Clayton County Public Schools Division of Human Resources and Strategic Improvement

Request for Family and Medical Leave (FML) Packet Guidelines for the Employee

This leave of absence packet will help guide you through the medical leave process. Please fully review the contents of this packet and complete the necessary steps listed below:

Action Steps:

- **Initiate Your Leave:**
  - The employee should complete the Medical Request for Leave Form and submit to his/her immediate supervisor and directly to the Division of Human Resources within thirty (30) days of anticipated need for leave.
  - If the need for leave is unforeseen, the employee must provide notice as soon as practical. If leave is unforeseeable, the employee must notify the Division of Human Resources Benefits Unit: Leave Management as soon as possible.
  - Completed forms should be either submitted to Clayton County Public Schools (CCPS) Division of Human Resources by email to FamMedLeave@clayton.k12.ga.us or delivered to Clayton County Public Schools, Division of Human Resources Benefits Unit – Attn: FamMedLeave, 1058 Fifth Avenue, Jonesboro, GA 30236.

Instructions for completing the Family and Medical Leave Request Form:

Step 1: Employee Information

Please provide your CCPS Employee I.D. Number or Social Security Number, home address, contact number, and email address.

Note: All HR correspondence will be sent to the requesting leave employee via email.

Step 2: Absence Information/ Types of Leave and Definitions

Continuous Leave is defined as leave taken in one long, uninterrupted block of time from start to finish (*For example*, November 1st through November 10th).

Intermittent Leave is defined as leave taken periodically, an hour or two at a time, a day or two at a time over the course of several weeks or months. (*For example*, reduced schedule, one day per week or month for appointments, treatment, therapy, etc.).

List the beginning and ending date of your anticipated leave. If you do not have the exact dates, please provide best estimate.

Step 3: Leave is Required For:

The employee should select the reason for leave (i.e. employee, family member or birth/adoption of a child).

- Supporting documentation is required (i.e. Medical Certification Form, official military identification for the Military Caregiver Request or Military Orders).
- When requesting Paid Parental Leave (PPL), you must specify the 15 days of leave on your request form.

Request for Leave Packet Continued

Step 4: Signatures

- Employee sign and date
- Obtain supervisor's signature and date

Forms are not accepted without BOTH signatures

Complete the Certification of Health Care Provider Form:

- Certification must be completed by a licensed physician and submitted to the Division of Human Resources within 15 calendar days of last day worked.
- Medical certification must include the following:
    1. Medical certification substantiating a serious health conditions that requires FML due to the employee inability to work or required to care for a qualified family member;
    2. The beginning and estimated ending date of employee's need for leave (or estimated duration of FML Leave);
    3. Confirm there is a regiment of treatment; and
    4. Health care provider's signature

AND/OR

(Intermittent FML) – Medical certification that the condition has or will cause episodic flare-ups periodically preventing employee or family member from participating in normal daily activities.

5. Based upon medical history and the doctor's knowledge of the medical condition, an estimate of the frequency of flare-ups and duration of related incapacity that may cause the employee to miss work over the next 6 months (such as one episode every 3 months lasting 1-2 days) and
6. Health care provider's signature

Intent to Return and/or Fitness for Duty Form, after doctor release

Step 1

- Enter your name, phone number and email address.
- Please provide authorization by signing and date

Step 2

- Attach your Job Description

Step 3

- Health care provider completes Section III.

Note: It is the employees' responsibility to ensure this form is returned to Clayton County Public Schools at least seven business days prior to returning to work .

Submit forms to the Division of Human Resources either by email to FamMedLeave@clayton.k12.ga.us or delivered to Clayton County Public Schools, Division of Human Resources, Benefits Unit – FamMedLeave, 1058 Fifth Avenue, Jonesboro, GA 30236.

Clayton County Public Schools
Division of Human Resources Strategic and Improvement

FAMILY AND MEDICAL LEAVE REQUEST FORM

EMPLOYEE INSTRUCTIONS

The employee must complete this form to request a medical leave of absence. Upon completion, the form should be submitted to the Division of Human Resources and Strategic Improvement by email at FamMedLeave@clayton.k12.ga.us or delivered to 1058 Fifth Avenue, Jonesboro, GA 30236.

EMPLOYEE INFORMATION

EMP ID_____**First Name**_____**MI**____**Last Name** _____

Complete Address_____**City**_____**Zip Code** _____

Phone Number_____**Alt. Phone Number** _____

Personal Email Address _____**@**_____

(All correspondence will be sent via email only)

School/Department_____**Position**_____

Employee's Supervisor/Manager _____**Phone Number** _____

FAMILY AND MEDICAL LEAVE INFORMATION

Type of Leave Requested ◯ **Continuous Days** ◯ **Intermittent** ◯ **Paid Parental Leave**

I am requesting Family and Medical Leave for the following dates (*maximum of 12 weeks per rolling calendaryear*)

_____ _____ _____

Beginning Date **Ending Date** **Anticipated Return to Work Date**

Before processing the request, the employee must provide anticipated (estimated) leave dates as requested.

I am requesting Paid Parental Leave for the following dates (*maximum of 6 weeks*)

_____ _____

Beginning Date **Ending Date**

LEAVE IS REQUIRED FOR:

Serious Health Condition Check one:

◯ **Employee**
OR
◯ **Spouse (*name*)**_____**OR**

◯ **Parent (*name*)**_____**OR**

◯ **Child (*name*)**_____**AGE** _____

◯ **Birth of Child**
Or
◯ **Adoption of a Child**

◯ **Placement of Child**
(Must provide supporting documentation)

Date (or expected date) of birth, adoption, or placement of a foster child: _____

Military:

◯ **Qualifying Exigency (call to active duty)** ◯ **To care for a covered service member with a qualified serious injury or illness**

◯ **Self** ◯ **Spouse** ◯ **Son** ◯ **Daughter** ◯ **Parent (do not include in-laws** ◯ **Next of Kin**

Supporting documentation is required (i.e., copy of official orders)

Signature of Employee:_____ **Date:** _____

The signature below indicates knowledge of leave and that the employee is applying for Family Medical Leave:

Signature of Principal/Supervisor:_____ **Date:**_____

Print Principal/Supervisor name: _____

Return the completed FML application to Clayton County Public Schools Division of Human Resources and Strategic Improvement at FamMedLeave@clayton.k12.ga.us or deliver to 1058 Fifth Avenue, Jonesboro, GA 30236.

