FMLA Family

Carroll Independent School District
Family Medical Leave Request

Employees who will be absent more than five consecutive days, have a need for intermittent leave, or any other qualifying event as defined by the Family and Medical Leave Act must submit a “Leave Request Form” to the Human Resource Department at least 30 days prior to the beginning of the leave. This request should be submitted as soon as possible if the extended absence is not foreseeable.

If your absence is due to leave for the employee’s serious health condition or that of a spouse, parent or child or military caregiver purposes, please complete the appropriate Family Medical Leave certification paperwork. In each case, medical certification shall be made by a health-care provider as defined by the Family and Medical Leave Act. You must provide medical certification prior to the beginning of your absence or as soon as possible if the absence is not foreseeable.

Extended absences can possibly have a financial impact on employees. Therefore it is required that all employees after meet with the Human Resources Coordinator to discuss their leave balance, required medical certification, financial impact and district reimbursement procedures.

Appointments to discuss the aforementioned items should be made at least **30 days prior to the beginning of the leave or as soon as foreseeable** by calling the Human Resources Coordinator at (817) 949-8213.

Failure to submit the request and secure an appointment could lead to reductions/docks in monthly salary payments to the employee.

Please contact the Human Resources Coordinator if you have any questions regarding this matter.

Lauren Wurman
Executive Director of Human Resources
Lauren.Wurman@southlakecarroll.edu

Jaclyn Hemmila
Human Resources Coordinator
Jaclyn.Hemmila@southlakecarroll.edu

Carroll Independent School District
Leave Request Form

2400 N. Carroll Ave.
Southlake, TX 76092
Ph: 817.949.8218

Name: ____ Date: ______________________

Address: ____

____

Phone: ____

Department / School: ____________________________________ Hire Date: _________________

Employee Statement:

I, ______________________________, request a leave of absence to begin on ____________________ and to end on ___________________.

If your absence is due to a qualifying Family Medical Leave Act event, please complete additional documents required for FMLA leave. Family and medical leave runs concurrently with accrued sick and personal leave, temporary disability leave, compensatory time, assault leave and absences due to a work-related illness or injury.

All leaves of absence must be approved in advance by your Principal / Supervisor.

Employee's Signature ____ Date ____________________

Approval:

Principal / Supervisor Signature ____________________________ Date ________________

Requested Substitute _____________________________________(must be approved by Principal and HR)

For Human Resources Use Only:

Human Resource Administrator ____ Date ________________

Superintendent / Designee (if non-FMLA) ______________________________ Date ________________

Substitute secured for employee _____________________________ Certified in TX ____ Yes ____ No

Long-term pay is approved for substitute _______ Yes _______ No

Copy: Principal / Supervisor
Payroll
Employee
HR

Appt date and time_____________________

CARROLL INDEPENDENT SCHOOL DISTRICT

Family Medical Leave Request

Name____

Campus/Department_____________________________________ Position: __________________________

MUST BE SUBMITTED TO THE HUMAN RESOURCE DEPARTMENT NOT LESS THAN 30 DAYS PRIOR TO BEGIN DATE OF LEAVE OR AS SOON AS PRACTICABLE. IT IS THE EMPLOYEES RESPONSIBILITY TO CONTACT THE HUMAN RESOURCE DEPARTMENT TO SCHEDULE AN APPOINTMENT TO DISCUSS THE FINANCIAL IMPACT OF THE LEAVE.

I understand that the leave I am requesting is an unpaid leave except where use of sick or personal leave days is allowed. I understand that while I am on leave I retain my current contract status and may use accumulated sick paid leave when applicable. I understand that while I am on leave the District will continue to pay its share of my medical premium as long as I am using sick leave or for a maximum of twelve weeks as covered under the Family and Medical Leave Act. I am responsible for continued payment of my portion of the medical premium. I am aware that after completing this leave if I do not return to duty, I must enroll under C.O.B.R.A. and must pay the total medical premium plus 2% in order to continue as a member of the District's group medical insurance plan.

DISTRICT OBLIGATIONS:

A. Shall allow eligible employees leave under FMLA.
B. Shall continue to pay health care premiums to the employee's health plan so that the employee remains covered during the leave period.
C. Shall return the employee to the same or equivalent position upon return to work from FMLA leave.

EMPLOYEE OBLIGATIONS:

A. Must take all paid leave concurrently with FMLA leave request.
B. Must provide medical certification of serious health condition prior to approval of the FMLA leave and at 30 day intervals thereafter.
C. Must request a foreseeable leave not less than 30 days prior to the beginning date of the leave or as soon as practicable.
D. Must continue to pay employee's share of health care premiums while on leave. If employee becomes 30 days behind in payment of premium, the health care coverage will lapse.
E. Must return to work at the time specified in the request. Instructional personnel should review Policy DEC (LEGAL) and DEC (LOCAL). Failure to return as specified may result in termination.
F. May be required to reimburse the District for health care premiums paid during the FMLA leave period that was unpaid if the employee does not return to work as specified and/or terminates employment.
G. Employee must provide the Human Resource Department with a Medical Release form prior to returning to duty.

