OHR 325 (Revised 07-09) **COMMITTEE**

Be sure to fill out each section accurately and completely.

STATE OF KANSAS
SHARED LEAVE PROGRAM
Wichita State University
Shared Leave Request Form

Reset Form

When completing form please write legibly and be clear and thorough with explanations. A Certification of Health Care Provider form must also be completed for each new request or request to extend shared leave.

PART I – To be completed by employee or employee's representative

Name: John Shocker Employee *myWSU id #*: N333V222

Home Address: 1234 Fairmount St.

Wichita (City) KS (State) 67202 (Zip)

Home Telephone: (316) 978-1234 Work Telephone (316) 978-3333

Department Name: Physical Plant

Supervisor's Name: Jennifer Wheat Extension 3333

Date of Employment: 6/1/00

Request is for: Self X Family Member n/a

Name of Family Member and explanation of relationship (please include age if child):
n/a

Date illness/injury began: 5/1/12 Anticipated duration: 4 weeks or 6/6/12 (hospitalization)

Estimate of number of hours requested: 360 Date all paid leave will be/was exhausted: est. 5/14/12

Last day of work: 5/4/12

In the description below, provide information that describes how your daily life functioning is, or will be, affected.

Shared leave will only be granted for serious, extreme, or life-threatening illnesses, injuries, impairments or physical or mental conditions which have caused, or are likely to cause, the employee to take leave without pay or terminate employment. Shared leave will not be granted for common or minor illnesses, injuries, impairments or physical or mental conditions. To be eligible for consideration, an employee must not have a history of leave abuse within the last year.

Describe and provide any necessary information that would help in concluding that the illness, injury, impairment or physical condition is serious, extreme or life-threatening:

The cancer makes me feel extremely weak and nauseous. Normal daily activities are affected such as sleeping, eating, walking etc. I am receiving experimental treatment which can only be performed at a clinic 100 miles away. The increased travel time to and from the clinic will be very costly and require additional time commitment. In addition, my wife has medical issues and I am the primary caregiver. Therefore, going without pay will cause extreme financial hardship.

Are you currently receiving Worker's Compensation? No

Are you currently receiving Long-Term Disability Payments? No

Have you applied for Worker's Compensation? No Date Applied: n/a

Have you applied for Long-Term Disability Payments? No Date Applied: n/a

(An employee receiving Workers' Compensation or Long-Term Disability is ineligible for Shared Leave.)

I certify that I understand, agree to and meet the requirement and conditions of the shared leave program as authorized in K.A.R. 1-9-23. I authorize the appointing authority to obtain any necessary information regarding my request for shared leave and to share that information with the Shared Leave Committee. I understand that denial of this application is not subject to appeal to the Civil Service Board. **I declare under penalty of perjury that the foregoing is true and correct.** Executed on date below.

Employee's Signature: John Shocker Date: 5/7/12

FORWARD COMPLETED FORM TO Lana Anthis, Wichita State University, Office of Human Resources, Campus Box #15, Wichita KS 67260-0015 or Fax to: (316) 978-3201.

You (WSU employee) must sign this form and indicate 1) if you will allow your pertinent medical information to be shared, and 2) if this is a work related injury/illness. This is required information.

WICHITA STATE UNIVERSITY
HUMAN RESOURCES

Shared Leave Program

Reset Form

CONFIDENTIALITY WAIVER FORM

Shared leave will only be granted for serious, extreme, or life-threatening illnesses, injuries, impairments or physical or mental conditions which have caused, or are likely to cause, the employee to take leave without pay or terminate employment. If you are receiving workers compensation, long-term disability payments, or both, you are not eligible to receive shared leave per Kansas Administrative Regulation (KAR) 1-9-23(C). Shared leave will not be granted for common or minor illnesses, injuries, impairments or physical or mental conditions.

I certify that I understand, agree to, and meet the requirements and conditions of the Shared Leave program as authorized in K.A.R. 1-9-23. I hereby authorize Wichita State University to obtain any necessary information regarding my request for shared leave.

The Office of Human Resources has my permission to give out my name in order to solicit donation of leave hours from eligible employees.

☑ **Yes** ☐ **No**

Is this a work related injury/illness? ☐ **Yes** ☑ **No**

John Shocker

Please Print Name

Signature

5/7/12

Date

Please return signed form to Lana Anthis at Campus Box #15.

Revised: 12/22/08

This form must be completed by your medical physician. Make sure they provide complete and accurate information.

CERTIFICATION OF HEALTH CARE PROVIDER

(Family and Medical Leave Act of 1993; Rev. 01/09)

Wichita State University *Office of Human Resources* Wichita, Kansas 67260-0015
Phone- (316) 978-3065* Fax- (316) 978-3201

(Rev. 1/2011)

1. Employee's Full Name: John Shocker *myWSU* ID # N333V222
2. Employee's Job Title: Electrician Regular Work Schedule: M-F; 7:45 - 4:30 pm
3. Employee's Essential Job Functions: Maintain electrical wiring and connections.

