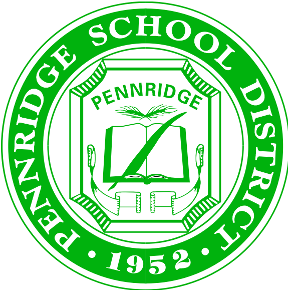


PENNRIDGE SCHOOL DISTRICT

DISTRICT ADMINISTRATION OFFICE

1200 North Fifth Street ● Perkasie, Pennsylvania 18944

OFFICE OF HUMAN RESOURCES

FMLA LEAVE PACKET

Below is a list of the items contained in this leave packet. Please read the following documents thoroughly. Once you have completed the attached paperwork you may submit your documents to HR and contact the Benefits office to set up an appointment to go over any questions you may have.

WHAT'S INSIDE	**WHAT YOU NEED TO DO:**
1. Application for leave	Complete Have your supervisor sign off Send to Human Resources
2. FMLA Fact Sheet	Review
3. Sick Leave Policy	Review
4. FMLA Policy	Review
5. WHD Health Care Provider form - Employee	Have your doctor complete Send to Human Resources
6. WHD Health Care Provider form - Employee's Family Member	Have your family member's doctor complete Send to Human Resources
7. ADA Accommodations Healthcare Provider Certification	Have your doctor complete only if needed
8. Madison LTD and Sick Use During Leave Form	Complete Return to Human Resources
9. Madison Application Mailing Instructions	Review
10. Madison Employee Application	Complete if you intend to apply for disability Mail to Madison National Life Insurance
11. Madison Attending Physician Statement	Have your doctor complete if you intend to apply for disability Mail to Madison National Life Insurance
12. Health Insurance coverage During Leave Form	Complete Return to Human Resources
13. Leave FAQ's	Review

Human Resources
Pennridge District Office
1200 N. Fifth Street
Perkasie, PA 18944
215-453-2716
nfoster@pennridge.org

PENNRIDGE SCHOOL DISTRICT

APPLICATION FOR LEAVE OF ABSENCE

REQUESTING A LEAVE

1. Employees must complete and submit to the building principal or supervisor this *Application for Leave*. Use the best information available if definite start and end dates are unknown. It is essential that you provide the Human Resources office with updated information, when it is available.

2. Notification of the school board's approval of the application will be mailed to the employee immediately following Board approval.

Name: ______________________________ **Date:** ______________

Position: ______________________________ **Building:** ______________

Length of Leave Requested: First Day out: __________ Date of Expected Return: ______________

I request a leave for the following reason:

☐ My personal serious health condition other than the birth of my child. (This notification must be accompanied with the "Certification of Health Care Provider" form).
(The District will utilize accrued sick leave running concurrently with up to a 12 week FMLA entitlement per Board Policy based upon a physician's order).

- ☐ My physician has completed the Certification of Health Care Provider Form and it is attached.
- ☐ My physician is in the process of completing the Certification of Health Care Provider Form and it will be forthcoming.

☐ My personal serious health condition for the birth of my child. (This notification must be accompanied with the "Certification of Health Care Provider" form).
(The District will utilize accrued sick leave running concurrently with up to a 12 week FMLA entitlement per Board Policy based upon a physician's order).

- ☐ My physician has completed the Certification of Health Care Provider Form and it is attached.
- ☐ My physician is in the process of completing the Certification of Health Care Provider Form and it will be forthcoming.
  - ☐ Unpaid Child Rearing Leave (to commence after my disability period per physician's order).

☐ Adoption of a child by me (12 week maximum FMLA entitlement- unpaid). (This notification must be accompanied with the appropriated notarized court documentation).

☐ Placement (by the state) of child with me for foster care (12 week maximum FMLA entitlement- unpaid). (This notification must be accompanied with the appropriated notarized court documentation).

☐ The serious health condition of my child, parent or spouse (12 week maximum FMLA entitlement-unpaid). (This notification must be accompanied with the "Certification of Health Care Provider" form).