COMPLETE THE APPROPRIATE SECTIONS BELOW:

PART I. ___ The birth of a child, or placement of a child with you for adoption or foster care;

I am requesting to take a leave under FMLA for the birth/adoption of a child. I understand that the District allows use of accumulated state sick leave, local sick leave and state personal leave only during my period of leave. I am aware that for adoption purposes I am allowed use of only local sick leave days and then state personal leave days. A doctor's medical release, specifying the date the employee is released to return to work, is required.

Continued

PART II. ____ Your own serious health condition.

PART III. ____ Because you are needed to care for your ____ spouse; ____ child; ____ parent due to his/her serious health condition

PART IV. ____ Because of a qualifying exigency arising out of the fact that your ____ spouse; _____son or daughter; ______ parent is on covered active duty or call to covered active duty status with the Armed Forces.

PART V. ____ Because you are the ____ spouse; _____son or daughter; ______ parent; _______ next of kin of a covered servicemember with a serious injury or illness.

The **approximate beginning** date of the leave is: ______/______/______ *
Month Day Year

*Generally, this is the anticipated delivery date or the first day of continued leave as required by the doctor, unless otherwise documented.

The **approximate return** date of the leave is: ______/______/______
Month Day Year

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE STATEMENTS AND CONDITIONS OF THIS LEAVE REQUEST.

Employee's Signature____ Date_________________

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

U.S. Department of Labor
Wage Hour Division

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR.
RETURN TO THE PATIENT.

OMB Control Number: 1235-0003
Expires: 6/30/2023

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave to care for a family member with a serious health condition to submit a medical certification issued by the family member's health care provider. 29 U.S.C. §§ 2613, 2614(c)(3); 29 C.F.R. § 825.305. The employer must give the employee **at least 15 calendar days** to provide the certification. If the employee fails to provide complete and sufficient medical certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

SECTION I - EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, this form asks the health care provider for the information necessary for a complete and sufficient medical certification, which is set out at 29 C.F.R. § 825.306. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308**. Additionally, you **may not** request a certification for FMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care.

Employers must generally maintain records and documents relating to medical information, medical certifications, recertifications, or medical histories of employees or 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.

(1) Employee name: ____
First *Middle* *Last*

(2) Employer name: ______________________________ Date: ______________ *(mm/dd/yyyy)*
(List date certification requested)

(3) The medical certification must be returned by ______________________ *(mm/dd/yyyy)*
(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee's diligent, good faith efforts.)

SECTION II - EMPLOYEE

Please complete and sign Section II before providing this form to your family member or your family member's health care provider. The FMLA allows an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of your family member. If requested by your employer, your response is required to obtain or retain the benefit of the FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). **You are responsible for making sure the medical certification is provided to your employer within the time frame requested, which must be at least 15 calendar days.** 29 C.F.R. §§ 825.305-825.306. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA leave request. 29 C.F.R. § 825.313.

(1) Name of the family member for whom you will provide care: ______________________________

(2) Select the relationship of the family member to you. The family member is your:

☐ Spouse ☐ Parent ☐ Child, under age 18
☐ Child, age 18 or older and incapable of self-care because of a mental or physical disability

Spouse means a husband or wife as defined or recognized in the state where the individual was married, including in a common law marriage or same-sex marriage. The terms "child" and "parent" include *in loco parentis* relationships in which a person assumes the obligations of a parent to a child. An employee may take FMLA leave to care for an individual who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave to care for a child for whom the employee has assumed the obligations of a parent. No legal or biological relationship is necessary.

Employee Name: ____________________

(3) Briefly describe the care you will provide to your family member: (*Check all that apply*)
☐ Assistance with basic medical, hygienic, nutritional, or safety needs ☐ Transportation
☐ Physical Care ☐ Psychological Comfort ☐ Other: ____________________

(4) Give your **best estimate** of the amount of leave needed to provide the care described: ____________________

____

(5) If a **reduced work schedule** is necessary to provide the care described, give your **best estimate** of the reduced schedule you are able to work. From __________ *(mm/dd/yyyy)* to __________ *(mm/dd/yyyy),* I am able to work __________ (*hours per day*) __________ (*days per week*).

Employee Signature ____________________ **Date** __________ *(mm/dd/yyyy)*

SECTION III - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form below. A family member of your patient has requested leave under the FMLA to care for your patient. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a family member with a serious health condition. For FMLA purposes, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that *involves inpatient care* or *continuing treatment by a health care provider*. For more information about the definitions of a serious health condition under the FMLA, see the chart at the end of the form.