(Position Description is Attached: ☑ Yes ☐ No)

4. Patient's Name (if different from employee): n/a

Relationship to Employee: n/a

If family member is your son or daughter, Date of Birth: n/a

Completion by the HEALTH CARE PROVIDER Required

Have your doctor be as specific as possible in describing how the symptoms will affect your ability to function at work.

INSTRUCTIONS to the HEALTH CARE PROVIDER: *The emplo FMLA either for him/herself or to care for a family member. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the employee/patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave.* ***Please be sure to sign the form on page 3 and complete page 4 if required.***

5. **Diagnosis:** Multiple myeloma

Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment for instance the use of specialized equipment): Patient will require extraction surgery as well as high dose chemotherapy treatments and subsequent follow-up visits. Dosage may cause severe nausea and weakness during treatment periods.

6. Was this employee/patient seen by the Physician or Health Care Provider? ☑ Yes ☐ No
7. Was the employee/patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ☑ Yes ☐ No If so, dates of admission: from 5/4/12 to present
8. Will the employee need to have treatment visits at least twice per year due to the condition? ☑ Yes ☐ No
9. Approximate Date Condition Commenced: 5/1/12 Probable Duration of Condition: indefinitely
10. Was the employee referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? ☑ Yes ☐ No If yes, state the nature of such treatments and expected duration of treatment:

*State the Probable Duration and Nature of **TREATMENT(s)** Patient will need to have cancerous tissue removed by the surgical oncologist on May 10, 2012. The procedure is necessary to the patient's survival and recovery. Periodic check ups and chemotherapy treatments will occur through November 6, 2012. Biopsy will need to be conducted six months after onset of chemotherapy.

Be sure the doctor indicates whether this is "necessary" or "elective" surgery/treatment.

11. Is the medical condition **Pregnancy**? ☐ Yes ☑ No
12. Use the information provided by Wichita State University in question #3 to answer this question. If WSU failed to provide a list of the employee's essential functions or a position description, answer these questions based upon the employee's own description of his/her job functions.
    a. Is the employee unable to perform any of his/her job functions due to the condition: ☑ Yes ☐ No

If yes, identify the job functions the employee is unable to perform: Patient will be unable to pull, lift, stand or concentrate for long periods of time while in recovery, during the four weeks after surgery. Some of these tasks may also be affected during the treatment period.

Indicate expected time frame for surgery, treatment and/or recovery.

13. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ☑ Yes ☐ No

If yes, estimate the beginning and ending dates for the period of incapacity: from 5/5/12 to 6/10/12

14. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ☑ Yes ☐ No

If yes, are the treatments or the reduced number of hours of work medically necessary? ☑ Yes ☐ No

a. Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment , including any recovery period: Patient will be seen 1 to 2 times per week for check-ups.

It is important for the committee to know how work schedules will be effected.

b. Estimate the part-time or reduced work schedule the employee needs, if any:

6 hour(s) per day; 5 days per week from 6/6/12 through 9/6/12

15. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ☐ Yes ☑ No

Is it medically necessary for the employee to be absent from work during the flare-ups? ☐ Yes ☐ No

If yes, explain:

a. Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., one episode every three months lasting one to two days):

Frequency: _____ times per _____ week(s) _____ month(s).

Duration: _____ hours or _____ day(s) per episode.

16. If leave is required to **care for an eligible family member** (of the employee), describe the care needed by the patient and why such care is medically necessary: n/a

Questions 16 - 19 refer to "care for an eligible family member". The doctor should indicate the extent to which the employee will be affected by their family member's illness/injury.

17. Will the **eligible family member** require follow-up treatments, including any time for recovery? ☐ Yes ☐ No

a. Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period: n/a

b. Explain the care needed by the **eligible family member**, and why such care is medically necessary:

n/a

18. Will the **eligible family member** require care on an intermittent or reduced schedule basis, including any time for recovery? ☐ Yes ☐ No

a. Estimate the hours the eligible family member needs care on an intermittent basis, if any:

_____ hour(s) per day; _____ days per week from _____ through _____

b. Explain the care needed by the **eligible family member**, and why such care is medically necessary:

n/a

19. Will the condition cause episodic flare-ups periodically preventing the **eligible family member** from participating in normal daily activities? ☐ Yes ☐ No

a. Based upon the eligible family member's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., one episode every three months lasting one to two days):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or _____ day(s) per episode.

b. Does the **eligible family member** need care during these flare-ups? ☐ Yes ☐ No

c. Explain the care needed by the **eligible family member**, and why such care is medically necessary:

n/a

(Signature of Health Care Provider)

Hematology/Oncology

(Type of Practice/Medical Specialty)

Adam Baker

(Health Care Provider Name) **Please Print**

5/8/12

(Date)

1234 Doctor Lane

(Address)

(123) 456-7890

(Telephone Number)

Wichita

(City)

KS 67202

(State) (Zip)

The Genetic Information Non-Discrimination Act of 2008 (GINA) for FMLA

The Genetic Information Non-Discrimination 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 individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. **The GINA Title II does allow you to provide information about the medical condition of an employee's spouse, parent or child to certify the need for leave under the Family and Medical Leave Act (FMLA).**

[1]Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking FMLA leave.