☐ Unpaid leave of absence (This request must be accompanied by a formal request submitted in writing and subject to approval by Superintendent and the Board of Education)

☐ Other: ____

If you require an extension of your leave, please update your original request below and resubmit to Human Resources:

☐ Extension of Employee Medical Leave of Absence (This notification must be accompanied with the "Certification of Health Care Provider" form).
Dates of prior approved leave are: ________________ to _______________

☐ Extension of Unpaid Leave of Absence
Dates of prior approved leave are: ________________ to _______________

In completing this written request for Leave, I attest that the information provided is to the best of my knowledge factual. I further attest that I have read and understand the FMLA Notice posted by my Employer. In addition, I recognize if I am requesting Leave for Medical reasons that I must submit a completed Certification of Health Care Provider form and that my Employer maintains the right to request an alternate medical review (at its own expense) of the facts and circumstances surrounding my request for Medical Leave. Moreover, I recognize that my employer will require that I use all of my available accrued sick leave up to the approval for disability compensation.

____ ____________________
Employee Signature Date

REVIEW AND APPROVAL:

____ ____________________
Building Principal Date

____ ____________________
Supervisor Date

____ ____________________
Director of Human Resources Date

EMPLOYEE RIGHTS

UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION

LEAVE ENTITLEMENTS

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

BENEFITS & PROTECTIONS

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

ELIGIBILITY REQUIREMENTS

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

REQUESTING LEAVE

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

EMPLOYER RESPONSIBILITIES

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

ENFORCEMENT

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243)   TTY: 1-877-889-5627

www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division

WH1420 REV 04/16

PENNRIDGE SCHOOL DISTRICT

SECTION: EMPLOYEES

TITLE: SICK LEAVE

ADOPTED: October 22, 2012

REVISED:

334. SICK LEAVE

1. Authority SC 1154	Board policy for certificated administrative and professional employees shall ensure that eligible employees receive paid sick leave days annually, in accordance with law, administrative compensation plan, individual contract, collective bargaining agreement, or Board resolution. Unused leave shall be cumulative.
	Board policy for noncertificated administrative and support employees shall ensure that eligible employees receive paid sick leave days annually, in accordance with the administrative compensation plan, individual contract, collective bargaining agreement or Board resolution. Unused leave shall be cumulative.
SC 510, 1154	The Board reserves the right to require any employee claiming sick leave pay to submit sufficient proof, including a physician's certification, of the employee's illness or disability.
Pol. 317	Misuse of sick leave shall be considered a serious infraction subject to disciplinary action.
SC 510, 1154	The Board shall consider the application of any eligible employee for an extension of sick leave, pursuant to law where applicable, when the employee's own accumulated sick leave is exhausted.
2. Delegation of Responsibility	The Superintendent shall report to the Board the names of employees absent for noncompensable cause or whose claim for sick leave pay cannot be justified.
3. Guidelines	Whatever the claims of disability, no day of absence shall be considered a sick leave day if the employee has engaged in or prepared for other gainful employment, or has engaged in any activity that would raise doubts regarding the validity of the sick leave request.
	<u>Proof Of Disability</u>
SC 510, 1154	An employee absent on sick leave may be required to submit a physician's written statement certifying his/her disability.

	A physician's statement may not be presumed to conclusively establish the employee's disability.
	Records
SC 510, 1154	The district's personnel records shall show the attendance of each employee; and the days absent shall be recorded, with the reason for such absence noted.
SC 510, 1154	A record shall be made of the unused sick leave days accumulated by each district employee, which shall be reported to the employee.
	References: School Code – 24 P.S. Sec. 510, 1154 Board Policy – 317

PENNRIDGE SCHOOL DISTRICT

SECTION: EMPLOYEES

TITLE: FAMILY AND MEDICAL LEAVES

ADOPTED: October 22, 2012

REVISED:

