



HUMAN RESOURCES DEPARTMENT

651-351-8340



www.stillwaterschools.org



1875 South Greeley Street
Stillwater, MN 55082



Employees of Stillwater Area Public Schools are eligible for family and medical leave if they have at least 12 months of service with the District and have worked at least 1,250 hours within the preceding 12 month period. The following information is provided to enable you to formally apply for family or medical leave under the provisions of the Family and Medical Leave Act.

1. Letter of Eligibility, Rights and Responsibilities (including how to continue group health and dental insurance)
2. FMLA Application Form to be received at least 30 days before the start of leave (except in emergencies)
3. Medical certification letter to be returned within 15 days of start of leave, if applicable
4. Official Notice of Family & Medical Leave Act

Cooperation with all requests for information regarding FMLA qualifying absences is essential: failure to comply may result in a leave being delayed or denied. Should you have any questions, please contact:

Deb Villafania at 351-8316 (Administrators, Principals, Teachers, CSS / TS & Custodians)
Kris Ann McIntyre at 351-8313 (Cafeteria, Para, SAC)

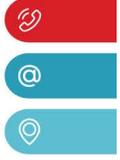


HUMAN RESOURCES DEPARTMENT

651-351-8340

www.stillwaterschools.org

1875 South Greeley Street
Stillwater, MN 55082



The Family and Medical Leave Act ("FMLA") protects your position and benefits during a qualified absence for up to 12 weeks in a rolling calendar 12 month period. Based on our records you have requested a leave of absence that may meet the FMLA criteria. If your leave of absence qualifies, the following rights and obligations apply to your family and/or medical leave of absence:

1. If you take a qualified leave of absence, it will be counted against your annual cumulative 12 weeks of available family and medical leave.
2. If your request for leave is due to the birth of a child or for the placement of a child for adoption or foster care, the leave must be taken within the twelve month period beginning with the date of such birth or placement for adoption or foster care (or first duty day used for family and/or medical leave of absence in the fiscal year).
3. If your request for leave is to care for your seriously ill immediate family member, or due to your own serious health condition, please provide the Human Resources Department with a medical certification issued by the physician of your ill family member or your physician. The medical certification form is enclosed in this packet. The physician certification must be returned to the Human Resources Department within 15 days from the date of this letter. If you fail to provide timely certification, the school district may deny your FMLA until the certification has been provided.
4. If the district doubts the validity of the physician's certification, it may require you to obtain a second opinion at the district's expense. If the opinions of the first and second physicians differ, the district may require you to obtain certification from a third physician at the district's expense. The district may also request re-certification at reasonable intervals.
5. FMLA can be a paid absence, an unpaid absence or it can be a combination of both. FMLA protection does not mean that the absence is paid. If you are eligible for and have accrued other forms of leave which are paid (such as vacation, sick leave, etc.), the district may allow you to substitute available paid leave for a portion of your FMLA.
6. For your health, dental or other benefits to continue during your FMLA leave, you must maintain your share of premium payments, including any changes in such premiums. The school district will continue to deduct your payments from your pay during the paid portions of your leave. Should any portion of your leave be unpaid, you are responsible for making these payments yourself. Call your Human Resources Technician to arrange continuation of coverage.
7. During your FMLA, unless your premium payment is more than thirty days late, the district will maintain coverage under any health and dental plan for the duration of such leave. However, the district may recover the premiums paid for maintaining coverage for you if you fail to return to work for reasons other than the continuation, recovery from, or additional onset of a serious health condition entitling you to FMLA or other circumstances beyond your control. If your inability to return to work is extended, the district may require additional certification.
8. While you are on FMLA, you must report to the Human Resources Department every four work weeks regarding your status and your intent to return to work upon the conclusion of the leave.
9. Spouses who are both employed by ISD 834 are permitted to take only a combined total of 12 weeks FMLA for ¹birth and care of a newborn child, ²placement of a child for adoption or foster care, or ³to care for a parent (not a parent-in-law) who has a serious health condition during a 12 month period.
10. Returning to Work: If your FMLA is due to your own serious health condition which makes you unable to perform your job, the district will require you to present a final medical certification statement from your physician indicating you are able to return work. Until such documentation is received, the district may deny you the right to return to work.
11. "Key" Employees Returning to Work: If you are a Key Employee, defined as a salaried FMLA-eligible employee who is among the highest paid ten percent of all employees within ISD 834, the district may deny you reinstatement to the same or equivalent position if such denial is necessary to prevent substantial and grievous economic injury to the operations of the district.

