**PENN HILLS SCHOOL DISTRICT**
**ADMINISTRATIVE OFFICES-Human Resources**
**260 Aster Street**
**Pittsburgh, Pennsylvania 15235**

412-793-7000 – Telephone
412-712-1009 – Fax
www.phsd.k12.pa.us

# FAMILY AND MEDICAL LEAVE (FMLA)

## EMPLOYEE'S SERIOUS HEALTH CONDITION

## *INFORMATION AND APPLICATION PACKET*

- **Memo to Employee**
- **Fact Sheet #28: The Family and Medical Leave Act**
- **Board Policy No. 335: Family and Medical Leave**
- **Leave of Absence Request Form**
- **WH-380-E Certification of Healthcare Provider for Employee's Serious Health Condition**
- **Fitness for Duty Certification**
- **Intermittent FMLA Tracking Form**

# FMLA
## EMPLOYEE'S SERIOUS HEALTH CONDITION


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**Date:** _____ **Employee No.:**_____

Enclosed please find the employee FMLA forms packet. Please read all of the information provided carefully.

Your request requires Board Approval and cannot be placed on the Agenda until all paperwork is received for processing.

**Step 1: Form WH-380-E:** Certification of Health Care Provider for Employee's Serious Health Condition

I. **Section I is to be completed by the District.**
II. **Section II is to be completed by you as the Employee.**
III. **Section III is to be completed by your physician.** Have your physician complete section III then, sign and date Form WH-380-E and return to you. Form WH-380-E is the Certification of Health Care Provider for Employee's Serious Health Condition form that must accompany the following Family & Medical Leave Request Form.

**Step 2: Family & Medical Leave Request Form:** Complete, sign and date then return the **FAMILY & MEDICAL LEAVE REQUEST FORM.** This signed form must accompany the WH-380-E which has been completed by your physician.

Submit both forms to the Human Resource office to begin the processing of your request for leave. Once you submit these forms they will be reviewed and if complete, your request will be placed on the Board Agenda.

**If you have any questions, please do not hesitate to contact me.**


***Dominique Ansani***

**Confidential Secretary – Human Resources**

**Phone: 412-793-7000 ext. 1228** **Fax: 412-712-1009** **Email: dansan@phsd.k12.pa.us**

# Fact Sheet #28: The Family and Medical Leave Act

The Family and Medical Leave Act (FMLA) entitles eligible employees of covered employers to take unpaid, job-protected leave for specified family and medical reasons. This fact sheet provides general information about which employers are covered by the FMLA, when employees are eligible and entitled to take FMLA leave, and what rules apply when employees take FMLA leave.

## COVERED EMPLOYERS

The FMLA only applies to employers that meet certain criteria. A **covered employer** is a:

- Private-sector employer, with 50 or more employees in 20 or more workweeks in the current or preceding calendar year, including a joint employer or successor in interest to a covered employer;
- Public agency, including a local, state, or Federal government agency, regardless of the number of employees it employs; or
- Public or private elementary or secondary school, regardless of the number of employees it employs.

## ELIGIBLE EMPLOYEES

Only eligible employees are entitled to take FMLA leave. An **eligible employee** is one who:

- Works for a *covered employer*;
- Has worked for the employer for at least *12 months*;
- Has at least *1,250 hours* of service for the employer during the 12 month period immediately preceding the leave*; and
- Works at a location where the employer has at least *50 employees within 75 miles*.

* Special hours of service eligibility requirements apply to airline flight crew employees. *See* Fact Sheet 28J: Special Rules for Airline Flight Crew Employees under the Family and Medical Leave Act.

The 12 months of employment do not have to be consecutive. That means any time previously worked for the same employer (including seasonal work) could, in most cases, be used to meet the 12-month requirement. If the employee has a break in service that lasted seven years or more, the time worked prior to the break will not count *unless* the break is due to service covered by the Uniformed Services Employment and Reemployment Rights Act (USERRA), or there is a written agreement, including a collective bargaining agreement, outlining the employer's intention to rehire the employee after the break in service. *See* "FMLA Special Rules for Returning Reservists".

