710 17th St. SW, Faribault, MN 55021
Office: 507-333-6000 | **Fax:** 507-333-6050

Employees of Faribault Public Schools are eligible for family and medical leave if they have at least 12 months of service with the District and have worked at least 1,250 hours within the preceding 12 month period. The following information is provided to enable you to formally apply for family or medical leave under the provisions of the Family and Medical Leave Act.

1. Letter of Eligibility, Rights and Responsibilities (including how to continue group health and dental insurance)

2. FMLA Application Form to be received at least 30 days before the start of leave (except in emergencies)

3. Medical certification letter to be returned within 15 days of start of leave, if applicable

4. Official Notice of Family & Medical Leave Act

Cooperation with all requests for information regarding FMLA qualifying absences is essential: failure to comply may result in a leave being delayed or denied.

Should you have any questions, please contact:
Meghan Knutson (Benefits Specialist)
507-333-6007 or mknutson@faribault.k12.mn.us

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The Family and Medical Leave Act ("FMLA") protects your position and benefits during a qualified absence for up to 12 weeks in a rolling calendar 12 month period. Based on our records you have requested a leave of absence that may meet the FMLA criteria. If your leave of absence qualifies, the following rights and obligations apply to your family and/or medical leave of absence:

1. If you take a qualified leave of absence, it will be counted against your annual cumulative 12 weeks of available family and medical leave.

2. If your request for leave is due to the birth of a child or for the placement of a child for adoption or foster care, the leave must be taken within the twelve month period beginning with the date of such birth or placement for adoption or foster care (or first duty day used for family and/or medical leave of absence in the fiscal year).

3. If your request for leave is to care for your seriously ill immediate family member, or due to your own serious health condition, please provide the Human Resources Department with a medical certification issued by the physician of your ill family member or your physician. The medical certification form is enclosed in this packet. The physician certification must be returned to the Human Resources Department within 15 days from the date of this letter. If you fail to provide timely certification, the school district may deny your FMLA until the certification has been provided.

4. If the district doubts the validity of the physician's certification, it may require you to obtain a second opinion at the district's expense. If the opinions of the first and second physicians differ, the district may require you to obtain certification from a third physician at
the district's expense. The district may also request recertification at reasonable intervals.

5. FMLA can be a paid absence, an unpaid absence or it can be a combination of both. FMLA protection does not mean that the absence is paid. If you are eligible for and have accrued other forms of leave which are paid (such as vacation, sick leave, etc.), the district may allow you to substitute available paid leave for a portion of your FMLA.

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6. For your health, dental or other benefits to continue during your FMLA leave, you must maintain your share of premium payments, including any changes in such premiums. The school district will continue to deduct your payments from your pay during the paid portions of your leave. Should any portion of your leave be unpaid, you are responsible for making these payments yourself. Call your Human Resources office to arrange continuation of coverage.

7. During your FMLA, unless your premium payment is more than thirty days late, the district will maintain coverage under any health and dental plan for the duration of such leave. However, the district may recover the premiums paid for maintaining coverage for you if you fail to return to work for reasons other than the continuation, recovery from, or additional onset of a serious health condition entitling you to FMLA or other circumstances beyond your control. If your inability to return to work is extended, the district may require additional certification.

8. While you are on FMLA, you must report to the Human Resources Department every four work weeks regarding your status and your intent to return to work upon the conclusion of the leave.

9. Spouses who are both employed by ISD 656 are permitted to take only a combined total of 12 weeks FMLA for birth and care of a newborn child, placement of a child for adoption or foster care, or to care for a parent (not a parent-in-law) who has a serious health condition during a 12 month period.

10. Returning to Work: If your FMLA is due to your own serious health condition which makes you unable to perform your job, the district will require you to present a final medical certification statement from your physician indicating you are able to return to work. Until such documentation is received, the district may deny you the right to return to work.

11. “Key” Employees Returning to Work: If you are a Key Employee, defined as a salaried FMLA-eligible employee who is among the highest paid ten percent of all employees within ISD 656, the district may deny you reinstatement to the same or equivalent position if such denial is necessary to prevent substantial and grievous economic injury to the operations of the district.

