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

REQUEST FOR FAMILY MEMBER PACKET

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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 above 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 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. **Signed**_____**Dated**_____	

Medical Certification Statement for Family Member

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

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees' family members, 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.

SECTION I: INSTRUCTIONS to the EMPLOYEE: Please complete and sign Section II before providing this form to your family member or your family member's health care provider. The FMLA allows an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of your family member. If requested by your employer, your response is required to obtain or retain the benefit of the FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). **You are responsible for making sure the medical certification is provided to your employer within the time frame requested, which must be at least 15 calendar days.** 29 C.F.R. §§ 825.305-825.306. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA leave request. 29 C.F.R. § 825.313.

(1) Name of family member for whom you will provide care: _____

(2) Select the relationship of the family member to you. The family member is your:

❑ Spouse ❑ Parent ❑ Child under age 18 ❑ Child 18 years or older and incapable of self-care because of a mental or physical disability

Spouse means a husband or wife as defined or recognized in the state where the individual was married, including in a common law marriage or same-sex marriage. The terms "child" and "parent" include in *loco parentis* relationships in which a person assumes the obligations of a parent to a child. An employee may take FMLA leave to care for an individual who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave to care for a child for whom the employee has assumed the obligations of a parent. No legal or biological relationship is necessary.

(3) Briefly describe the care you will provide to your family member: *(Check all that apply)*:

❑ Assistance with basic medical, hygienic, nutritional, or safety needs ❑ Transportation
❑ Physical Care ❑ Psychological Comfort Other: _____

(4) Give your **best estimate** of the amount of leave needed to provide the care described: _____
_____

(5) If a **reduced work schedule** is necessary to provide the care described, give your **best estimate** of the reduced schedule you are able to work. From _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)* I am able to work _____ *(hours per day)* _____ *(days per week)*.

Employee Signature _____ **Date:** _____*(mm/dd/yyyy)*

SECTION II: INSTRUCTIONS to the HEALTH CARE PROVIDER: Please provide your contact information, complete all relevant parts of this Section, and sign the form below. A family member of your patient has requested leave under the FMLA to care for your patient. The FMLA allows an employer to require that the employee submit a timely, complete, and

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sufficient medical certification to support a request for FMLA leave to care for a family member with a serious health condition. 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 at the end of the form.

You also 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 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) Patient's Name: _____

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

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

(4) For FMLA to apply, care of the patient must be medically necessary. Briefly describe the type of care needed by the patient (*e.g., assistance with basic medical, hygienic, nutritional, safety, transportation needs, physical care, or psychological comfort)*. _____

_____

(5) 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.

- ❑ **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).*

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- ❑ **Chronic Conditions**: *(e.g. asthma, migraine headaches)* Due to the condition, it is medical 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.

(6) 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.

(7) 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): _____

_____

(8) 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)*

_____

(9) 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 _____ *(mm/dd/yyyy)* and end date _____ *(mm/dd/yyyy)* for the period of incapacity.

(10) 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:** _____*(mm/dd/yyyy)*

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) [ ] You need to care for your family member due to a serious health condition.
b) [ ] 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.
c) [ ] 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 will return to work:_____

_____ _____

Signature of Employee **Date**

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

Office: 361-242-5600 ext. 10016
Fax: 361-242-7552
Email: msaldana@calallen.org