SAN ELIZARIO INDEPENDENT SCHOOL DISTRICT
FMLA Request

This Family/Medical Leave of Absence is for the following **qualifying reason:**

____Birth of a child and to care for a newborn child of the employee.

____Placement with the employee of a child through adoption or foster care of a child.

____Care for the employee's spouse, dependent child, or parent of the employee who has a serious health condition.

Name/Relationship of person: _____

____A serious health condition that renders the employee unable to perform the functions of his or her job.

Anticipated date FMLA leave is to begin: _____ end: _____ (if known)

Immediate Supervisor: _____ was informed of this request on_____

Supervisor's Signature: _____

If the purpose of FMLA is to care for a sick family member or because of the employee's serious health condition, the leave may be taken intermittently or on a reduced schedule provided such arrangements are medically necessary. Campus approval for intermittent leave is required if the leave is taken because of a birth or placement of a child. I hereby agree that while I'm on leave, I will continue to pay my share of health insurance premiums, unless I elect to discontinue such coverage. I also agree that if I fail to work at the end of the leave period, I will reimburse the District for the cost of health benefits provided during my leave, unless I fail to return to work because of the continuation, recurrence or onset of a serious health condition. I will provide medical certification from the appropriate health care provider stating that I am unable to perform the functions of my position on the date that my leave expired or that I am needed to care for my spouse/parent/child because he/she has a serious health condition on the date that my leave expired. I understand that I may not be permitted to resume my position with the District, until I provide medical certification as appropriate.

_____ _____

Employee name (please print) **Campus/Department**

_____ _____

Employee signature **Date**

<u>This section to be completed by the HEALTH CARE PROVIDER:</u>

Certification of Health Care Provider (Family and Medical Leave Act of 1993):

Reason for Leave _____

Date leave will begin _____ Expected Return Date _____

_____

Signature of Health Care Provider **Date**

_____

Address & Phone Number **Date**

This section is to be completed by the Risk Management Department.

____ Leave of absence approved (FMLA eligibility requirements met)

____ Leave of absence *denied* because:

__ Employee does not meet FMLA eligibility requirements:

__ Employee does not have a **qualifying reason** for FMLA.

__ Employee's designated year allotment of FMLA (12 weeks) has been exhausted.

_____ _____

Risk Management Coordinator **Date**

SAN ELIZARIO INDEPENDENT SCHOOL DISTRICT
FMLA Request

NOTICE OF PLACEMENT ON FAMILY AND MEDICAL LEAVE

Date: _____

To: _____
(Employee's name)

From: _____
(Name of appropriate employer representative)

SUBJECT: Request for Family and Medical Leave

On _____(date), we became aware of your need to take family and medical leave for:

___ the birth of your child, or the placement of a child with you for adoption or foster care; or

___ a serious health condition that makes you unable to perform the essential functions of your job; or

___ a serious health condition affecting your __**spouse,** __ **child,** __ **parent**, for which you are needed to provide care, or
___ to run concurrently with workers' compensation leave.

This is to inform you that you are eligible and __ **have been** __ **will be** placed on FMLA leave beginning on _____ (date). This leave will be counted against your annual family and medical leave entitlement. We understand that your anticipated date of return to work is _____ (date if available).

If the circumstances of your leave will change and you're able to return to work sooner than the anticipated date you __ **will** __ **will not** be required to notify the district at least two workdays prior to the date you intend to report for work.

You have the right under FMLA to take up to 12 weeks of unpaid leave in a 12-month period for the reasons listed above. Your health benefits will be maintained during FMLA leave under the same conditions as if you continued to work, and 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 leave. 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 or (2) other circumstances beyond your control, you will be required to reimburse the district for its share of health insurance premiums paid on your behalf during your FMLA leave.

You __ **will** __ **will not** be required to furnish medical certification of a serious health condition. If required, you must furnish certification by _____ (date no sooner than 15 days after being given notice of this requirement) or the district may delay the commencement of your leave until the certification is submitted.

