WV, 25443. (Phone 304-876-5299; Fax 304-876-5197)

Employee's Signature

Date

It is the employee's responsibility to submit this form to the Department of Human Resources prior to returning to work. Shepherd University will take the suggestions that medical providers make into consideration, but it is the employer's decision as to whether requested accommodations can be met in a reasonable fashion. Employees will be notified by their supervisors if their duties can be modified to meet the restrictions described, or if such modifications cannot be made and they will need to remain off work on medical leave.