FMLA Request – Form #1

SECTION 1: FMLA Request – to be completed by the employee OR the department (if employee is unavailable):

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.

Employee Name: _____ Employee ID#: _____

Employee Telephone Number: _____ Employee Type: _____

Anticipated FMLA Dates: *Start* _____ *End* _____ *(required, estimate if not sure)*

☐ ***I am requesting FMLA on an intermittent basis***

This Family and Medical Leave of Absence is for the following **qualifying reason**:

- ☐ Due to the birth of a child and/or to care for a newborn child of the employee or spouse OR placement of a child through adoption or foster care
- ☐ Due to the employee's serious health condition
- ☐ Due to a covered servicemember with a serious injury or illness who is the ☐ spouse, ☐ child, or ☐ parent, or ☐ next of kin of an employee
- ☐ Due to care of the employee's ☐ spouse, ☐ child, or ☐ parent who has a serious health condition
- ☐ Due to a qualifying exigency arising out of the fact that your ☐ spouse, ☐ child, or ☐ parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserve

A medical or qualifying reason certification will be required for all FMLA leave requests.

_____ _____

Signature of Employee or Designee *Date*

SECTION 2: Notice of Eligibility and Rights & Responsibilites - To be completed by the DEPARTMENT (within 5 days of the request).

Date notified of a need for FMLA _____ **Employee is ☐ eligible / ☐ not eligible for FMLA.**

- An employee is not eligible because: ☐ worked less than 12 months (within last 7 years) / ☐ worked less than 1,250 hours
- If an employee met the eligibility requirements, a medical certification is requested to determine whether his/her absence qualifies as FMLA leave. Certification form #2 ☐ given to the employee / ☐ available online at www.bcn-nshe.org/hr/benefits/leave/ . **Certification due by** _____ (allow at least 15 calendar days) by fax # (775) 784-4221 or submitted to BCN Benefits office, Artemesia Building (MS 0240), Reno, NV 89557.
- Employee will be required to use all available paid leave (e.g., sick leave, compensatory time, annual leave) before using unpaid leave.
- Employee has the following leave accruals available: _____ sick leave; _____ compensatory time; _____annual leave as of _____ (date). Employee has used a total of _____ hours of FMLA in the past 12 months.
- Employee will be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment.

Leave Keeper (name):_____ Signature: _____

Supervisor/Appointing Authority (name): _____ Signature (Optional): _____

Once BCN Benefits staff obtains the information from you as specified above, we will inform you, within 5 business days, whether your leave will be designated as FMLA leave and count towards your FMLA leave entitlement. If you have any questions, please do not hesitate to contact Benefits office by phone (775) 784-6112.

***Distribution:** 1) Department retains original 2) Scanned copy to BCNBenefits@unr.edu. 3) Employee receives copy*