You __ **will** __ **will not** be required to furnish periodical medical certification of a serious health condition every _____ (indicate interval of periodic reports, as appropriate for the particular leave situation) during this period of family and medical leave.

You __ **will** __ **will not** be required to present a fitness-for-duty certificate prior to being restored to employment. If such certification is required but not received, your return to work may be delayed until the certification is provided.

NOTICE OF PLACEMENT ON FAMILY AND MEDICAL LEAVE

You __ **will** __ **will not** be required to use all applicable and available paid leave concurrently with FMLA leave.

If you normally pay a portion of the premiums for your health insurance, you must continue to pay for these premiums just as you did before FMLA leave. Arrangements for payment have been discussed with you and it is agreed that you will make premium payments as follows. (Set forth dates that specifically cover the agreement with the employee):

_____

_____

_____

You have a 30-day (or indicate longer period, if applicable) grace period in which to make premium payments. If payment is not made in a timely manner, your group health insurance may be cancelled, provided the district notifies you in writing at least 15 days before the date that your health coverage will lapse; or, at its option, the district may pay your share of premiums during FMLA leave and recover these payments from you upon your return to work. The district __ **will** __ **will not** pay your share of health insurance premiums while you are on leave.

The district __ **will** __ **will not** do the same with other benefits (e.g., life insurance, disability insurance, etc.) while you are on FMLA leave. If the district does pay your premiums for other benefits, when you return you __ **will** __ **will not** be expected to reimburse it for the payments made on your behalf.

SAN ELIZARIO INDEPENDENT SCHOOL DISTRICT
FMLA Request

MEDICAL CERTIFICATION FROM HEALTH CARE PROVIDER

1. Employee's Name

   _____

2. Patient's name (if different from employee)

   _____

3. Reason for Leave:

   1. [ ] Hospital Care
   2. [ ] Absence
   3. [ ] Pregnancy
   4. [ ] Chronic conditions requiring treatments.
   5. [ ] Permanent/long-term condition requiring supervision
   6. [ ] Multiple treatments (no chronic conditions)
   7. [ ] None of the above

Other notes and/or explanation:

_____

_____

4. Date leave will begin: _____
5. Expected return date: _____
6. Signature of Health Care Provider: _____
7. Print Name of Health Care Provider: _____
8. Address: _____
9. Phone Number: _____
10. Date (Health Care Provider completed this form): _____

SAN ELIZARIO INDEPENDENT SCHOOL DISTRICT
FMLA Request

FMLA Information for the Employee:

- You have the right under the FMLA for up to 12 weeks of leave from July 1st through June 30th for reasons listed on your request form. This absence will be counted as part of your annual FMLA leave entitlement of 12 weeks per year.
- If medical certification is required, it must be returned by the specified date or the District may deny leave.
- If your medical leave is due to a serious health condition other than intermittent absences, your health care provider MUST provide a Release/Return to Work form stating that you are fit to return to work. If this medical release is not received, your return to work may be delayed until such form is provided.
- If your leave is due to child placement in your home or is determined to be intermittent by your health care provider, you will NOT be required to present a medical release prior to being restored to employment.
- If you now pay a portion of the premiums for health insurance and other benefits, these payments will continue during the period of FMLA if you remain in pay status. Contact the Risk Management office concerning continuation of insurance and premium payments during FMLA. Failure to follow instructions provided may cause your health care and benefits coverage to be cancelled.
- You may be required to furnish recertification relating to a serious health condition.
- At the conclusion of FMLA, you will be reinstated to the same position held at the time the leave began or to an equivalent position with equivalent pay, benefits, and working conditions.
- If you do not return to work following FMLA for a reason other than
    1) recurrence, or onset of a serious health condition which would entitle you to FMLA leave, or
    2) other circumstances beyond your control, you may be required to reimburse the District for its share of health insurance premiums paid on your behalf during FMLA.

Received by Employee: _____on _____

This section to be completed by the Risk Management Office.

_____ _____

Departmental Signature **Printed Name**

Employee's Name: _____

Date given to Employee: _____

VIA: ____ US Mail ____ Hand Delivered ____ Other (specify): _____