Should you have any questions at all regarding FMLA, please don't hesitate to contact the Human Resources Department.

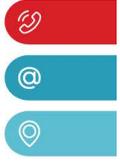


HUMAN RESOURCES DEPARTMENT

651-351-8340

www.stillwaterschools.org

1875 South Greeley Street
Stillwater, MN 55082



Disability Leave & Parental Leave

Please review the entire sections on a Disability and/or Parental Leave in your **Master Contract** and if you have any additional questions, please feel free to call your Human Resource Technician.

Deb Villafania at 351-8316 (Teacher / Principal / District Director / CSS & TS)

Kris Ann McIntyre at 351-8313 (Cafeteria / Custodian / Para / SAC)

You have the right to request a parental leave without pay after your physician verifies that you are physically able to return to work. In accordance with the policy of Independent School District #834 an employee must notify district officials at least one month prior to a requested leave.

During the first three months of a parental leave, all Stillwater Area Public Schools' provided benefits will continue in the same manner as for active employees if your contract language allows.

After the initial three-month period, you are eligible to continue your benefits for the duration of your leave by paying the full monthly premiums (COBRA). If you do not continue your benefits, your insurance will terminate as of the last day of the third month of your parental leave. Please note the District does not provide a VEBA contribution while on COBRA.

The following forms must be completed and returned to the Human Resources Department for a Disability Leave and Parental Leave request:

FMLA Application

You must complete this form and indicate whether a parental leave will be utilized. Have your principal or supervisor sign the form, and return it to the Human Resources Department. If there is a change in your parental leave please submit an updated FMLA Application at least one month prior to your requested leave.

Medical Certification Statement

If you are put on disability before you deliver your baby, your physician must complete this form which verifies the last day you can fulfill your work responsibilities.

And/Or:

Your physician must complete this form following the termination of your disability to verify when you will be physically able to return to work.

During the time you are unable to work you will use sick leave to continue your regular salary. If you should need to utilize Short Term Disability benefits after you have exhausted your sick leave, you will be compensated on the 15th and last day of each month at the percentage stated in your Master Contract.

Benefits Change Form

If the reason for parental leave is occasioned by pregnancy, your newborn child is covered under your coverage for 30 days from the date of birth. However, you have 30 days from the date of birth to add your newborn to your family coverage. You will not have to submit evidence of insurability if you enroll your newborn within 30 days. However, your spouse (and other family members) may have to submit evidence of insurability to the insurance company.



HUMAN RESOURCES DEPARTMENT

651-351-8340

www.stillwaterschools.org

1875 South Greeley Street
Stillwater, MN 55082



FAMILY AND MEDICAL LEAVE (FMLA) APPLICATION

Employee's Name _____ Job Title _____ Date _____

Supervisor Signature _____ Location _____

TYPE OF LEAVE: *(Check one)*

Family Medical Leave start date _____ End date _____

Have you taken a Family/Medical Leave within the last 12 months?

No Yes (Date of Previous Leave: _____)

This Family/Medical Leave is for:

Birth/Adoption/Foster care of a child Serious health condition of employee

Serious health condition of family member:

Child Spouse Parent

Will you use any accrued sick leave during this leave? No Yes How many days? _____

If enrolled in the Sick Bank, would you like to request sick bank days? No Yes How many days? _____

Will you use any accrued vacation time during this leave? No Yes How many days? _____

Will you take this leave in an intermittent/reduced schedule? No Yes How many days? _____

EMPLOYEE ACKNOWLEDGEMENT

I understand that my insurance benefits will continue during my leave provided I go on paying the employee portion of the premium. I am aware that if the insurance premium is not deducted from my paycheck, it is due by the twenty fifth (25th) of each month. If payment is not made within 30 days, I understand that my benefits may be discontinued.