335. FAMILY AND MEDICAL LEAVES

1. Authority 29 U.S.C. Sec. 2601 et seq 29 CFR Part 825	The Board shall provide eligible administrative, professional and support employees with unpaid leaves of absence in accordance with the Family And Medical Leave Act, hereinafter referred to as FMLA.
	Employee requests for FMLA leave shall be processed in accordance with law, Board policy and administrative regulations.
2. Delegation of Responsibility	The Superintendent shall develop and disseminate administrative regulations to implement FMLA leave for eligible employees.
29 U.S.C. Sec. 2619	The district shall post, in conspicuous places in the district customarily used for notices to employees and applicants, a notice regarding the provisions of the FMLA and the procedure for filing a complaint.
	Employee requests for leave, both FMLA and non-FMLA, shall be submitted in writing on a district form to the Superintendent.
3. Guidelines 29 U.S.C. Sec. 2611, 2612	Employees' eligibility for FMLA leave shall be based on the criteria established by law.
29 U.S.C. Sec. 2612	Eligible employees shall be provided up to twelve (12) workweeks of unpaid leave in a twelve-month period for the employee's own serious health condition; for the birth, adoption, foster placement or first-year care of a child; to care for a seriously ill spouse, child or parent; or to address specific qualifying exigencies pertaining to a member of the Armed Forces alerted for foreign deployment or during foreign deployment.
29 U.S.C. Sec. 2612	Eligible employees shall be provided up to twenty-six (26) workweeks of unpaid leave in a single twelve-month period to care for an ill or injured covered servicemember.

29 CFR Sec. 825.200	The district shall utilize a rolling twelve-month period measured backwards from the date leave is used to determine if an employee has exhausted his/her FMLA leave in any twelve-month period.
29 U.S.C. Sec. 2612	When an employee requests an FMLA leave and qualifies for and is entitled to any accrued paid sick, vacation, personal or family leave, the employee may utilize such paid leave during the FMLA leave.
	References: Family and Medical Leave Act – 29 U.S.C. Sec. 2601 et seq. Family and Medical Leave, Title 29, Code of Federal Regulations – 29 CFR Part 825 Board Policy – 000, 813

PLEASE RETURN THE COMPLETED FORM TO 215-453-8699 OR HR@PENNRIDGE.ORG

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

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

OMB Control Number: 1235-0003
Expires: 6/30/2023

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 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: ○ 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 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.

PLEASE RETURN THE COMPLETED FORM TO 215-453-8699 OR HR@PENNRIDGE.ORG

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

U.S. Department of Labor
Wage Hour Division

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

OMB Control Number: 1235-0003
Expires: 6/30/2023

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave to care for a family member with a serious health condition to submit a medical certification issued by the family member'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 or 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.

(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.)

SECTION II - 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 the 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, age 18 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.

Employee Name: ____

(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 III - 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 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, such as providing the diagnosis and/or course of treatment.

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 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)*.
____
____

Employee Name: ____

(5) 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.

(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 if the benefits and protections of the FMLA apply.

(7) 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): ____________________
____

(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: *(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)*

Employee Name: ____

(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 date: ____________________ *(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 to provide care for the patient 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.

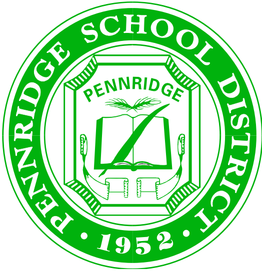
Signature of
Health Care Provider ____ **Date** __________________ *(mm/dd/yyyy)*

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: ○ 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 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.



PENNRIDGE SCHOOL DISTRICT

Perkasie, Pennsylvania 18944-2295

Human Resources

HEALTHCARE PROVIDER'S CERTIFICATION OF MEDICAL IMPAIRMENT

Employee (First, Last Name): ____

Home Address (Street, City, State, Zip Code): ____

____

Home Telephone Number: ____

Position: ___________________ Work Location: ____

Dear Healthcare Provider:

We are responding to your patient's request for an accommodation on the basis of a possible medical impairment. Your assistance in this process would be most beneficial.

Thank you in advance for your assistance.

