



NOTICE OF ELIGIBILITY and RIGHTS & RESPONSIBILITIES (Family and Medical Leave Act)

Employee Portion: Instructions

- 1) Read the entire form (front and back) and complete employee area below.
- 2) Return the completed form to Human Resources. A copy will be returned to you.

In general, to be eligible an employee must have worked for an employer for at least 12 months, have worked at least 1,250 hours in the 12 months preceding the leave, and work at a site with at least 50 employees within 75 miles.

[Part A – NOTICE OF ELIGIBILITY]

Is this request for your own condition or that of a family member?

(Please check which applies) Self Family Member

Is your spouse also employee at Austin Public Schools District 492? Yes No If Yes, list spouse name _____

Name _____ Hire Date _____

School Building _____ Work Phone _____

Home Phone _____ Position _____

Reason for Request _____ m

FMLA Start Date _____ Proposed End Date _____

Please check one of the following:

- I am requesting that this leave be granted under FMLA for one of the following reasons:
- _____ The birth of a child, or placement of a child with you for adoption or foster care;
 - _____ Your own serious health condition;
 - _____ Because you are needed to care for your _____ spouse; _____ child; _____ parent due to his/her serious health condition;
 - _____ Because of a qualifying exigency arising out of the fact that your _____ spouse; _____ son or daughter; _____ parent is on active duty or call to activity duty status in support of a contingency operation as a member of the National Guard or Reserves.
 - _____ Because you are the _____ spouse; _____ son or daughter; _____ parent; _____ next of kin of a covered service member with a serious injury or illness.

I agree to the FMLA designation and will be supplying the employer with medical certification.

- Although I have not requested that this leave be granted under FMLA, I recognize the employer's right to count it against my FMLA entitlement if my absences are for my or my qualifying family members' serious health condition or qualifying service members serious health condition. Therefore, I agree to that designation without requiring the employer to obtain medical certification.

- I have been out for a sick leave eligible reason that does not qualify as a "serious health condition." I have not received or my qualifying family member has not received "inpatient care or continuing treatment", so I cannot provide medical certification. Therefore, I understand that these absences will not be counted toward my FMLA entitlement.

This Notice is to inform you that you:

_____ Are eligible for FMLA leave (See Part B below for Rights and Responsibilities)

_____ Are **not** eligible for FMLA leave, because (only one reason need be checked, although you may not be eligible for several reasons):

- _____ You have not met the FMLA's 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately _____ months toward this requirement.
- _____ You have not met the FMLA's 1,250-hours-worked requirement.

If you have any questions, contact Sue Stark at 507-460-1902 or view the details online at the Austin Public Schools website under federal & state laws or view the FMLA poster located in your local building office or the Human Resources Office.

[Part B – RIGHTS AND RESPONSIBILITIES FOR TAKING FMLA LEAVE]

As explained in Part A, you meet the eligibility requirements for taking FMLA leave and still have FMLA leave available in the applicable 12-month period. **However, in order for us to determine whether your absence qualifies as FMLA leave, you must return the following information to us by _____.** (If certification is requested, employers must allow at least 15 calendar days from receipt of this notice; additional time may be required in some circumstances.) If sufficient information is not provided in a timely manner, your leave may be **denied**.

_____ Sufficient certification to support your request for FMLA leave. A certification form that sets forth the information necessary to support your request _____ is/ _____ is not enclosed.

_____ Sufficient documentation to establish the required relationship between you and your family member.

_____ Other information needed: _____

_____ No additional information requested.

If your leave does qualify as FMLA leave you will have the following responsibilities while on FMLA leave (only checked blanks apply):

_____ Contact the Benefits Specialist at 460-1906 to make arrangements to continue to make your share of the premium payments on your health insurance to maintain health benefits while you are on leave. You have a minimum 30-day grace period in which to make premium payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse, or at our option, we may pay your share of the premiums during FMLA leave, and recover these payments from you upon your return to work.

_____ You will be required to use your available paid _____ **sick**, _____ **vacation**, and or _____ **other leave** during your FMLA absence. This means that you will receive your paid leave and the leave will also be considered protected FLMA leave and counted against your FMLA leave entitlement.

_____ Due to your status with the district, you are considered a “key employee” as defined in the FMLA. As a “key employee,” restoration to employment may be denied following FMLA on the grounds that such restoration will cause substantial and grievous economic injury to us. We _____ **have**/ _____ **have not** determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic harm to us.

_____ While on leave you will be required to furnish us with periodic reports of your status and intent to return to work every _____ days.

If the circumstances of your leave change, and you are able to return to work earlier than the date indicated on the reverse side of this form, you will be required to notify us at least two (2) work days prior to the date you intend to report for work.

If your leave does qualify as FMLA you will have the following **rights** while on FMLA leave:

- You have a right under the FMLA for up to 12 weeks of unpaid leave in a 12-month period calculated as a “rolling” 12 month period measured backward from the date of any FMLA leave usage.
- You have a right under the FMLA for up to 26 weeks of unpaid leave in a single 12-month period to care for a covered service member with a serious injury or illness. This single 12 month period commenced on _____.
- Your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work.
- You must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA-protected leave (subject to the terms of any applicable collective bargaining agreements). (If your leave extends beyond the end of your FMLA entitlement, you do not have return rights under FMLA.)
- If you do not return to work following FMLA leave for a reason other than: 1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; 2) the continuation, recurrence, or onset of a covered service member’s serious injury or illness which would entitle you to FMLA leave; or 3) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave.