## LEAVE ENTITLEMENT

Eligible employees may take up to **12 workweeks** of leave in a 12-month period for one or more of the following reasons:

- The birth of a son or daughter or placement of a son or daughter with the employee for adoption or foster care;
- To care for a spouse, son, daughter, or parent who has a serious health condition;
- For a serious health condition that makes the employee unable to perform the essential functions of his or her job; or
- For any qualifying exigency arising out of the fact that a spouse, son, daughter, or parent is a military member on covered active duty or call to covered active duty status.

An eligible employee may also take up to **26 workweeks** of leave during a "single 12-month period" to care for a covered servicemember with a serious injury or illness, when the employee is the spouse, son, daughter, parent, or next of kin of the servicemember. The "single 12-month period" for military caregiver leave is different from the 12-month period used for other FMLA leave reasons. *See* Fact Sheets 28F: Qualifying Reasons under the FMLA and 28M: The Military Family Leave Provisions under the FMLA.

Under some circumstances, employees may take FMLA leave on an intermittent or reduced schedule basis. That means an employee may take leave in separate blocks of time or by reducing the time he or she works each day or week for a single qualifying reason. When leave is needed for planned medical treatment, the employee must make a reasonable effort to schedule treatment so as not to unduly disrupt the employer's operations. If FMLA leave is for the birth, adoption, or foster placement of a child, use of intermittent or reduced schedule leave requires the employer's approval.

Under certain conditions, employees may choose, or employers may require employees, to "substitute" (run concurrently) accrued paid leave, such as sick or vacation leave, to cover some or all of the FMLA leave period. An employee's ability to substitute accrued paid leave is determined by the terms and conditions of the employer's normal leave policy.

**NOTICE**

Employees must comply with their employer's usual and customary requirements for requesting leave and provide enough information for their employer to reasonably determine whether the FMLA may apply to the leave request. Employees generally must request leave 30 days in advance when the need for leave is foreseeable. When the need for leave is foreseeable less than 30 days in advance or is unforeseeable, employees must provide notice as soon as possible and practicable under the circumstances.

When an employee seeks leave for a FMLA-qualifying reason for the first time, the employee need not expressly assert FMLA rights or even mention the FMLA. If an employee later requests additional leave for the same qualifying condition, the employee must specifically reference either the qualifying reason for leave or the need for FMLA leave. *See* Fact Sheet 28E: Employee Notice Requirements under the FMLA .

Covered employers must:

(1) Post a notice explaining rights and responsibilities under the FMLA. Covered employers may be subject to a civil money penalty for willful failure to post. For current penalty amounts, see www.dol.gov/whd/fmla/applicable_laws.htm;

(2) Include information about the FMLA in their employee handbooks or provide information to new employees upon hire;

(3) When an employee requests FMLA leave or the employer acquires knowledge that leave may be for a FMLA-qualifying reason, provide the employee with notice concerning his or her eligibility for FMLA leave and his or her rights and responsibilities under the FMLA; and

(4) Notify employees whether leave is designated as FMLA leave and the amount of leave that will be deducted from the employee's FMLA entitlement.

*See* Fact Sheet 28D: Employer Notice Requirements under the FMLA.

## CERTIFICATION

When an employee requests FMLA leave due to his or her own serious health condition or a covered family member's serious health condition, the employer may require certification in support of the leave from a health care provider. An employer may also require second or third medical opinions (at the employer's expense) and periodic recertification of a serious health condition. *See* Fact Sheet 28G: Certification of a Serious Health Condition under the FMLA. For information on certification requirements for military family leave, *See* Fact Sheet 28M(c): Qualifying Exigency Leave under the FMLA; Fact Sheet 28M(a): Military Caregiver Leave for a Current Servicemember under the FMLA; and Fact Sheet 28M(b): Military Caregiver Leave for a Veteran under the FMLA.