I understand that the school district will return me to the same or an equivalent position on return from leave unless subject to restoration provisions for "key employees." However, I will not be eligible for reinstatement if a workforce reduction or layoff occurs while I am on leave and I would have been affected had I been working full time or part-time.

I understand that the leave for a serious health condition of an employee or covered family member requires medical certification, completed by the medically disabled individual's physician: 1) before the leave begins or as soon as practical; 2) while on leave to re-certify medical need as necessary; and 3) authorizing return to work for employee's own illness to determine fitness for duty.

Employee's Signature

Date

Human Resources Department Approval

Date



HUMAN RESOURCES DEPARTMENT

651-351-8340

www.stillwaterschools.org

1875 South Greeley Street
Stillwater, MN 55082



Medical Certification Statement

1. Employee's Name _____ 2. Patient's Name (*If different*) _____

3. Nature of Condition: Describe the medical facts which support your certification, including a brief statement as to how the medical facts meet the criteria of a **“serious health condition”** (*page 3 describes serious health condition*) _____

4a. Date condition commenced _____ 4b. Probable duration of condition _____

4c. Will it be necessary for the employee to take work only **intermittently or to work on less than a full schedule** as a result of the conditions (including for treatment described in question 5 below)

Yes No

If yes, give the probable duration: _____

5a. If additional **treatments** will be required for the condition, provide an estimate of the probable number of such treatments: _____

5b. If any of these treatments will be provided by **another provider of health services** (e.g., physical therapist), please state the nature of treatments: _____

5c. If a **regimen of continuing treatment** by the patient is required under your supervision, provide a general description of such regimen: _____

5d. Was medication, other than over-the-counter medication, prescribed? Yes No



HUMAN RESOURCES DEPARTMENT

651-351-8340

www.stillwaterschools.org

1875 South Greeley Street
Stillwater, MN 55082



Employee

6a. 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 No Does not apply

6b. 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** (Answer after reviewing statement from employer of essential functions of employee's position, or if none provided, after discussion with the employee.)

Yes No Does not apply

6c. If neither a. nor b. applies, is it necessary for the employee to be **absent from work for treatment**?

Yes No

Family Member

7a. 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?

Yes No

7b. If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery?

Yes No

7c. 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

Date

Type of Practice

() _____
Telephone Number

Address

() _____
Fax Number

*Note: Due to the confidential nature of this information, please return the completed form marked "Strictly Confidential" to:

Human Resources/ Stillwater Area Public Schools/1875 S. Greeley Street/ Stillwater, MN 55082/ Fax: (651) 351-8330



HUMAN RESOURCES DEPARTMENT

651-351-8340

www.stillwaterschools.org

1875 South Greeley Street
Stillwater, MN 55082



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 incapacity² or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

(a) A period of incapacity² of **more than three consecutive calendar days** (including any subsequent treatment or period of incapacity² relating to the same condition), that also involves:

- (1) **Treatment³ 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 treatment⁴** 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 incapacity² (e.g., asthma, diabetes, epilepsy, etc.).

5. Permanent/Long-term Conditions Requiring Supervision

A period of **Incapacity²** 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 severe 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 Incapacity² 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), and kidney disease (dialysis).

This optional form may be used by employees to satisfy a mandatory requirement to furnish a medical certification (when requested) from a health care provider, including second or third opinions and recertification (29 CFR 825.306).

Note: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

³ Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

⁴ A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

Public Burden Statement

We estimate that it will take an average of 20 minutes to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, Department of Labor, Room S-3502, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE; IT GOES TO THE EMPLOYEE.