- If we have not informed you above that you must use accrued paid leave while taking your unpaid FMLA leave entitlement, you have the right to have _____ **sick**, _____ **vacation**, and/or _____ **other leave** run concurrently with your unpaid leave entitlement, provided you meet any applicable requirements of the leave policy and/or your working agreement. Applicable conditions related to the substitution of paid leave are referenced or set forth below. If you do not meet the requirements for taking paid leave, you remain entitled to take unpaid FMLA leave.

_____ For a copy of conditions applicable to sick/vacation/other leave usage, please refer to your bargaining agreement if applicable and District Policy 410.

_____ If you cannot return on the designated date, you shall, in advance and in writing, request another type of district leave. If you exhaust your eligible FMLA time and request another type of district leave, you are no longer entitled to further district paid medical and dental benefits. Any personnel action (e.g., unrequested leaves, schedule salary actions, etc.) that would have affected you as an active employee, will still apply to you during your FMLA time away and upon your return. This is not an employee contract and is not intended to be one. My signature below documents that I have read both sides of this form in its entirety.

Once we obtain the information from you as specified above, we will inform you, within 5 business days, whether your leave will be designated as FMLA leave and count towards your FMLA leave entitlement. If you have any questions, please do not hesitate to contact Mark Raymond at 507-460-1904.

Employee Signature _____ Date _____

OFFICE USE ONLY

Date request form was received _____ Available FMLA Hours/Weeks _____

Sick Accrual Balance _____ Vacation Accrual Balance _____

Two (2) signed copies are retained: 1) Employee 2) Employee Records in HR

IMPORTANT: PLEASE READ THIS FORM GENERAL OVERVIEW OF FAMILY AND MEDICAL LEAVE ACT OF 1993

FMLA requires employers to provide up to twelve (12) weeks of unpaid, job protected leave to “eligible” employees for certain family and medical reasons. Employees are eligible if they have worked for the employer for at least one year, and for 1,250 hours over the previous 12 months. FMLA must be granted for any of the following reasons: to care for the employee’s child after birth, or for adoption or foster care; to care for the employee’s spouse, son or daughter, or parent who has a serious health condition; or for a serious health condition that makes the employee unable to perform his/her job. FLMA also requires employers to provide up to twenty-six (26) weeks of unpaid, job protected leave to eligible employees to care for a covered service member with a serious injury or illness OR due to exigent circumstances you are in need of supporting a qualifying service member who is on active duty or a call to active duty status. The employee may be required to provide advance notice and medical certification. FMLA may be denied if requirements are not met. When the FMLA request is foreseeable, **30 days** advance notice should be provided. Medical Certification will be required to support a request due to a serious health condition. A second or third medical opinion (at the employer’s expense) and a fitness for duty report to return to work may also be required. For the duration of the FMLA request, the employer must maintain the same health coverage as the active employee had as of the FMLA start date. Upon return to work, an employee must be reinstated to the same or an equivalent job.

***NOTE:** At the employer’s option, certain kinds of paid leave may be substituted for unpaid leave.*

IMPORTANT: Please Read

- *The time you have requested will be deducted from your FMLA 12 or 26 week entitlement.*
- *Medical certifications must be provided for most FMLA Requests. Failure to provide this certification could result in denial of your FMLA Request.*
- *Except in the case of on-the-job injuries (OJIs), you will be required to exhaust your sick accruals for the duration of your own serious health condition before being placed on unpaid status (or as provided for in your collective bargaining agreement). For other than your own serious health condition, you can elect to use your own vacation time or sick time accruals available as provided for in your collective bargaining agreement, but are not required to do so. If you elect to use vacation time or designated sick time accruals, you must use that before going to the unpaid portion of your FMLA. Concurrent district sick guidelines still apply.*
- *For OJIs, you are not required to exhaust sick and vacation accruals, though you may elect to do so (or as provided for in your collective bargaining agreement).*
- *If you wish to maintain your life insurance, flexible spending accounts and/or medical and dental insurance contributions (if applicable), you are responsible for continuing to make your monthly payments.*
- *At the time you are placed off FMLA status, you will receive a notification from the Benefits Department, enabling you to continue coverage. You can call Benefits Administration (507-460-1906) if you have additional questions regarding your FMLA benefit coverage.*
- *If you do not return from your FMLA, unless excused by another District leave, you may be responsible for any premiums paid by the District during your FMLA time away.*
- *You may be required to have a fitness-for-duty physical prior to returning to work.*
- *Subject to your collective bargaining agreement, you will be restored to the same or an equivalent job upon your return to work at the end of your FMLA.*
- *For placement of a child with you for adoption or foster care, you will be asked to submit a certified legal certificate of placement if available.*
- *Contact Human Resources at 507-460-1904 if you have further questions.*