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Disability Leave & Parental Leave

Please review the entire sections on a Disability and/or Parental Leave in your Employment Contract and if you have any additional questions, please feel free to call Meghan Knutson at 507-333-6007

You have the right to request parental leave without pay after your physician verifies that you are physically able to return to work. In accordance with the policy of ISD 656, an employee must notify district officials at least one month prior to a requested leave.

During the first three months of a parental leave, all Faribault Public Schools' provided benefits will continue in the same manner as for active employees if your contract language allows.

After the initial three-month period, you are eligible to continue your benefits for the duration of your leave by paying the full monthly premiums (COBRA). If you do not continue your benefits, your insurance will terminate as of the last day of the third month of your parental leave. Please note the District does not provide a VEBA contribution while on COBRA.

The following forms must be completed and returned to the Human Resources Department for a Disability Leave and Parental Leave request:

FMLA Application
You must complete this form and indicate whether a parental leave will be utilized. Have your principal or supervisor sign the form, and return it to the Human Resources Department. If there is a change in your parental leave please submit an updated FMLA Application at least one month prior to your requested leave.

Medical Certification Statement
If you are put on disability before you deliver your baby, your physician must complete this form which verifies the last day you can fulfill your work responsibilities.

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And/Or:
Your physician must complete this form following the termination of your disability to verify when you will be physically able to return to work. During the time you are unable to work you will use sick leave to continue your regular salary. If you need to utilize Short Term Disability benefits after you have exhausted your sick leave, you will be compensated on the 15th and last day of each month at the percentage stated in your Employment Contract.

Benefits Change Form
If the reason for parental leave is occasioned by pregnancy, your newborn child is covered under your coverage for 30 days from the date of birth. However, you have 30 days from the date of birth to add your newborn to your family coverage. You will not have to submit evidence of insurability if you enroll your newborn within 30 days. However, your spouse (and other family members) may have to submit evidence of insurability to the insurance company.

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FAMILY AND MEDICAL LEAVE (FMLA) APPLICATION

Employee's Name _____ Job Title _____

Supervisor Signature _____ Location _____ Date _____

Type of Leave: ☐Family ☐Medical

Last Day Worked: _____ Leave Start Date:_____

Last Day Out: _____ Return to Work Date:_____

Have you taken a Family/Medical Leave within the last 12 months? ☐ No ☐Yes

This Family/Medical Leave is for:

☐ Birth/Adoption/Foster care of a child

☐ Serious health condition of employee

☐ Serious health condition of family member: ☐ Child ☐ Spouse ☐ Parent

Will you be using any accrued sick leave during this leave? ☐No ☐Yes # of days? _____

Will you be using any vacation/personal time during this leave? ☐No ☐Yes # of days? _____

Will this leave be taken on an intermittent/reduced schedule? ☐ No ☐Yes

I understand that my insurance benefits will be continued during my leave provided I continue paying the employee portion of the premium if applicable. If the insurance premium is not deducted from my paycheck, it is due by the twentieth (20th) of each month. If payment is not made within 30 days, I understand that my benefits may be discontinued. I understand that if I do not return from my approved leave of absence (LOA), ISD 656 will adjust my final pay to reflect the accurate amount owed. I understand that the school district will return me to the same or an equivalent position on return from leave unless subject to restoration provisions for 'key employees." However, I will not be eligible for reinstatement if a workforce reduction or layoff occurs while I am on leave and I would have been affected had I been working full time or part-time. Leave for the serious health condition of the employee or the covered family member requires medical certification, completed by medically disabled individual's physician: 1) before the leave begins or as soon as practical; 2) while on leave to recertify medical need as necessary; and 3) authorizing return to work for employee's own illness to determine fitness for duty.