Tara Mossman

Tara Mossman
Director of Human Resources

1. Have you examined the employee? YES NO (Circle One)

   Date of last examination:____

2. Does the employee have a "physical or mental impairment?" YES NO (Circle One)

3. Identify each diagnosis to indicate whether chronic or acute; permanent or temporary; the severity; date of onset; and expected duration.

Diagnosis	**Chronic or Acute**	**Permanent or Temporary**	**Severity (Mild, Moderate, Severe)**	**Date of Onset**	**Expected Duration**

4. Does the employee's medical condition preclude or substantially limit the individual from performing any of the required duties. If so, identify which specific duties the employee is precluded from performing or substantially limited in his or her ability to perform **due to medical necessity**. **For the purposes of this document and in accordance with guidance promulgated relative to the ADA, the definition of a substantial limitation means that the employee would not be able to perform the task in a manner that would be comparable to that of the general population.**

____

____

5. Is there a medical reason to believe that the employee will experience injury, harm or aggravation of his or her medical condition by attempting to perform the duties that you have provided in your response to number 4 above? If so, what is the degree of injury, harm or aggravation that should be expected and what likelihood that will occur? What is the timeframe in which it is likely to occur?

____

____

6. Is the employee likely to recover significantly to perform the duties described in the attached job description? If so, what is the expected time frame for recovery? If not, what is the **medical reason** that would inhibit recovery?

____

____

7. Indicate all major life activities the employee is restricted from or substantially limited in his or her ability to perform. **The ADA provided some guidance regarding the interpretation of major life activities. These activities are included but are not limited to:**

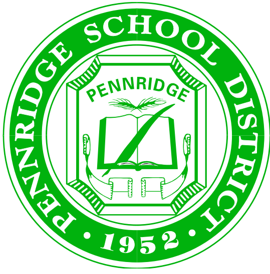
☐ Walking ☐ Speaking ☐ Breathing ☐ Hearing ☐ Seeing
☐ Thinking ☐ Lifting ☐ Learning ☐ Working ☐ Concentrating
☐ Interacting with Others

8. If it is your professional opinion based on an objective assessment that the individual should be restricted from any of the major life activities listed in number 6 above due to medical necessity, what types of accommodations or measures do you recommend to enable the employee to perform the duties outlined in the attached job description?

____

____

Health Care Provider's Signature	Date
Health Care Provider's Name (please print)	Health Care Provider's Phone Number
Health Care Provider's Fax Number	Health Care Provider's e-Mail



PENNRIDGE SCHOOL DISTRICT

DISTRICT ADMINISTRATION OFFICE

1200 North Fifth Street ● Perkasie, Pennsylvania 18944

Human Resources

MADISON LONG TERM DISABILITY AND SICK DAY USE DURING LEAVE

Name: ____________________ **EEID:** ________ **Job Class:** ________

Building: ____________________ **Elimination Period with Madison:** ________

Start Date of Leave: ____________________ **End Date of Leave:** ________

# of Sick Days Accrued: ____________________ **# of Personal Days Accrued:** ________

# of Vacation Days Accrued: ____________ **# of Undesignated Days Accrued:** ________

It is my intention to use the following number of days towards my leave/FMLA:

Sick days: ______ **Personal Days:** ______ **Vacation Days:** ________ **Undesignated Days:** ________

Once your doctor clears you from his care sick days and long-term disability are no longer available options. At this time you will be home billed for any Madison deductions you would otherwise be responsible for.

______________________________ ____________________

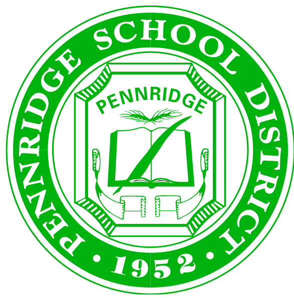
Signature Date

PLEASE NOTE: It is the employee's responsibility to notify Human Resources in writing of any change to the above information.