[2]"Incapacity," for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery therefrom.

[3]Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

[4]A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health conditions. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

Continue to Page 4 to complete the Return to Work Authorization form.

WICHITA STATE UNIVERSITY
HUMAN RESOURCES

RETURN TO WORK AUTHORIZATION

This section will need to be completed once you return to work.

Rev. 02/2011

Employee Name: _____ *myWSU* ID#: _____

Department Name: _____ Campus Box # _____

Supervisor's Name: _____

***I have taken into consideration the job description and this patient may return to**:

_____ Regular Duty as of _____

_____ Modified Duty as of _____ Until Date: _____

with the following restrictions:

_____No Repetitive Gripping
_____No Repetitive Bending/Twisting
_____No Repetitive Lifting
_____No Pushing/Pulling/Reaching
_____No Lifting **Above** Shoulder Level
_____No Lifting **Above** Waist Level
_____No Squatting/Crawling/Kneeling
_____No Driving Motor Vehicles
_____No Climbing
_____Weight Limit _____lbs.

_____Awkward Position
_____Limited Outside Work
_____Limited Exposure Extreme Heat/Cold
_____No Dust/Mold/Fumes/Smoke/Gases
_____No Exposure Chemicals
_____Limited Walking/Running/Jumping
_____No Repetitive Turning
_____No Repetitive Stooping
_____Limited Sitting/Standing
_____Limited Balancing/Carrying/Holding

_____Other, please specify: _____

_____

Physician Comments: _____

_____

_____ _____
Examining Physician Name (Please Print) Type of Practice/Medical Specialty

_____ _____
Examining Physician Signature Date

_____ _____
Examining Physician Address Phone Number

_____ _____
Employee Signature Date

Return to Human Resources, FMLA Coordinator, Box 15.

Job Posting Preview

Posting Details

If you have a copy of your job description please attach.

Posting Number:	0600797
Posting Type:	External
Position Number:	999410
Department:	Physical Plant
Location:	Main Campus
Classification Title:	Electrician
Position Title:	Electrician
Exempt:	Non-Exempt
Position Type:	Classified Hourly
Position Status:	Full-time
Benefits Eligible?	Yes
Proposed Salary or Hourly Rate:	14.60
Regular Hours of Work:	7:45 AM to 4:30 Monday-Friday (Occasional emergency work nights and weekends)
Posting Date:	02/17/2012
Closing Date:	03/03/2012
Special Instructions to Applicants:	
Summary of Responsibilities:	*This is skilled electrical work performing maintenance or assisting highly skilled electricians in major construction, renovation and maintenance tasks. Work involves routine maintenance of electrical systems, machinery, appliances and other electrical devices. Also work may involve assisting other highly skilled craft and trades workers in the performance of a variety of skilled tasks in installation, maintenance, renovation and repair of electrical systems.
Minimum Education (Required):	*Education- General *Six months of experience in electrical work. Education may be substituted for experience as determined relevant.
Minimum Experience (Required):	*Six months of experience in electrical work. Education may be substituted for experience as determined by the agency.
Required licenses, certificates and registrations:	*Valid driver's license for use of state vehicles and if incumbent is a holder of another state license must acquire a Kansas state license within the time limit required by law *Knowledge of the standard practices, methods, tools and materials of the electrical trade.

Knowledge, skills and abilities (Required):	*Knowledge of the occupational hazards and safety precautions of the trade. *Ability to work from drawings and specifications. *Ability to care for the tools, materials and equipment of the trade. *Ability to use the tools, materials and equipment used in the electrical trade. *Ability to locate and adjust defects in electrical systems and equipment. *A knowledge of and skill in electrical trades related to and applicable in an operation such as a large Physical Plant complex. *Ability to work at high elevations on aerial lifts and platforms. *Necessary at entry.
Preferred Education:	None
Preferred Experience:	*Preferred three (3) years experience in electrical trade that involved performing tasks related to a large complex.

Job Duties

% of Time	Responsibility / Duty
	Under the general direction of the Physical Plant Supervisor, this position is responsible for performing highly skilled electrical tasks in support of highly skilled electricians involved in construction/renovation projects and independently performing maintenance tasks
40	New construction/Major Renovations/Remodeling The following tasks require a knowledge of the standard practices, material and tools of the electrical trade; and skill in performing electrical tasks. Work is reviewed by lead electricians (electrician senior) and / or supervisor.
40	Maintenance/Troubleshooting Performs skilled electrical work in the completion of maintenance tasks including but not limited to troubleshooting, repairing and altering secondary circuits; replacing switches, receptacles and lighting fixtures and Breaker boxes. Pulls wire makes necessary connections and tests circuit.
20	May operate equipment such as bobcats and aerial lift platforms in the completion of some projects.