# FAMILY AND MEDICAL LEAVE REGULATION

Consistent with the federal Family and Medical Leave Act of 1993 (FMLA) as amended, the Board of Education shall provide up to twelve (12) workweeks of unpaid, job protected leave in a twelve (12) month period for its eligible employees. In addition, FMLA provides eligible employees with 26 workweeks of leave in a single 12 month period to care for a covered service member with a serious illness or injury incurred in the line of duty.

An eligible employee must have been employed for at least twelve months, have worked at least 1,250 hours during the prior twelve months, and be employed at a worksite where at least 50 employees are employed by that employer within a 75 mile radius of that worksite.

*Right to Benefits During Leave*

An eligible employee is entitled to a total of twelve workweeks of unpaid family and medical leave. Any employee who uses the unpaid leave shall have his/her health benefits continued during the leave, shall not have any previously accrued benefits altered and shall be returned to an equivalent position according to established Board policies and collective bargaining agreements. The employee is not entitled to accrue seniority during the leave.
An employee may elect, or the District may require, an employee to use available paid leave time for purposes of a family or medical leave. However, an employee may only use accrued paid leave in accordance with the applicable collective bargaining agreement.
*Family and Medical Leave*

Family leave is available when a child is born to the employee, adopted by an employee or one is placed with the employee for foster care. Medical leave is available in order for the employee to take care of a spouse, child, parent who has a serious health condition, when the employee has a serious health condition rendering him/her unable to perform the functions of the employee's job. Military caregiver leave is available to employees who are family members of covered service members with a serious illness or injury incurred in the life of duty on active duty. Additionally, this applied to covered veterans who require care and have been other than dishonorably discharged from service within the last five (5) years. Military caregiver leave is a special entitlement that allows the employee to extend FMLA leave to 26 workweeks. Qualifying exigency leave is available to employees when a family member is notified of impeding call or called to active duty in support of a contingency operation.

A child shall include any individual whether biological, adopted, a foster child, a stepchild, a legal ward, or a child standing in loco parentis who is under eighteen years of age or, if over eighteen, is incapable of self-care due to a mental or physical disability. A parent shall include the biological parent of the employee or an individual who stood in loco parentis to the employee when he/she was a child. Next of kin shall mean the nearest blood relative other than spouse, parent, son, daughter, as defined in federal regulation.

A serious health condition means an illness, injury, impairment, or physical or mental condition that involves:

a) Any period of incapacity or treatment in connection with inpatient care (i.e., an overnight stay) at a hospital, hospice or residential medical care facility;
b) Any period of incapacity requiring absence from work or other regular daily activities for more than three (3) full and consecutive calendar days, that also involves in-person treatment by a health care provider two (2) or more times within thirty (30) days of the onset of the incapacity (including once within seven (7) days of the first day of incapacity), or in-person treatment by a health care provider on at least one (1) occasion which results in a regimen of continuing treatment by or under the supervision of the health care provider;
c) A period of incapacity or treatment for a chronic serious health condition which requires periodic visits (at least twice a year) for treatment by or under the supervision of a health care provider, continues over an extended period of time, and may cause episodic rather than a continuing period of incapacity;
d) A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective such as Alzheimer's Disease or the terminal stage of an illness (employee or family member must be under continuing supervision by a health care provider);
e) A period of absence to receive multiple treatments (at least twice in one (1) year) by or pursuant to the orders of a health care provider for restorative surgery after an

injury or accident, or for a condition that would likely result in a period of incapacity longer than three (3) consecutive, full calendar days in the absence of medical treatment or intervention; or

f) Any period of incapacity due to pregnancy or for prenatal care.

Family leave must be taken within one year of the birth or placement of the employee's child. If both spouses are employed by the District, the combined amount of leave for family leave or medical leave may be limited to twelve weeks.