For **<u>professional employees</u>**, beginning on the ninety-first calendar day after all accumulated sick leave has been exhausted; Madison National Life may compensate the employee at 60% of his/her regular rate of pay. This elimination period may be less depending on your choice to buy or not buy a shorter elimination period (14, 30 or 60). The determination of this benefit is made by application to Madison National Life. Employees are responsible for completing the employee application and retaining the medical documentation to submit directly to Madison. Pennridge will complete the employer portion and submit it directly to Madison National Life.

For **<u>classified employees (PESPA)</u>**, beginning on the ninety-first calendar day after all accumulated sick leave has been exhausted; Madison National Life may compensate the employee at 60% of his/her regular rate of pay. This elimination period may be less depending on your choice to buy or not buy a shorter elimination period (14, 30 or 60). The determination of this benefit is made by application to Madison National Life. Employees are responsible for completing the employee application and retaining the medical documentation to submit directly to Madison. Pennridge will complete the employer portion and submit it directly to Madison National Life.

For **<u>administrators (Act 93) and transportation</u>**, Madison National Life may compensate the employee at a percentage of his/her regular rate of pay. This benefit is an optional benefit to these groups and is based on your choice to buy or not buy a shorter elimination period. If you participate in the short/long term disability option, the determination of this benefit is made by application to Madison National Life. Employees are responsible for completing the employee application and retaining the medical documentation to submit directly to Madison. Pennridge will complete the employer portion and submit it directly to Madison National Life.



PENNRIDGE SCHOOL DISTRICT

DISTRICT ADMINISTRATION OFFICE
1200 North Fifth Street ● Perkasie, Pennsylvania 18944

Human Resources

FROM: Nicole Foster
Benefits Specialist

RE: Madison Application Instructions

The district provides long term disability coverage for its employees with Madison National Life. You may have elected to participate in the short-term disability (buy-down) option offered with Madison as well. The following documents are necessary to begin the claim process:

1. Employee's Statement of claim for Benefits
2. Attending Physician's Statement
3. Employer's Statement of Claim for Benefits (A copy for your file)

Please complete the *Employee's Statement of Claim for Benefits* form and submit directly to Madison National Life at the information listed on the top of the form.

Have your physician complete the *Attending Physician's Statement* and submit it directly to Madison National Life at the information listed on the top of the form.

You may submit your form along with the Physician's statement. The district does not need a copy of either of these documents.

In order to complete your application to Madison the district will complete the *Employer's Statement of Claim for Benefits,* and submit it directly to Madison National Life.

These documents are all required in order for Madison to consider your claim for benefits. If you have questions regarding the information being required on your forms, please call the number listed at the top of the forms.

If you have any further questions regarding your leave, please feel free to call me at 215-453-2716 or email me at nfoster@pennridge.org.

Madison National Life

Insurance Company, Inc.
P.O. BOX 2865 CLINTON, IA 52733-2865
Telephone: 800-356-9601 Extension 2410 Fax: 608-830-2701

EMPLOYEE'S STATEMENT OF CLAIM FOR BENEFITS

As your disability insurer we are committed to assisting you in a return to health and to productive employment. Please complete the following form as thoroughly as possible. By accepting forms and investigating the claim, the Company does not admit that there is any insurance in force and does not waive any of its rights and / or defenses. Any incomplete claim form will not be accepted. **We highly recommend that you also provide medical records from each of your treating physicians to help expedite the review of your claim.** Lack of medical records may result in a delay in the review of your claim.

