FMLA LEAVE REQUEST POLICY

Dear District 70 Employee,

Enclosed is a series of forms, information and documentation to help you through your request for leave from Pueblo School District No. 70. This packet will insure that your leave request is processed through the appropriate channels involving you, your physicians and the staff of District 70.

This packet also covers the necessary paperwork that must be submitted for the “Family Medical Leave Act” as prescribed in “Article 7” of the Negotiated Agreement with the Pueblo County Education Association (PCEA).

Please use the following checklist when compiling your leave request materials. Failure to complete all of the required items may result in a delay or denial of your leave request.

1. ___ Employee “Leave/Absence Request” form. (This form does require a signature of the Principal/Supervisor before being submitted to Personnel).

2. ___ Submit the “Certification of Health Care Provider” with a physician’s signature.

3. ___ Provide a “Fit for Duty Certificate” with a physician’s signature to Personnel upon returning to work.

All provisions for the leave request must comply with the “Family Medical Leave Act” of 1993. Additionally, please review “Article 7” of the Negotiated Agreement concerning donated days from fellow employees, sick leave bank, and borrowing days from the Board of Education under extenuating circumstances.

Leave with pay is available for all employees for the birth of a child and for adoption providing that accumulated leave is not exhausted. Leave with pay will be deducted from any accumulated days of the employee. Leave without salary and fringe benefits is also granted to all employees with medical verification.

Please contact the Personnel Department at 295-6516 if you have any questions regarding the process or during the term of your leave.
PUEBLO COUNTY SCHOOL DISTRICT 70
EMPLOYEE FMLA LEAVE REQUEST

Name: ___________________________ Date: ____________________

Work Location: ___________________ Position: ___________________

I request leave of absence for the following reason (FMLA packet required):

____ My own serious health condition. (12 week maximum)

____ My own disability due to pregnancy, childbirth, or related medical condition. (12-week Maximum)

____ Paternity leave for the birth of your child or during the 12 months following birth. (12-week maximum)

____ A serious health condition affecting my: child____, spouse____, or parent ____ for which I need to provide care for. (12-week maximum)

____ The placement of a child with me for adoption or foster care. (12-week maximum)

____ A qualifying exigency relating to a call to active duty. (12-week maximum)

____ The need to care for my spouse, child, parent, or next of kin who is a recovering service member. (26-week maximum)

I expect that this leave will begin on _______________ and will end on _______________.
(If you have provided less than 30 days’ notice, please explain why on the reverse side of this form.)

I understand that all leaves of absence are without pay after my paid time (annual or vacation as appropriate) is depleted. I also understand that I may be required to provide medical certification to support my request for leave, at any time during my leave, and at the end of my leave for return to work purposes. I also certify that my request for absence is correct in accordance with the provisions of the Negotiated Agreement of documents covering terms and conditions of employment.

Signature of Employee: ___________________________ Date: ____________________

Signature of Supervisor/Principal: ___________________________ Date: ____________________

Conditions: You shall not be otherwise gainfully employed while on leave. You shall give notice of intent to work in accordance with the Negotiated Agreement which covers the terms and conditions of employment.
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: ____________________________

Name of family member for whom you will provide care: ____________________________

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: ____________________________
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):

   ____________________________________________________

   ____________________________________________________

   ____________________________________________________

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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 ____________

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.
FAMILY MEDICAL LEAVE ACT

The following is a brief history behind the Family Medical Leave Act (FMLA):

The purpose of the act is:

1. To balance the demands of the workplace with the needs of families, to promote the stability and economic security of families, and to promote the national interests in preserving family integrity;
2. To entitle employees to take reasonable leave for medical reasons, for the birth or adoption of a child, and for the care of a child, spouse or parent(s) who has a serious medical condition;
3. To accomplish the purposes described in paragraph (1) and (2) in a manner that accommodates the legitimate interest of employers.
4. To accomplish the purposes described in paragraphs (1) and (2) in a manner that, is consistent with the Equal Protection clause of the Fourteenth Amendment, minimizes the potential for employment discrimination on the basis of sex by ensuring generally that leave is available for eligible medical reasons (including maternity-related disability) and for compelling family reasons on a gender neutral basis; and
5. To promote the goal of equal employment opportunity for women and men, pursuant to such clause.

FMLA guidelines require the employer address the conditions when granting leave under the Act:

Leave entitlement: FMLA entitles employees to take 12 weeks of leave per year to (1) address serious health concerns, (2) care for family members who have serious health conditions and (3) to participate in early child rearing. Employees are granted 30 days (6 weeks) for the birth of a child and/or adoption without medical verification. Employees have the option with this leave to use their accumulated annual leave while on FMLA or be granted FMLA without pay and save their accumulated annual leave.

Eligible Employee: An "eligible employee" is an employee who:
1. Has been employed by the District for at least 12 months, and
2. Has been employed for at least 1,250 hours of service during the 12-month period immediately preceding the commencement of the leave.

Medical Certification: You are required to furnish a "Certification of Health Care Provider" form to take this leave, with the exception of Maternity Leave up to six weeks.

Return to Duty: You will need to present a "Certified Employee Fit for Duty Certificate" from your medical provider before returning to work. A "Certified Employee Fit for Duty Certificate" is required in maternity/medical related leave should the leave go beyond 30 days (6 weeks).

Annual Leave: Employees who have accumulated annual leave may be granted FMLA leave with pay for the length of time they have annual leave. Once you have exhausted your paid leave, you will be on leave without pay. It is the employee's responsibility to verify the number of accumulated annual days you have with the Payroll Department.

Health/Dental/Life Insurance Benefits: FMLA guidelines stipulate that employers will continue to pay their contribution toward the premium of health/dental/life insurance benefits up to 12 weeks. If you do not return to work, you will need to reimburse the district. Please make arrangements with the Payroll Department regarding your contribution of the premium.

At the end of FMLA Leave, the employee shall make arrangements with the Payroll Department regarding insurance options.

Increment Movement: Increment steps shall be granted on September 1 of each year during the term of leave. Employees who complete a minimum of 90 work days in the previous 12 month period shall receive an increment step increase as per the Association of Certified Employees Negotiated Agreement.

Hire Dates: Hire dates are not affected while on FMLA leave.

Paid days are subject to earned accumulated annual leave. Leave requests beyond accumulated leave will result in leave without pay. You may return to work before the stated date. You will need a "Certified Employee Fit for Duty", completed by your physician, to return to work. If you have any questions, need clarification, or assistance in any other way, please feel free to contact the Personnel Services Department at 255-6517.