Timelines

Request for leave- (1st page) within 30 days of foreseeable leave.

Medical Certification- (2-4 pages) within 15 days of request.

Return to work form- (5th page) within one week of returning to work.

FMLA

EMPLOYEE REQUEST PACKET

SALDANA, MELISSA
CALALLEN ISD
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FAMILY/MEDICAL LEAVE
EMPLOYEE REQUEST FOR LEAVE FORM

1. Name of employee.	**2. Campus and position.**
3. Employee mailing address.	
4. Reason for requested leave. a. [ ] The birth of a child, or placement of a child with you for adoption or foster care, and to bond with the newborn or newly-placed child b. [ ]] Because of employee's own serious health condition that makes him/her unable to perform job functions c. [ ] You need to care for your family member due to a serious health condition. d. [ ] A qualifying exigency arising out of the fact that your family member is on covered active duty or has been notified of an impending call or order to covered active duty status. e. [ ] You are needed to care for your family member who is a covered servicemember with a serious injury or illness.	
5. If "c" please check one" [ ] Spouse [ ]Child [ ] Parent	**6. If "c" state name and address of relation.**
7. Date on which you wish to commence leave.	**8. Date of anticipated return to work (<u>REQUIRED</u>).**
9. Are you requesting leave on an intermittent or reduced leave schedule? [ ] Yes [ ] No	**10. If "Yes," please give schedule of when you anticipate you will be unavailable for work.**

Employee seeking leave must provide medical certification within 15 days or as soon as practicable.

Employees seeking to return to work after a leave because of their own serious illness [reason "4(b)"], also must provide a medical certification of ability to perform job duties before they are allowed to resume to work.

I hereby agree that while I am 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 return 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 or because of other circumstances beyond my control. If I am unable to return to work because 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.

Signed _____ Dated _____

Return to:
Calallen ISD Human Resources
4205 Wildcat Dr.
Corpus Christi, TX 78410

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Fax: 361-242-7552
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Calallen ISD
178903
COMPENSATION AND BENEFITS
LEAVES AND ABSENCES

Medical Certification Statement for Employee

This form must be completed when requesting Family and Medical Leave on Application for Leave form.

SECTION I: INSTRUCTIONS to the EMPLOYEE: Please complete this section before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). **Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313**. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Employee's name: _____ Date _____

SECTION II: INSTRUCTIONS to the 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.

Health Care Provider's name: *(Print)* _____

Heath Care Provider's business address: _____

Type of practice /Medical specialty: _____

Telephone (___) _____ Fax (___) _____ Email:_____

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, applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

Medical Certification Con't

- ❑ **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.

(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)** (schedule 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: *(cardiologist, physical therapy)* _____

Provide your **best estimate** of the beginning date _____ *(mm/dd/yyyy)* and end date _____ *(mm/dd/yyyy)* for treatments.

Provide your **best estimate** of the duration of the treatment(s), including any period of recovery *(e.g., 3 days/week)*

_____

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Medical Certification Con't

(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 this 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, episode of incapacity are estimated to occur _____ times per (❑ day / ❑ week / ❑ month) and are likely to last approximately _____ (❑ hours / ❑ days) per episode.

_____ _____

Signature of Health Care Provider **Date**

Definitions of a Serious Health Care Condition *See 29 C.F.R. §§ 825.113-.115)*
Inpatient Care
• An overnight stay in a hospital, hospice, or residential medical care facility. • 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: • 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, • 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. 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.

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FAMILY/MEDICAL LEAVE

Employee Return to Work Form

This form must be handed in to the personnel department one (1) week prior to the anticipated date of return.

Section A. To be completed by Employee.

1. Name of employee:_____
2. Employee's campus and position:_____
3. Reason for original request of leave was:
   a. [ ] The birth of a child, or placement of a child with you for adoption or foster care, and to bond with the newborn or newly-placed child
   b. [ ] Because of employee's own serious health condition that makes him/her unable to perform job functions
   c. [ ] You need to care for your family member due to a serious health condition.
   d. [ ] A qualifying exigency arising out of the fact that your family member is on covered active duty or has been notified of an impending call or order to covered active duty status.
   e. [ ] You are needed to care for your family member who is a covered servicemember with a serious injury or illness.
4. Original date requested for leave to commence:_____
5. Actual date you have been released to return to work:_____

Section B. To be completed by health care provider.

[ ] the employee is able to return to work as of_____(date) without restrictions.

[ ] the employee can return to work as of_____(date) with the following restrictions, which are expected to last through_____(date).

Restrictions:

_____

_____

_____ _____

Signature of Health Care Provider **Date**

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