BACKGROUND INFORMATION

Type of benefit this claim is being filed for? (Please check all applicable claims):

☐ **Short Term Disability benefits** ☐ **Long Term Disability benefits** ☐ **Life Insurance Waiver of Premium benefits**

Name (print): ______________________ Social security number: ______________________

Address: ______________________ Telephone number: ______________________

City: ______________________ State: __________ Zip: __________ Email address: ______________________

Date of birth: ______________________ ☐ Male ☐ Female Height: __________ Weight: __________ ☐ Single ☐ Married

Name and birth date of spouse and all dependent children (Dependent children are all unmarried children (1) under age 18, (2) under age 19 (if in elementary or secondary school or (3) disabled children regardless of age if their disability began before age 22):

____

____

Your employer's name: ______________________ Occupation/Job title: ______________________

Date of hire: ______________________ Annual salary: ______________________

Please indicate the extent of your formal education (*circle one*)

Grade: 1 2 3 4 5 6 7 8 9 10 11 12 College: 1 2 3 4 Masters Ph.D. Trade School

If your education exceeds 12th grade, please indicate your major: ______________________

Briefly describe your past work experience for the last 20 years (*begin with your most recent job*):

Job title, Employer, City and State	Duties:	Dates worked:
(a)		
(b)		
(c)		
(d)		

CLAIM INFORMATION

Is your claim related to an accident or injury? ☐ No ☐ Yes If yes, date and time of accident or injury: ______________________

Describe how and where the accident or injury occurred: ______________________

____

Is your claim related to your occupation? ☐ No ☐ Yes If yes, have you filed a Worker's Compensation claim? ☐ No ☐ Yes

If you have filed a Workers' Compensation Claim, please indicate the status of your claim as well as your weekly benefit amount if your claim has been approved: ______________________

If you are receiving Workers' Compensation benefits, have you been contacted by the Workers' Compensation carrier regarding vocational rehabilitation Services? ☐ No ☐ Yes ☐ My Workers' Compensation claim is currently being disputed

Is your claim related to an illness ☐ No ☐ Yes If yes, Date symptoms first appeared: ______________________

Please list all symptoms associated with your claim: ______________________

____

Date you ceased work: __________ Have you returned to work? ☐ No ☐ Yes If yes, date returned: __________ ☐ Full-time ☐ Part-time

If you have returned to work part time please indicate the number of hours: __________ per day __________ days per week

Continued on Reverse Side

Name ______________________ DOB# ______________________

CLAIM INFORMATION CONTINUED

When do you plan to return to your job either on a full-time or part-time basis? Please explain in detail: ______________________

Please describe the primary tasks of your occupation: ______________________

Has your doctor provided work restrictions? ☐ No ☐ Yes If yes, please describe: ______________________

Can you return to your job or another job with your current employer if accommodations were made? ☐ No ☐ Yes If yes, please describe the accommodation needs: ______________________

Are there any concerns you have about returning to work? ☐ No ☐ Yes If yes, please describe: ______________________

MEDICAL INFORMATION

Please provide us with a brief description of your condition(s). Describe any physical and/or psychiatric/psychological limitations related to your return to work: ______________________

Date first treated for this condition: ____________ Name of physician that provided initial treatment: ____________

Have you ever had the same or similar condition in the past? ☐ No ☐ Yes If yes, give name and address of doctor:

Name ____________ Street Address ____________

City ____________ State ____________ Zip ____________ Phone ____________

Have you ever been hospitalized for the same or similar condition in the past? ☐ No ☐ Yes If yes, give name and address of hospital:

Name ____________ Street Address ____________

City ____________ State ____________ Zip ____________ Phone ____________

If claim is related to Pregnancy: Expected date of delivery: ____________ Actual Date of Delivery: ____________ ☐ Vaginal ☐ C-Section

Were / are there any complications associated with your pregnancy? ☐ No ☐ Yes If yes, please describe: ______________________

OTHER INCOME BENEFITS / FEDERAL TAXES

Your monthly benefit may be affected by other income benefits received. We ask that you indicate yes below if you have applied for any of the following. If you are receiving benefits, please provide documentation showing your gross benefit amount and benefit effective date. Failure to provide documentation of your other income benefits may result in a delay in benefit payment from our company.