## JOB RESTORATION AND HEALTH BENEFITS

Upon return from FMLA leave, an employee must be restored to his or her original job or to an equivalent job with equivalent pay, benefits, and other terms and conditions of employment. An employee's use of FMLA leave cannot be counted against the employee under a "no-fault" attendance policy. Employers are also required to continue group health insurance coverage for an employee on FMLA leave under the same terms and conditions as if the employee had not taken leave. *See* Fact Sheet 28A: Employee Protections under the Family and Medical Leave Act .

## OTHER PROVISIONS

Special rules apply to employees of local education agencies. Generally, these rules apply to intermittent or reduced schedule FMLA leave or the taking of FMLA leave near the end of a school term.

Salaried executive, administrative, and professional employees of covered employers who meet the Fair Labor Standards Act (FLSA) criteria for exemption from minimum wage and overtime under the FLSA regulations, 29 CFR Part 541, do not lose their FLSA-exempt status by using any unpaid FMLA leave. This special exception to the "salary basis" requirements for FLSA's exemption extends only to an eligible employee's use of FMLA leave.

## ENFORCEMENT

It is unlawful for any employer to interfere with, restrain, or deny the exercise of or the attempt to exercise any right provided by the FMLA. It is also unlawful for an employer to discharge or discriminate against any individual for opposing any practice, or because of involvement in any

proceeding, related to the FMLA. *See* Fact Sheet 77B: Protections for Individuals under the FMLA . The Wage and Hour Division is responsible for administering and enforcing the FMLA for most employees. Most federal and certain congressional employees are also covered by the law but are subject to the jurisdiction of the U.S. Office of Personnel Management or Congress. If you believe that your rights under the FMLA have been violated, you may file a complaint with the Wage and Hour Division or file a private lawsuit against your employer in court.

**For additional information, visit our Wage and Hour Division Website: http://www.wagehour.dol.gov and/or call our toll-free information and helpline, available 8 a.m. to 5 p.m. in your time zone, 1-866-4-USWAGE (1-866-487-9243).**

This publication is for general information and is not to be considered in the same light as official statements of position contained in the regulations.

**U.S. Department of Labor**
Frances Perkins Building
200 Constitution Avenue, NW
Washington, DC 20210

**1-866-4-USWAGE**
TTY: 1-866-487-9243
**Contact Us**

| | |
|---|---|
| Book | Policy Manual |
| Section | 300 Employees |
| Title | Family and Medical Leaves |
| Code | 335 |
| Status | Active |
| Adopted | August 25, 2014 |
| Last Revised | June 22, 2020 |
| Last Reviewed | June 29, 2020 |

## Authority

The Board shall provide eligible administrative, professional and support employees with unpaid leaves of absence in accordance with the Family And Medical Leave Act, hereinafter referred to as FMLA.[1][2]

Employee requests for FMLA leave shall be processed in accordance with law, Board policy and administrative regulations.

## Delegation of Responsibility

The Superintendent shall develop and disseminate administrative regulations to implement FMLA leave for eligible employees.

The district shall post, in conspicuous places in the district customarily used for notices to employees and applicants, a notice regarding the provisions of the FMLA and the procedure for filing a complaint.[3]

Employee requests for leave, both FMLA and non-FMLA, shall be submitted in writing on a district form to the Superintendent of designee.

## Guidelines

Employees' eligibility for FMLA leave shall be based on the criteria established by law.[4][5]

Eligible employees shall be provided up to twelve (12) workweeks of unpaid leave in a twelve-month period for the employee's own serious health condition; for the birth, adoption, foster placement or first-year care of a child; to care for a seriously ill spouse, child or parent; or to address specific qualifying exigencies pertaining to a member of the Armed Forces alerted for foreign deployment or during foreign deployment.[5]

Eligible employees shall be provided up to twenty-six (26) workweeks of unpaid leave in a single twelve-month period to care for an ill or injured covered servicemember.[5]

The district shall utilize a rolling twelve-month period measured backwards from the date leave is used to determine if an employee has exhausted his/her FMLA leave in any twelve-month period.[6]

Instructional employees may be required to continue FMLA leave to the beginning of a grading period or term if conditions or leave are those specified in the FMLA.