Clayton County Public Schools Division of Human Resources
MEDICAL RELEASE INTENT TO RETURN TO WORK AND FITNESS FOR DUTY

SECTION I – To be completed by EMPLOYEE/PATIENT

First Name_____ **MI** ____ **Last Name** _____

Phone Number _____ **Personal Email Address** _____

I authorize the health care provider identified for determining my fitness for duty. In addition, I authorize a designated CCPS Human Resources professional to contact the health care provider to authenticate and/or certify the information if needed. I understand that if I do not agree to this authorization, my return to work may be delayed or denied, which may result in termination of employment.

Employee's Signature: _____ **Date:** _____

An employee who fraudulently obtains Family Medical Leave will be subject to disciplinary action, up to and including termination.

SECTION II – Instructions for EMPLOYEE

Attach a Job Description

SECTION III: To be completed by HEALTH CARE PROVIDER

Place Stamp Here

Name of Health Care Provider _____
Address _____
Phone Number_____

PLEASE COMPLETE THE FOLLOWING AND RETURN THE FORM TO THE EMPLOYEE/PATIENT OR TO THE DEPARTMENT CONTACT LISTED BELOW PRIOR TO THE RETURN TO WORK DATE

Important: Please limit your answers below to the serious health condition for which the Employee has been on leave.

THE GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA): The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

1. **Is the employee now able to perform those essential functions of his or her job that could not previously be performed because of the serious health condition for which the employee has been on leave?**

   ☐ **No** ☐ **Yes** ☐ **Yes, with restrictions**

2. **Employee released to return to work effective:** _____ **[Indicate date]**

3. **If the employee is released to work but is restricted in his or her ability to perform the essential functions of his or her job as a result of the serious health condition for the employee has been on leave, please describe those restrictions:**
4. **The forgoing restrictions are**

   ☐ **Permanent**
   ☐ **Temporary, until** _____ **[Indicate date]**

Signature of Health Care Provider: _____ **Date:** _____

Return completed form to: Clayton County Public Schools, Division of Human Resources, Benefits Unit at: 1058 Fifth Avenue, Jonesboro, GA 30236 or email to FamMedLeave@clayton.k12.ga.us

This form is protected by HIPPA

Certification of Health Care Provider for Employee's Serious Health Condition under the Family and Medical Leave Act

U.S. Department of Labor
Wage and Hour Division

WAGE AND HOUR DIVISION

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR. RETURN TO THE PATIENT.

OMB Control Number: 1235-0003
Expires: 6/30/2026

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. 29 U.S.C. §§ 2613, 2614(c)(3); 29 C.F.R. § 825.305. The employer must give the employee at least 15 calendar days to provide the certification. If the employee fails to provide complete and sufficient medical certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

SECTION I - EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, this form asks the health care provider for the information necessary for a complete and sufficient medical certification, which is set out at 29 C.F.R. § 825.306. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308.** Additionally, you **may not** request a certification for FMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care.

Employers must generally maintain records and documents relating to medical information, medical certifications, recertifications, or medical histories of employees 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.

(1) Employee name: _____
First Middle Last

(2) Employer name: _____ Date: _____ (mm/dd/yyyy)
(List date certification requested)

(3) The medical certification must be returned by _____ (mm/dd/yyyy)
(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee's diligent, good faith efforts.)

(4) Employee's job title: _____ Job description ☐ is / ☐ is not attached.

Employee's regular work schedule: _____

Statement of the employee's essential job functions:

_____

(The essential functions of the employee's position are determined with reference to the position the employee held at the time the employee notified the employer of the need for leave or the leave started, whichever is earlier.)

SECTION II - 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 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, such as providing the diagnosis and/or course of treatment.

Employee Name: _____

Health Care Provider's name: (Print) _____

Health Care Provider's business address: _____

Type of practice / Medical specialty: _____

Telephone: _____ Fax: _____ E-mail: _____

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, as 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).

☐ **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.

Employee Name: _____

(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)** (scheduled 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: (e.g. cardiologist, physical therapy) _____

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

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

_____

(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 the 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, episodes of incapacity are estimated to occur _____ times per (☐ day ☐ week ☐ month) and are likely to last approximately _____ (☐ hours ☐ days) per episode.

Employee Name: _____

PART C: Essential Job Functions

If provided, the information in Section I question #4 may be used to answer this question. If the employer fails to provide a statement of the employee's essential functions or a job description, answer these questions based upon the employee's own description of the essential job functions. An employee who must be absent from work to receive medical treatment(s), such as scheduled medical visits, for a serious health condition is considered to be **not able** to perform the essential job functions of the position during the absence for treatment(s).

(10) Due to the condition, the employee (☐ was not able / ☐ is not able / ☐ will not be able) to perform **one or more** of the essential job function(s). Identify at least one essential job function the employee is not able to perform:

_____

Signature of Health Care Provider _____ Date: _____ (mm/dd/yyyy)

Definitions of a Serious Health 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: o 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, o 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 of time. 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.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 15 minutes for respondents 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 information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR. RETURN TO THE PATIENT.