Salary Continuation/Commission	☐ No	☐ Yes	Social Security Disability or Retirement	☐ No	☐ Yes	Unemployment Benefits	☐ No	☐ Yes
Vacation/Bonus Pay	☐ No	☐ Yes	Retirement Benefits	☐ No	☐ Yes	Other Income Benefits	☐ No	☐ Yes
Automobile No-Fault	☐ No	☐ Yes	Short Term Disability	☐ No	☐ Yes	Workers' Compensation	☐ No	☐ Yes

If you have been awarded any of the above other income benefits, please list the type of benefit, benefit amount, frequency of payment, and benefit effective date: ______________________

Have you tried any type of other work since the date your ceased work, as noted above? (either for this employer, another employer or through self-employment) ☐ No ☐ Yes if yes, provide name and address of employer, type of work, when employment began and number of hours worked per week: ______________________

If your employer pays any portion of the premium or premiums are withheld from your pay on a pre-tax basis, you may elect to have Federal Income Tax withheld from each payment. Federal Tax withholding is not mandatory. Do you want amounts withheld for Federal Tax Purposes? ☐ No ☐ Yes, If Yes you **must** indicate a dollar amount or percentage that you would like to have withheld from your benefit payment: ____________

The information I have provided on this form is accurate to the best of my knowledge.
I have received and read the fraud warning statements provided with this form.

Signature ______________________ **Date** ____________

Madison National Life

Insurance Company, Inc.

P.O. BOX 2865 CLINTON, IA 52733-2865

Telephone: 800-356-9601 Extension 2410 Fax: 608-830-2701

REIMBURSEMENT AGREEMENT
GROUP DISABILITY INSURANCE BENEFIT
(Please read carefully)

When Madison National Life Insurance Company, Inc. (“MNL”) has made benefit payments to you in excess of the amount required by the provisions of this policy, or during periods of time for which you subsequently receive retroactive benefits from any source that may offset your benefits under the group policy, you must, in a timely manner, reimburse MNL for such payments, including duplicate or erroneous payments. In addition and upon request, you must execute and deliver to MNL such documents as may be required and do whatever else is necessary to secure our rights to recover any excess, duplicate, or erroneous payments. Such reimbursement will be due and payable immediately upon our notification to and demand of you. Or, at our option, the subsequent payment of benefits or the refund of any premium owed you by MNL may be reduced or refused as a setoff and applied toward such reimbursement. If you delay in notifying MNL of your receipt of a reimbursable income benefit or in making reimbursement to MNL, MNL will have the right to charge interest at a reasonable rate on the delinquent amount owed to MNL. Our acceptance of premium and other fees, or our providing or paying disability benefits, does not constitute a waiver of our right to enforce the provisions of this agreement and/or the group policy in the future. The provisions of this agreement are in addition to, and not in lieu of, any other rights or remedies available to MNL at law or in equity.

Agreement

If my application for group disability insurance benefits is approved, in consideration of the payment of benefits without reduction on account of other benefit payments to which I or my eligible dependents may become entitled under the United States Social Security Act or from any of the other income sources described and provided for in the group policy, I hereby agree to reimburse Madison National Life Insurance Company, Inc. for any and all overpayments made to me under the group disability plan provided by employer. I understand that MNL agrees to make payment in this manner in consideration of my agreement to promptly notify MNL of the amounts and effective dates of any such benefits. Further, I agree that any benefits due me, my beneficiaries, heirs, executors, administrators or assigns under the applicable group policy may be applied to any outstanding overpayment whether resulting from retroactive award of Social Security or any other income benefits as described in the applicable policy.

With respect to any group life insurance coverage provided me by MNL and in consideration of the foregoing, I hereby assign to MNL, as creditor beneficiary, an amount of such group life insurance equal to the amount of any overpayment which may be outstanding under any applicable group disability policy at the time of death.

In witness of the above, the parties hereto have caused this Agreement to be executed, as of the date indicated.

At ________________________, _________________, this _______day of________, 20_____
(City of Residence) (State of Residence)

____
Printed Name of Claimant

____
Signature of Claimant

____
Signature of Spouse

____
Witness (must be over age 18)

Fraud Warnings

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines, confinement in prison and/or denial of insurance benefits. This warning applies to the following states: Alabama, Alaska, Arkansas, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, West Virginia, Wisconsin, Wyoming.

