Southern Utah University Parental Leave

POLICY NUMBER: 9.12 https://my.suu.edu/help/article/3504/912-parental-leave/

Any Benefit-Eligible Employee who is on an Active Appointment at the time of the leave and who has been employed at the University for at least six (6) months immediately preceding the Qualifying Event is eligible to receive paid Parental Leave.

Professional and Classified Staff:

Each eligible employee may receive up to six (6) weeks (30 work days) of paid leave for each Qualifying Event, subject to the provisions in this Policy. Pay during the leave shall be at 100% of the eligible employee's regular rate of pay. Six weeks for primary care provider, two weeks for secondary care provider. https://my.suu.edu/hr/parental-leave

Faculty:

A faculty member may elect modified duties as permitted and described in Policy 6.15 or the paid leave provided under this Policy. The faculty member is eligible only for one benefit, either this paid Parental leave or the modified duties, per Qualifying Event. Once the faculty member has utilized one of the benefits, even in part, they are no longer eligible for the other benefit.

https://www.suu.edu/hr/benefits/pdf/faculty-parental-leave-form.pdf

Part time and reduced appointment:

Part time and reduced appointment positions will receive pro-rated leave based on their appointment ratio/time to the extent they qualify during the timeframe in which they have an Active Appointment. https://my.suu.edu/hr/parental-leave

All employees will need fill out the attached leave request forms and the following 4 pages and return them to HR through this secure link. https://my.suu.edu/secure/upload/gabriellecox/

SUU SOUTHERN UTAH UNIVERSITY

FAMILY AND MEDICAL LEAVE AUTHORIZATION FORM – Extended Absence

Employees who have worked for at least 1,250 hours during the 12-month period immediately prior to this request for FMLA leave are eligible for FMLA leave.

Name _____ T-Number _____

Department _____ Hire Date _____

TYPE OF LEAVE REQUESTED

Check one box:

- ☐ Employee Family and Medical Leave
- ☐ Extension of previously taken Employee Family and Medical Leave
  Previous days taken were _____
- ☐ Leave to care for newborn or adopted child or child place (via state procedure) for foster care

The Leave will begin on _____ and end on _____

Reason for Leave (list any medical conditions, etc, relating to the absence):

_____
_____
_____
_____
_____

REASON FOR LEAVE

I request family and medical leave for the following reason (check one box):

- ☐ My personal serious health condition
- ☐ Serious health condition of my child
- ☐ Serious health condition of my parent
- ☐ Serious health condition of my spouse
- ☐ Birth of my child
- ☐ Adoption of a child by me or placement of a child with me for foster care
- ☐ Servicemember leave for a "qualifying exigency"
- ☐ Servicemember leave to care for a family member injured in the line of military duty

I understand that this time off will be recorded as FMLA time off and count towards said time off for the current year.

_____
Employee Signature

_____
Date

INSURANCE PREMIUM RECOVERY AUTHORIZATION FORM

I certify by my signature that I have read and understand the following:

I acknowledge the University's legal right to recover the cost of any premium paid by it to maintain my coverage in group health benefits during any period of unpaid leave under the following conditions:

- I fail to return from leave at the expiration of the leave to which I am entitled; and
- The reason I fail to return to work is not one of the following:
  - The continuation, recurrence, or onset of a serious health condition that entitles me to leave to care for a child, parent or spouse with a serious health condition, or if I am unable to perform the functions of my position due to my own serious health condition; or
  - Other conditions beyond my control prevent me from returning.

Printed Name _____ T-Number _____

Signature _____ Date _____

INSURANCE PREMIUM REIMBURSEMENT AGREEMENT

I certify by my signature that I have read and agree to the do the following:

If I fail to return from leave, for any reason other than #1 and #2 above, I agree to coordinate with the University to develop a mutually acceptable schedule to reimburse the University for the cost of any premium paid by it to maintain my coverage in group health benefits during any period of unpaid leave taken by me.

Printed Name _____ T-Number _____

Signature _____ Date _____

LEAVE CERTIFICATION REQUIREMENTS

Section I: To request leave for the care of a child, parent, or spouse with a serious health condition

I have attached a certification from the health care provider who is treating my child, parent, or spouse. The certification includes the following:

1. The date on which the condition commenced;
2. The probable duration of the condition;
3. The appropriate medical facts within the knowledge of the health care provider regarding the condition;
4. An estimate of the time needed to care for the individual involved (including any recurring medical treatment;
5. A statement that the condition warrants my participation to provide care.

Section II: To request leave for the care of any employee's personal serious health condition.

I have attached certification from the health care provider who is treating my own serious health condition. The certification includes the following:

1. The date on which my condition commenced;
2. The probable duration of the condition;
3. The appropriate medical facts within the knowledge of the health care provider regarding the condition;
4. A statement that I am unable to perform the functions of my position due to my condition.

Section III: Additional certification requirements for intermittent leave or for leave on a reduced leave schedule

In addition to the foregoing certifications from the health care provider involved, I have attached additional information from the health care provider as stipulated below:

- Leave for the employee
    - A statement of medical necessity for my intermittent leave or reduced leave schedule and the expected duration of the schedule;
    - A listing of the dates of my planned medical treatment and the duration of the treatment(s).
- Leave to care for a son, daughter, spouse or parent
    - A statement attesting to the necessity of intermittent leave or reduced leave for me to provide care or to assist in their recovery;
    - An estimate of the expected duration and schedule of my intermittent or reduced leave.

I certify by my signature that I have read and understand the University's certification policy.

Printed Name _____ T-Number _____

Signature _____ Date _____

LEAVE REQUEST WHEN EMPLOYEE & SPOUSE BOTH WORK FOR SUU

Check the leave being requested:

☐ Family & Medical Leave to care for a newly arrived child

☐ Family & Medical Leave to care for a parent with a serious health condition

I have a spouse employed at the University:

Spouse's Name _____ T-Number _____

Department _____ Hire Date _____

I certify by my signature that I have read the following and agree to abide by it –

In any case in which an employee and their spouse are:

- Both employed by Southern Utah University;
- Both entitled to leave;
- If the leave is taken for the birth or adoption of a child or to care for the serious health condition of a parent;

then the aggregate number of workweeks of leave to which both may be entitled is limited to twelve (12) workweeks during any 12-month period.

If there is a change in circumstances with respect to the above, I will notify the University immediately.

Printed Name _____ T-Number _____

Signature _____ Date _____