

APPLICATION FOR LEAVE UNDER THE FAMILY AND MEDICAL LEAVE ACT

EMPLOYEE _____ POSITION _____

LEAVE REQUESTED From _____
To _____

If leave is requested on an intermittent or reduced leave schedule, describe the requested leave schedule:

REASON FOR LEAVE (check and complete as appropriate):

- ___ A. Because of the birth of a son or daughter of mine and in order to care for such son or daughter.
- ___ B. Because of the placement of a son or daughter with me for adoption or child care.
- ___ C. In order to care for my spouse, son, daughter, or parent, who has a serious health care condition (name ill family member and briefly describe condition): _____.
- ___ D. Because of a serious health care condition that makes me unable to perform the functions of my position (briefly describe condition):

_____.

LEAVE DEDUCTION

Your leave will be counted against your annual FMLA leave entitlement. The "leave year" is a "rolling" twelve-month period; measured backward from the date an employee last used an FMLA leave.

MEDICAL CERTIFICATION

If you checked Reasons A, B, C or D, you are requested to submit a written certificate from a health care provider (your ill family member's, for Reasons **B or C**; your own for Reasons A or D). The certification must be: (1) completed in substantial compliance with the Employer's "FMLA Certification of Physician or Practitioner" form, and (2) be submitted within 15 calendar days of your Application for Leave, or if such is not practicable under your circumstances, within the earliest time possible using diligent, good faith efforts. Failure to submit a sufficient timely certification may result in your leave request being denied until or unless the certificate is submitted, and if you have commenced leave before the

certificate was due, in the denial of continuation of your leave and in your absence being deemed unexcused.

REPORTS DURING LEAVE

During your leave, you will be required, upon employer's request, to provide: (1) subsequent recertification of medical certifications and (2) reports on your status and your intent to return to work.

SUBSTITUTION OF PAID LEAVE

If you checked Reasons A, B, C, or D, you have the right to substitute, if any, for the unpaid FMLA leave. If the employee does not have accrued paid vacation leave, personal leave, or sick leave, the additional FMLA leave will be unpaid leave.

HEALTH INSURANCE BENEFITS

Group health insurance benefits will be maintained during your leave, provided you pay the share of health plan premiums you paid prior to your leave, as may be adjusted due to changes in premium rates. To the extent substituted paid leave is used, your share of premiums will be paid by payroll deduction. To the extent the leave is unpaid, you must pay your share of premiums to the employer. Your payment must be received by the employer prior to the first day of each month during your leave.

If you fail to return to work after your FMLA leave entitlement is exhausted or expires, you will owe the employer's share of health insurance premiums, to the extent permitted by the FMLA, and the employer may deduct any sums otherwise due you to recover such debt, and use other legal means to collect such debt.

FITNESS-FOR-DUTY CERTIFICATE

If you checked Reason D, you will be required, prior to returning to work, to provide a certificate from your health care provider stating, in connection with the condition that caused your leave, that you are able to return to work.

RIGHT TO RESTORATION

Upon return from FMLA leave, you are entitled to be restored to the same position you held when the leave started, or to an equivalent position. The "equivalent position" is defined by School District policy. If you qualify as a "key" employee (an employee who is salaried and is among the highest paid 10 percent of employees within 75 miles of your work site), you may be denied restoration after leave if restoration would cause substantial and grievous economic injury to the operations of the employer.

I certify that the above information given by me is correct and that I have read the foregoing and understand my rights under the FMLA.

DATED this ____ day of _____, 20__.

BY: _____
Employee

Send notices to me at: _____

ACTION ON FMLA REQUEST

Your leave request dated the ____ day of _____, 20__ is _____ granted _____ denied, subject to your (check if applicable) _____ submitting sufficient medical certification within 15 calendar days of the above date. Substitution of paid leave will be made as follows:

- ___ days Vacation leave
- ___ days Personal leave
- ___ days Medical or Sick leave
- ___ a determination on substitution is unable to be made at this time; you will be notified when it is made

You _____ do _____ do not qualify as a "key" employee for FMLA restoration limitation purposes.

Comments:
_____.

DATED this ____ day of _____, 20__.

BY: _____, Superintendent
PLATTSMOUTH COMMUNITY SCHOOL DISTRICT

**PLATTSMOUTH COMMUNITY SCHOOLS
FMLA CERTIFICATION OF HEALTH CARE PROVIDER**

- 1. Employee's Name: _____
- 2. Patient's Name (If other than employee): _____
- 3. The attached sheet describes what is meant by a "serious health condition" under the Family and Medical Leave Act. Does the patient's condition¹ qualify under any of the categories described? If so, please check the applicable category.

(1)___(2)___(3)___(4)___(5)___(6)___, or ___ None of the above

- 4. Describe the **medical facts** which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories:

- 5.a. State the approximate **date** the condition commenced, and the probable **duration** of the condition (and also the probable duration of the patient's present incapacity² if different): _____

- b. Will it be necessary for the employee to take work only **intermittently or to work on a less than full** schedule as a result of the condition (including for treatment described in Item 6 below): ("yes" or "no")

If yes, give the probable duration: _____

- c. If the condition is a **chronic condition** (condition #4) or **pregnancy**, state whether the patient is presently incapacitated² and the likely duration and frequency of **episodes of incapacity**²:

- 6.a. If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments.

If the patient will be absent from work or other daily activities because of **treatment** on an **intermittent** or **part-time** basis, also provide an estimate of the probable number and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery, if any:

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

- 7.a. 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" or "no")

- b. 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** (the employee or the employer should supply you with information about the essential job functions)? _____ If yes, please list the essential functions the employee is unable to perform: _____

- c. If neither a. nor b. applies, is it necessary for the employee to be **absent from work for treatment**?

¹ Here and elsewhere on this form, the information sought relates **only** to the condition for which the employee is taking FMLA leave.

² "Incapacity," for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery therefrom.

- 8.a. 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?

b. If no, would the employee's presence to provide **psychological comfort** be beneficial to the patient or assist in the patient's recovery? _____

c. 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)

(Type of Practice)

(Address)

(Telephone number)

To be completed by the employee needing family leave to care for a family member:
State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule: _____

(Employee Signature)

(Date)

Return upon completion to:

_____, Superintendent
Plattsmouth Community Schools
1912 Old Hwy. 34
Plattsmouth, NE 68048

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

1. Hospital Care 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 inpatient care.
2. Absence Plus Treatment (a) A period of incapacity* of more than three consecutive calendar days (including any subsequent treatment or period of incapacity* relating to the same condition), that also involves:
 - (1) Treatment 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 care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or
 - (2) 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 Any period of incapacity* due to pregnancy, or for prenatal care.
4. Chronic Conditions Requiring Treatments A chronic condition which:
 - (1) Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;
 - (2) Continues over an extended period of time (including recurring episodes of a single underlying condition); and
 - (3) May cause episodic rather than a continuing period of incapacity* (e.g., asthma, diabetes, epilepsy, etc.).
5. Permanent/Long-term Conditions Requiring Supervision 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, a stroke, or the terminal stages of a disease.
6. Multiple Treatments (Non-Chronic Conditions) 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* of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).

Reviewed: Mar. 11, 2013, Feb. 10, 2014, Feb. 9, 2015, Feb. 8, 2016, Feb. 13, 2017

Revised: Oct. 9, 2017

Reviewed: Feb. 12, 2018, Feb. 11, 2019, Mar. 9, 2020, Mar. 8, 2021, Mar. 14, 2022, Mar. 13, 2023, Mar. 18, 2024