When an employee requests an FMLA leave and qualifies for and is entitled to any accrued paid sick, vacation, personal or family leave, the employee is required to utilize such paid leave concurrent with the FMLA leave.[5]

In addition, employees on an approved FMLA leave are not permitted to hold employment outside the district.

Legal

1. 29 U.S.C. 2601 et seq
2. 29 CFR Part 825
3. 29 U.S.C. 2619
4. 29 U.S.C. 2611
5. 29 U.S.C. 2612
6. 29 CFR 825.200

Pol. 813

# Penn Hills School District

# EMPLOYEE LEAVE OF ABSENCE FORM

DATE:_____ EMPLOYEE NUMBER:_____

NAME:_____ BUILDING:_____

POSITION:_____ CERTIFICATION:_____

LEAVE START DATE:_____ LEAVE END DATE:_____

ANTICIPATED DATE OF RETURN:_____

TYPE OF LEAVE:
- [ ] Maternity
- [ ] Medical
- [ ] Sabbatical
- [ ] F.M.L.A.

PLEASE INDICATE NUMBER OF BENEFIT DAYS TO USE FOR PAYROLL AND ATTENDANCE RECORDS:

_____ Sick
_____ Personal
_____ Emergency
_____ Vacation
_____ Leave Without Pay
_____ Income Protection

_____ TOTAL NUMBER OF DAYS

Is substitute required for coverage during your leave?
- [ ] Yes
- [ ] No

Substitute Shadow Day Date(s): ____/____/____ Before Leave
____/____/____ After Leave

Information above subject to change if necessary.

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

**U.S. Department of Labor Wage and Hour Division**

WAGE AND 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 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. 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 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.)*

(4) Employee's job title: _____ Job description (☐ is / ☐ is not) attached.
Employee's regular work schedule: _____
Statement of the employee's essential job functions: _____
_____
*(The essential functions of the employee's position are determined with reference to the position the employee held at the time the employee notified the employer of the need for leave or the leave started, whichever is earlier.)*

## SECTION II - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form. Your patient has requested leave under the FMLA. 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 due to the serious health condition of the employee. 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 on page 4.

You 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.

**Employee Name:** _____

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

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

(3) 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.

☐ **Inpatient Care**: 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): _____

☐ **Incapacity plus Treatment**: *(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)*

☐ **Pregnancy**: The condition is pregnancy. List the expected delivery date: _____ *(mm/dd/yyyy)*.

☐ **Chronic Conditions**: *(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.

☐ **Permanent or Long Term Conditions**: *(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).

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

☐ **None of the above**: 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.

**Employee Name:** _____

(4) 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)* _____

_____

## PART B: Amount of Leave Needed

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 FMLA coverage.

(5) 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): _____

_____

(6) 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)*

_____

(7) Due to the condition, it is medically necessary for the employee to work a **reduced schedule**.

Provide your **best estimate** of the reduced schedule the employee is able to work. From _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)* the employee is able to work: *(e.g., 5 hours/day, up to 25 hours a week)*

_____

(8) 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.

(9) Due to the condition, it (☐ was / ☐ is / ☐ will be) medically necessary for the employee to be absent from work 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.

**Employee Name:** _____

## PART C: Essential Job Functions

If provided, the information in Section I question #4 may be used to answer this question. If the employer fails to provide a statement of the employee's essential functions or a job description, answer these questions based upon the employee's own description of the essential job functions. An employee who must be absent from work to receive medical treatment(s), such as scheduled medical visits, for a serious health condition is considered to be *not able* to perform the essential job functions of the position during the absence for treatment(s).