Employee's signature_____Date_____

HR Department approval_____Date_____

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Medical Certification Statement

1. Employee's Name _____

2. Patient's Name (If different) _____

3. Nature of Condition: Describe the medical facts which support your certification, including a brief statement as to how the medical facts meet the criteria of a "**serious health condition**" (*page 3 describes serious health condition*)

_____
_____
_____

4a. Date condition commenced _____

4b. Probable duration of condition_____

4c. Will it be necessary for the employee to take work only **intermittently or to work on less than a full schedule** as a result of the conditions (including for treatment described question 5 below). ☐Yes ☐No If yes, give the probable duration:

_____

5a. If additional **treatments** will be required for the condition, provide an estimate of the probable number of such treatments:

_____
_____

5b. If any of these treatments will be provided by **another provider of health services** (e.g., physical therapist), please state the nature of treatments:

_____
_____

5c. If **a regimen of continuing treatment** by the patient is required under your supervision, provide a general description of such regimen:

_____
_____

5d. Was medication, other than over-the-counter, prescribed?☐Yes ☐No

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Employee

6a. If medical leave is required for the employee's absence from work because of the **employee's own condition** (including absences due to pregnancy or a chronic condition), is the employee **unable to perform work of any kind**? ☐Yes ☐No ☐Does not apply

6b. If able to perform some work, is the employee **unable to perform any one or more of the essential functions of the employee's job** (Answer after reviewing statement from employer of essential functions of employee's position, or if none provided, after discussion with the employee.) ☐Yes ☐No ☐Does not apply

6c. If neither A. nor B. apply, is it necessary for the employee to be **absent from work for treatment**? ☐Yes ☐No

Family Member

7a. If leave is required to care for a family member of the employee with a serious health condition, does the patient require assistance for basic medical or personal needs or safety, or for transportation? ☐Yes ☐No ☐Does not apply

7b. If not, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery? ☐Yes ☐No ☐Does not apply

7c. If the patient will need care only intermittently or on a part-time basis please indicate the probable duration of this need:

_____

_____

_____

Signature of Health Care Provider_____ Date_____

Telephone Number_____ Fax Number_____

*Note: Due to the confidential nature of this information, please return the completed form marked "Strictly Confidential" to: Human Resources / Faribault Public Schools / 710 17th St SW / Faribault, MN 55021 / Fax: (507)333-6050

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A "**Serious Health Condition**" means an illness, injury impairment, or physical or mental condition that involves one of the following:

1. Hospital Care
    a.
    a. **Inpatient care** (i.e. an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such impatient care.
2. Absence Plus Treatment
    a. A period of incapacity of **more than three consecutive calendar day**s (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:
        i. **Treatment of two or more times** by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health services (e.g. physical therapist) under orders of, or on referral by, a health care provider: or
        ii. **Treatment** by a health care provider on at least one occasion which results in a **regimen of continuing treatment** under the supervision of the health care provider**.**
3. Pregnancy
    a. Any period of incapacity due to **pregnancy**, or for **parental care.**
4. Chronic Conditions Requiring Treatments
    a. A chronic condition which
        i. Requires **periodic visits** for treatment by a heath care provider, or by a nurse or physician's assistant under direct supervision of a health care provider:
        ii. Continues over an **extended period of time** (including recurring episodes of a single underlying condition); and
        iii. May cause **episodic** rather than a continuing period of incapacity (e.g. asthma, diabetes epilepsy, etc.).
5. Permanent/Long-term Conditions Requiring Supervision
    a. A period of **incapacity** which is **permanent or long-term** due to a condition for which treatment may not be effective. The employee or family member must be **under the continuing supervision of, but need not be receiving active treatment by, a health care provider.** Examples include Alzheimer's, severe stroke, or the terminal stages of a disease.

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6. Multiple Treatments (Non-Chronic Conditions)
    a. Any period of absence to receive **multiple treatments** (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for **restorative surgery** after an accident or other injury, **or** for a condition that **would likely result in a period of incapacity for more than three consecutive days in the absence of medical intervention or treatment,** such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), and kidney disease (dialysis).

This optional form may be used by employees to satisfy a mandatory requirement to furnish a medical certification (when requested) from a health care provider, including second or third opinions and recertification (29 CFR 825.306).

Note: Persons are not required to respond to his collection of information unless it displays a currently valid OMB control number.

Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examination, or dental examinations.

A regimen for continuing treatment includes, for example, a course of prescriptions medication (e.g. antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves: bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

Public Burden Statement

We estimate that it will take an average of 20 minutes 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 of information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, Department of Labor, Room S-3502.200 Constitution Avenue, N.W. Washington, D.C. 20210

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE: IT GOES TO THE EMPLOYEE