You also may, but are **not required** to, provide other appropriate medical facts including symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment. Please note that some state or local laws may not allow disclosure of private medical information about the patient's serious health condition, such as providing the diagnosis and/or course of treatment.

Health Care Provider's name: *(Print)* ____________________

Health Care Provider's business address: ____________________

Type of practice / Medical specialty: ____________________

Telephone: (_____) __________ Fax: (____) __________ E-mail: ____________________

PART A: Medical Information

Limit your response to the medical condition for which the employee is seeking FMLA leave. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. **After completing Part A, complete Part B to provide information about the amount of leave needed.** Note: For FMLA purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. 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).

(1) Patient's Name: ____________________

(2) State the approximate date the condition started or will start: ____________________ *(mm/dd/yyyy)*

(3) Provide your **best estimate** of how long the condition lasted or will last: ____________________

(4) For FMLA to apply, care of the patient must be medically necessary. Briefly describe the type of care needed by the patient (*e.g., assistance with basic medical, hygienic, nutritional, safety, transportation needs, physical care, or psychological comfort*).

____

____

Employee Name: ____

(5) Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

- ☐ **<u>Inpatient Care</u>**: The patient (☐ has been / ☐ is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): ______________________________

- ☐ **<u>Incapacity plus Treatment</u>**: *(e.g. outpatient surgery, strep throat)*
  Due to the condition, the patient (☐ has been / ☐ is expected to be) incapacitated for *more than* three consecutive, full calendar days from ____________ *(mm/dd/yyyy)* to ____________ *(mm/dd/yyyy)*.

  The patient (☐ was / ☐ will be) seen on the following date(s): ______________________________
  ____

  The condition (☐ has / ☐ has not) also resulted in a course of continuing treatment under the supervision of a health care provider *(e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment)*

- ☐ **<u>Pregnancy</u>**: The condition is pregnancy. List the expected delivery date: ______________ *(mm/dd/yyyy)*.

- ☐ **<u>Chronic Conditions</u>**: *(e.g. asthma, migraine headaches)* Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

- ☐ **<u>Permanent or Long Term Conditions</u>**: *(e.g. Alzheimer's, terminal stages of cancer)* Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

- ☐ **<u>Conditions requiring Multiple Treatments</u>**: (*e.g. chemotherapy treatments, restorative surgery)* Due to the condition, it is medically necessary for the patient to receive multiple treatments.

- ☐ **<u>None of the above</u>**: If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed. Go to page 4 to sign and date the form.

(6) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. *(e.g., use of nebulizer, dialysis)* ____
____

<u>PART B: Amount of Leave Needed</u>

For the medical condition(s) checked in Part A, complete all that apply. 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 if the benefits and protections of the FMLA apply.

(7) Due to the condition, the patient (☐ had / ☐ will have) **planned medical treatment(s)** (scheduled medical visits) *(e.g. psychotherapy, prenatal appointments)* on the following date(s): ______________________________
____

(8) Due to the condition, the patient (☐ was / ☐ will be) **referred to other health care provider(s)** for evaluation or treatment(s).

State the nature of such treatments: *(e.g. cardiologist, physical therapy)* ______________________________

Provide your **best estimate** of the beginning date ______________ *(mm/dd/yyyy)* and end date ______________ *(mm/dd/yyyy)* for the treatment(s).

Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery
____ *(e.g. 3 days/week)*

Employee Name: ____

(9) Due to the condition, the patient (☐ was / ☐ will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.

Provide your **best estimate** of the beginning date: ____________________ *(mm/dd/yyyy)* and end date ________________ *(mm/dd/yyyy)* for the period of incapacity.

(10) Due to the condition it, (☐ was / ☐ is / ☐ will be) medically necessary for the employee to be absent from work to provide care for the patient on an **intermittent basis** (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, episodes of incapacity are estimated to occur ________________________________ times per (☐ day / ☐ week / ☐ month) and are likely to last approximately ___________________ (☐ hours / ☐ days) per episode.

Signature of Health Care Provider ____ **Date** __________________ *(mm/dd/yyyy)*

Definitions of a Serious Health Condition *(See 29 C.F.R. §§ 825.113-.115)*
Inpatient Care
• An overnight stay in a hospital, hospice, or residential medical care facility. • Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.
Continuing Treatment by a Health Care Provider (any one or more of the following)
Incapacity Plus Treatment: A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either: o Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or, o At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.
Pregnancy: Any period of incapacity due to pregnancy or for prenatal care.
Chronic Conditions: Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.
Permanent or Long-term Conditions: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.
Conditions Requiring Multiple Treatments: Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.

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 15 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 Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR. RETURN TO THE PATIENT.

Attach to all medical certification forms or requests for medical information.

Date: ______________________________

To: Healthcare Provider

______________________________ *(Employee)*

From: Human Resource Department – Carroll ISD

The Genetic Information Nondiscrimination 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 an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

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