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FMLA Leave Recording of Time Off

RVC Administrative Procedure (3:30.090)

All Family Medical Leave Act (FMLA) time shall be submitted to Human Resources, attention Benefits & Wellness Coordinator. The process is as follows:

1. Once determined that your leave has been approved as qualifying FMLA, correspondence related to your scheduled time off will be forwarded to you from the Benefits & Wellness Coordinator in Human Resources.

Your supervisors(s), along with applicable Human Resources and Payroll personnel will be notified of the approved dates and, if applicable, hours of your approved time off from work.

- It is your responsibility to submit weekly by 12:00 PM every Friday, a Leave Request Card (Example 1) noting any time off for FMLA to the attention of the Benefits & Wellness Coordinator, either through interoffice mail and/or email. If the Leave Request Card is being sent via email, an original will need to follow via interoffice mail.
- 3. Even if you are on intermittent FMLA and have not taken any FMLA time off, an email needs to be sent from you to the Benefits & Wellness Coordinator informing that no FMLA time off has been taken.
- 4. If you are an hourly employee and complete a timecard, you will still need to submit a Leave Request Card and also track the FMLA time taken on your timecard (Example 2). This process of completing a weekly Leave Request Card must be completed for the duration of dates of your FMLA approved time off even if you are an exempt employee.
- 5. Once the information is received in Human Resources, the Benefits & Wellness Coordinator will record your time in Colleague/Ellucian.
- 6. Reminder, that if you are taking FMLA time for your own condition, you will not be able to return to work unless you have provided Human Resources with a completed Return to Work Form (Form #4) (Example 3).

Reference: N/A Implemented: February 3, 2020

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Example 1: Leave Request Card

When filling out your Leave Request Card:

- 1. Determine if you would like Payroll to take the time/pay from sick, vacation, personal, or compensatory pay.
- 2. Please put FMLA in the appropriate box and the dates to take the time.
- 3. Please explain how many hours per day.
- 4. This needs to be done every week and turned in to Human Resources Benefits and Wellness Coordinator every week after your supervisor signs off on your time.

Screenshot of an example Leave Request Card:

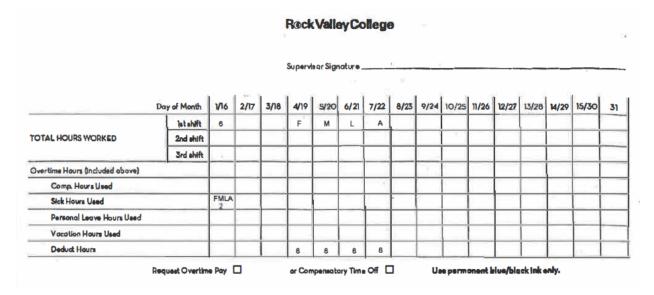
Name					
SIGNATURES		82	REASON	DATES	KOURS
Applicant	•		SICK	FMLA/10-14-19 - 10-17-19	8
Supervisor					
Part-time faculty only			VACATION	(2 hours per day)	
CH (Contact hours) misse	ed @ \$20 per nour	Amount	PERSONAL		
Budget Number (sub pay))	- 51330			_
Budget Number (reductio	n in pay) —	19 <u>*0</u>	TIME WO PAY		
UBSTITUTES (when app	plicable)				-
Name	ID#	Contact Hr	COMPENSATORY		
lame	ID#	Contact Hr	COLLEGE BUSINESS		
lame	ID#	Contact Hr	JURY DUTY/ OTHER		

LEAVE REQUEST CARD RVC Policy governs all leaves

applicant has not earned sufficient leave time (vacation, sick, personal, or compensatory), pay will be deducted

Example 2: Timecard

Screenshot of an example Timecard:



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Example 3: Return to Work Form (Form #4)

Screenshot of example Return to Work Form:

R @ckValleyCo						FORM #
Please return/fax this form number is 815-921-4769. Pl						ork. The fax
Employee Name:			SSN:			
Dear DOCTOR: This form m medical restrictions are indic limitations and the length of	ated, we ask th	at you prov	ide us with a d			
Associate/Employee's Work	Status: (Please	e Check One	:)			
Released to full time	duty WITHO	UT restrictio	ons on			
Released to RESTRI	CTED duty fr	om		through		
If hours are reduced, MAY W	VORK	HOURS/DAY &			DAYS/WEEK	
RESTRICTED DUTY as fol	lows: May lift	1.1	lbs. May	y push/pull	1	os.
COMMENTS:	-					
Associate/Employee MAY:	(67-100%) Continuous	(34-66%) Frequent	(4-33%) Occasional	(1-3%) Seldom	(0%) Never	
Simple Grasping Gripping with Force					(
Fine Manipulation						
Pushing						
Pulling Bending						-
Kneeling		1		(-
Twisting/Turning	1					
Climbing	-					
Carrying						1
Sitting						
Walking						
Standing						
Working above shoulder level						
Overtime allowance (Circle One): FOLLOW-UP CARE	Yes No					
Expected length of treatment		Days	Week	18	Months	
(indicate number of days, weeks o						
Next Appointment/Referral	Date:					
HAS ASSOCIATE/EMPLOYEE	RE ACHED MAX	XIMUM MED	ICAL IMPROV	EMENT? Y	es No	
Physician Signature:				Date:		
Physician Name:		Specialty:				
Address:						
Office Number:				Number:		

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