(10) Due to the condition, the employee (☐ was not able / ☐ is not able / ☐ will not be able) to perform *one or more* of the essential job function(s). Identify at least one essential job function the employee is not able to perform:

_____

_____

**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.<br>• 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:<br>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,<br>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. |

**FITNESS FOR DUTY TO RETURN FROM LEAVE CERTIFICATION**

An employee on Family and / or Medical Leave because of his/her own medical condition must present this release to his/her supervisor prior to or on the day he/she returns to work.

TO: Health Care Provider

Our employee, _____, began a period of medical care leave for his/her serious health condition on _____.
(date employee commenced leave)

As a condition of return to work, the employee must have a signed medical release. This form must be completed by his/her health care provider, before the employee is allowed to resume his/her job duties.

1. Employee Name: _____

1. Employer and Job Title: _____

1. Date of Medical Examination: _____

4. Date employee may return from leave

_____

5. Please indicate with a check mark the status of the employee's release for duty.

   A copy of this employee's job description is attached. Please review prior to completion of work status.
   Please note: Should employee not be released to his/her full duty position, the employer is not required to modify the position he/she was originally hired to perform.

   _____ Full, unrestricted duty (Skip question 6 and proceed to item 7.)
   _____ Modified duty (Complete question 6.)
   _____ Not released for any type of duty (Go to item 7.)

6. If you are releasing the employee to modified duty, you must complete the following:

   a. Estimated date that employee will be able to return to full, unrestricted duty:
      _____.
   b. Date of your next medical evaluation of the employee:
      _____.
   c. Indicate the <u>exact</u> work restrictions which apply to the employee at this time on the following chart.

**Employee's Name:**_____

**(Complete this section if the employee is being released to modified duty.)**

| PHYSICAL EXAMINATIONS | FULL RESTRICTIONS | PARTIAL RESTRICTIONS | NO RESTRICTIONS |
|---|---|---|---|
| Sedentary-Lifting 0 to 10 pounds | | | |
| Light-Lifting 10 to 20 pounds | | | |
| Moderate-Lifting 20 to 50 pounds | | | |
| Heavy-Lifting 50 to 100 pounds | | | |
| Pulling/Pushing, Carrying | | | |
| Reaching or working above shoulder | | | |
| Walking (hrs) | | | |
| Standing (hrs) | | | |
| Sitting (hrs) | | | |
| Stooping (hrs) | | | |
| Kneeling (hrs) | | | |
| Repeated Bending (hrs) | | | |
| Climbing (hrs) | | | |
| Operating a motor vehicle, crane, tractor, etc. | | | |
| Other: | | | |
| Exposure Limitation (Specify): | | | |

7. **I hereby certify that the foregoing facts are true and correct.**

_____ _____

Signature of Health Care Provider Date

_____ _____

Print Name of Health Care Provider Phone Number

_____

Type of Practice

_____

Address

_____

City State Zip

# Intermittent FMLA Tracking Form

Employee Name: _____ Month/Year: _____

Building: _____ Position Title: _____

You have requested the need for intermittent leave under the Family and Medical Leave Act.

You are eligible for up to 12 weeks of leave per 12 month rolling period under the Family Medical Leave Act and you will be reinstated to your job after your leave. Penn Hills School District will continue your health insurance during your leaves as per the regulations and your union contract. When a health care provider certifies a need for intermittent FMLA leave for a period exceeding 30 days, PHSD may not require additional certifications during that period unless a request is made to extend the leave, circumstances change significantly or PHSD receives information that casts doubt on the need for leave.

In order to document the dates and times that you are utilizing your leave, it is necessary that you complete the following form with each occurrence during each month.

Please submit the completed form by the end of each month to the Human Resource Office.
Please direct any questions that you may have to the Human Resource Office.
If your leave situation changes, you will need to submit a revised letter indicating the changes.

| DATE | TIME PERIOD OFF | FMLA TIME TAKEN (minimum ½ day pay per contract) | COVERAGE REQUIRED |
|---|---|---|---|
| Ex. 1/15/10 | 11:45 – 3:15 | 3.5 hours | Substitute required |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
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| | | | |
| | | | |
| | | | |

Signature: _____ Date: _____