*Notice to Take Leave*

The employee shall notify the District of his/her request for family or medical leave at least 30 days prior to the date when the leave is to begin, when such leave is foreseeable. If such leave is not foreseeable then notice shall be given as early as is practical. If the employee requests medical leave, reasonable attempts shall be made to schedule treatment so as not to disrupt the district's operations.

Employees, absent unusual circumstance, must comply with the District's usual and customary notice and procedural requirements for requesting leave.

*Intermittent Leave*

An employee who requests family leave, shall not be provided intermittent leave or a reduced leave schedule unless the employee and District mutually agree. Intermittent leave may be provided for medical leave, however, the District may transfer the employee to a comparable position if it will better accommodate such intermittent periods of leave. For instructional employees who request medical leave and it is foreseeable that the medical treatment shall cause the employee to be on leave for more than 20% of the total number of working days in the period of leave, the District may require the employee to take a block of time or to transfer to an equivalent position for which the employee is qualified, but which better accommodates intermittent periods of leave.

*Military Leave: Leave Related to Active Duty or a Call to Active Duty*

If the necessity for leave because of a qualifying exigency arising from the fact that a family member is on active duty or has been notified of an impending call to active duty is foreseeable, the employee shall give such notice to the district as soon as is reasonable and practicable.

The Board may require that a request for leave because of a qualified exigency arising from the fact that the employee's spouse, son, daughter, or parent is on active duty or has been notified of an impending call to active duty be supported by a certification issued in accordance with regulations.

*Certification*

The District may require the employee requesting medical leave to present a certification from the health care provider of the person for whom the employee is taking the leave. Upon request by the district, the employee must provide the certification within 15 days. The certificate shall include:

1. the date on which the serious health 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 the employee is needed to care for the family member and an estimate of the amount of time that such employee shall be needed or a statement that the employee is unable to perform the functions of the employee's position; and
5. the dates and duration of medical treatment if the request for intermittent leave is for a planned medical treatment.

If the District doubts the validity of the certification, then, at the District's expense, a second opinion may be required from a health care provider selected by the District. The school physician cannot give this opinion. If the two opinions conflict, a third health care provider, at the District's expense, may be chosen by the two parties to render a final opinion.

*Restoration*

An instructional employee who begins any type of leave at least five (5) weeks before the end of an academic term, may be required not to return until the new term begins if the leave is at least three (3) weeks long and the employee would return during the last three (3) weeks of the term.

An instructional employee who begins leave, for any purpose other than personal illness, less than three (3) weeks prior to the end of the term and the leave is longer than five (5) working days, may be required not to return until the new term begins.

*Failure to Return*

The District may recover the health care premiums paid during the leave if the employee fails to return from the leave. However, recovery cannot occur if the employee fails to return because of the continuation, recurrence, or onset of a serious health condition or due to circumstances beyond the control of the employee.

*Effect on Existing Laws or Agreements*

The Board shall ensure that family and medical leave, consistent with the Family and Medical Leave Act, is provided to all eligible employees, whether or not they are covered by a collective bargaining agreement. Any collective bargaining agreement which contains greater leave benefits than this policy shall remain in force.

*Notice of Policy*

The District shall post a notice prepared or approved by the Secretary of Labor stating the pertinent provisions of the Family and Medical Leave Act, including information concerning enforcement of the law.

Adoption date: June 30, 2015

Certification of Health Care Provider for Employee's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 5/31/2018

**SECTION I: For Completion by the EMPLOYER**

**INSTRUCTIONS to the EMPLOYER:** The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: _____

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions: _____

_____

Check if job description is attached: .

**SECTION II: For Completion by the EMPLOYEE**

**INSTRUCTIONS to the EMPLOYEE:** Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: _____
First Middle Last

**SECTION III: For Completion by the HEALTH CARE PROVIDER**

**INSTRUCTIONS to the HEALTH CARE PROVIDER:** Your patient has requested leave under the FMLA. 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 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. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b). Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____) _____ Fax:(_____) _____


CONTINUED ON NEXT PAGE

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

Probable duration of condition: _____

**Mark below as applicable:**
Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
___No ___Yes. If so, dates of admission:

_____

Date(s) you treated the patient for condition:

_____

Will the patient need to have treatment visits at least twice per year due to the condition? ___No ___ Yes.

