What's Covered Under FMLA?

The synopsis of the Family Medical Leave Act below pertains to companies with 50 or more employees.

California State Law allow employees to take partially paid family leave. This paid family leave program will allow workers to take up to six weeks off to care for a newborn, a newly adopted child, or ill family member.

Under this law, employees are eligible to receive 55 percent of their wages during their absence, up to a maximum of $728 per week. All employers are covered by FMLA.

You are eligible for FMLA if you:

- Work for an employer with 50 or more employees
- Have worked for that employer for at least 12 months
- Have accrued at least 1,250 hours prior to starting your FMLA leave

You may take 12 work weeks of protected leave in a 12-month period to:

- Treat or recover from a serious health condition that makes you unable to perform your job
- To care for a child, spouse or parent suffering from a serious health condition
- Care for and bond with a newborn or new adopted or foster child.

Covered health conditions include:

- Injuries or illness that involve medical treatment and incapacitate you or a family member for three or more days or involve a hospital stay of at least one night.
- Incapacity resulting from chronic ailments — like migraines, asthma, pregnancy, diabetes, orthopedic conditions — even episodes as short as one day or part of a day.

You may take time off intermittently or by reducing scheduled days/hours.

Here's an example: If you have been diagnosed with a chronic illness like migraines, be sure to use FMLA leave for any episode. That way your employer can't use your FMLA-protected absences as "occurrences" against your employment. Be sure to tell your supervisor when you call in sick that your absence is an FMLA call-off and follow up in writing.

Your employer may not deny you time off because of production needs or because you hold an important position. Your employer may request a certification prepared by your health care provider verifying that your leave is for a purpose recognized by FMLA.

Your employer must maintain your health insurance.

Your employer does not have to maintain your salary but, under most Union contracts, you must use PTO or other sick leave benefits even if you didn't meet the requirements of the timeline for requesting same.

You may not be warned, suspended or discharged for taking FMLA time off.

If you know in advance you need to take FMLA time off, you do need to inform your employer as soon as practical.

When your leave is completed, your employer must restore you to your regular job or to an equivalent position with the same pay, benefits, duties, status, terms and conditions of employment.

SEIU Local 121RN can grieve violations of your FMLA rights through our union contract and complaints can also be submitted to the Department of Labor.

Los Angeles Department of Labor office: (213) 894-6375

For assistance with FMLA issues or to make a complaint to the Department of Labor, please contact your SEIU Local 121RN steward or Union Representative. If you do not know who your Union Representative is, go to www.seiu121rn.org and click on the "Find Your Union Rep" button in the left-hand margin. Or you may call our main office at (818) 284-4555.

Don't forget to fill out a pre-designation of personal physician form in case you are hurt on the job!

Employee Personal Physician Designation Form

TO: _____
(Name of Hospital / Company)

FROM: _____
(Print Your Name) (Sign Your Name)

In the event that I am injured or become ill on the job, I reserve the right to be treated by my own physician and/or chiropractor from the time of my injury or illness.

SEIU 121RN Nurse Alliance

My Physician's Name is:

_____

_____
Street Address

_____
City, State, Zip

Give Upper Half to Your Employer

_____
(Area Code) Telephone number

Employee Personal Physician Designation Form

TO: _____
(Name of Hospital / Company)

FROM: _____
(Print Your Name) (Sign Your Name)

In the event that I am injured or become ill on the job, I reserve the right to be treated by my own physician and/or chiropractor from the time of my injury or illness.

My Physician's Name is:

_____

_____
Street Address

_____
City, State, Zip

Keep Lower Half for Your Records

_____
(Area Code) Telephone number

Received by the Hospital by (Signature)_____