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 my 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 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: (_________)

Form WH-380-E Revised May 2015
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.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Page 3 CONTINUED ON NEXT PAGE Form WH-380-E Revised May 2015
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 placed on 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 you 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 295-6517.
Form to be completed by health care provider. An employee on a medical leave under the Family and Medical Leave Act (FMLA) must present this Fitness for Duty Certification to the Personnel Services Center prior to returning to work.

The Family and Medical Leave Act (FMLA) guidelines are applied to eligible employees who are on paid or unpaid leave. This form is for return to work purposes of medical leave of absence due to an illness or injury, whether work or non-work related. Because employees are valuable resources, health care providers should assist employees in returning to work as soon as possible.

Health Care Professionals: Your patient has three return to work options.

- **Full Release.** The patient has no work restrictions. They can return to his or her prior position because you, the health care provider certify, that he or she can perform the essential functions of their job.

- **Modified Duty.** The patient has some work restrictions. Work restrictions must be specifically notated below. Each modified duty work restriction request will be reviewed carefully to determine if the employee can perform the essential functions of the job and return to work.

- **Not Released.** The patient is not released to work in any capacity due to physical or behavioral limitations.

1. **Employee / Patient**

2. **Date of Medical Examination**

3. **Please check the status of the employee’s release for duty**

   - [ ] Full, unrestricted duty effective ________________
   - [ ] Modified duty effective ________________ and next evaluation date ________________
   - [ ] Not released for any type of duty. Next evaluation date will be ________________

4. **Restrictions, Considerations, or Notes**

   ____________________________

   I hereby certify that the facts in this document are true and correct.

   ____________________________________________  Date  Phone Number

   Printed Name of Health Care Provider