Was medication, other than over-the-counter medication, prescribed? ___No ___Yes.

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
____No ____Yes. If so, state the nature of such treatments and expected duration of treatment:

_____

2. Is the medical condition pregnancy? ___No ___Yes. If so, expected delivery date: _____

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition: ____ No ____ Yes.

If so, identify the job functions the employee is unable to perform:

_____

4. 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 such as the use of specialized equipment):

_____

_____

_____

_____

_____

_____

_____

PART B: AMOUNT OF LEAVE NEEDED

5. 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? ___No ___Yes.

   If so, estimate the beginning and ending dates for the period of incapacity: _____

6. 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? ___No ___Yes.

   If so, are the treatments or the reduced number of hours of work medically necessary? ___No ___Yes.

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

   _____

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

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

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ____No ____Yes.

   Is it medically necessary for the employee to be absent from work during the flare-ups? ____ No ____Yes. If so, explain:

   _____

   _____

   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., 1 episode every 3 months lasting 1-2 days):

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

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

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

**Signature of Health Care Provider** **Date**

**PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT**

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**

Certification of Health Care Provider for Family Member's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

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OMB Control Number: 1235-0003
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**SECTION I: For Completion by the EMPLOYER**

**INSTRUCTIONS to the EMPLOYER:** The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: _____

_____

**SECTION II: For Completion by the EMPLOYEE**

**INSTRUCTIONS to the EMPLOYEE:** Please complete Section II before giving this form to your family member or his/her medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a covered family member with a serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Your name: _____
First Middle Last

Name of family member for whom you will provide care: _____
First Middle Last

Relationship of family member to you: _____

If family member is your son or daughter, date of birth: _____

Describe care you will provide to your family member and estimate leave needed to provide care:

_____

_____

_____

_____ _____
Employee Signature Date



CONTINUED ON NEXT PAGE

**SECTION III: For Completion by the HEALTH CARE PROVIDER**

**INSTRUCTIONS to the HEALTH CARE PROVIDER:** The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. 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 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 patient needs leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e). Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address:_____

Type of practice / Medical specialty: _____

Telephone: (_____)_____ Fax:(_____)_____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
   ___No ___Yes. If so, dates of admission: _____

   Date(s) you treated the patient for condition: _____

   Was medication, other than over-the-counter medication, prescribed? ___No ___Yes.

   Will the patient need to have treatment visits at least twice per year due to the condition? ___No ____ Yes

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
   ____ No ____Yes. If so, state the nature of such treatments and expected duration of treatment:

   _____

   _____

2. Is the medical condition pregnancy? ___No ___Yes. If so, expected delivery date: _____

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

_____

_____

_____

_____

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ___No ___Yes.

   Estimate the beginning and ending dates for the period of incapacity: _____

   During this time, will the patient need care? __ No __ Yes.

   Explain the care needed by the patient and why such care is medically necessary:

   _____

   _____

   _____

   _____

   _____

5. Will the patient require follow-up treatments, including any time for recovery? ___No ___Yes.

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

   _____

   Explain the care needed by the patient, and why such care is medically necessary: _____

   _____

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? __ No __ Yes.

   Estimate the hours the patient needs care on an intermittent basis, if any:

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

   Explain the care needed by the patient, and why such care is medically necessary:

   _____

   _____

   _____

   _____

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ____No ____Yes.

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., 1 episode every 3 months lasting 1-2 days):

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

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

Does the patient need care during these flare-ups? ____ No Yes.

Explain the care needed by the patient, and why such care is medically necessary: _____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

**Signature of Health Care Provider** **Date**

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