ARIZONA WARNING: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

CALIFORNIA WARNING: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO WARNING: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damage. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DISTRICT OF COLUMBIA WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

FLORIDA WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

KENTUCKY WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

NEW HAMPSHIRE WARNING: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NEW JERSEY WARNING: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW YORK WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

OREGON WARNING: Any person who knowingly and with intent to defraud or solicit another to defraud an insurer by submitting an application, or by filing a claim containing a false statement as to any material fact, may be violating state law.

PENNSYLVANIA WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

WASHINGTON WARNING: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Signature: ______________________________ Date: ____________________

Madison National Life

Insurance Company, Inc.

P.O. BOX 2865 CLINTON, IA 52733-2865
Telephone: 800-356-9601 Extension 2410 Fax: 608-830-2701

Patient Authorization to Release Protected Medical Information

You are not required to sign the authorization, but if you do not Madison National Life Insurance may not be able to evaluate or administer your claim(s). Please complete this form in detail to assist us in providing a timely review of your claim for benefits. Please note that we are requesting that you document each of your treating providers, including any physicians, therapists, counselors, specialists, social workers, or any other representative that is providing treatment for your claimed condition(s). Facility name must be included in order to assure that this authorization form will be accepted.

Name (print): ______________________ **Date of birth:** ______________ **Telephone number:**______________________

I authorize the use and/or release of my protected medical and/or mental health information to Madison National Life Insurance Company for the purpose of determining insurance eligibility. I authorize the release of information from:

1) Provider / Facility Name: ______________________________________ Specialty: ____________________
   Address ____ Phone Number: ____________________
   Medical Record Department Fax Number: ______________________________ Date Last Treated: ____________________

2) Provider / Facility Name: ______________________________________ Specialty: ____________________
   Address ____ Phone Number: ____________________
   Medical Record Department Fax Number: ______________________________ Date Last Treated: ____________________

3) Provider / Facility Name: ______________________________________ Specialty: ____________________
   Address ____ Phone Number: ____________________
   Medical Record Department Fax Number: ______________________________ Date Last Treated: ____________________

4) Provider / Facility Name: ______________________________________ Specialty: ____________________
   Address ____ Phone Number: ____________________
   Medical Record Department Fax Number: ______________________________ Date Last Treated: ____________________

5) Provider / Facility Name: ______________________________________ Specialty: ____________________
   Address ____ Phone Number: ____________________
   Medical Record Department Fax Number: ______________________________ Date Last Treated: ____________________

to: **Madison National Life Insurance Company (address, telephone and fax number documented above)**

This form serves as an authorization for Madison National Life Insurance to obtain information documenting medical treatment, including patient notes, treatment records, lab reports, physical therapy, diagnosis and prognosis from January 1, 2009 through two years from the date of the signature on this form. This form is also intended to be used to obtain psychological testing and psychological / psychiatric treatment including patient notes and treatment records from January 1, 2009 through two years from the date of the signature on this form.

Also this form provides Madison National Life Insurance the authorization to obtain information from any pharmacy, other insurance or annuity company, any consumer reporting agency, financial institution or tax preparer, any governmental agency (e.g., Social Security Administration or Public Retirement System), all former and/or current employers, educational facility/entity, vocational or rehabilitation organization, employer sponsored disability/retirement carrier, worker's compensation carrier, and or any other entity or institution that may have information needed by Madison National Life Insurance for the review of my claim for benefits. I understand this information will be used for the sole purpose of evaluating and administering my claim for benefits. I understand that I may revoke this authorization at any time by requesting the revocation in writing and submitting it to Madison National Life and to the providers listed above. I understand if I revoke this authorization, Madison National Life Insurance may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s). This authorization will remain valid for two full years from the date of my signature.

I understand that in the course of conducting its business, Madison National Life Insurance may release / redisclose this information about me to a reinsurer, a plan administrator, or any person performing business or legal services for Madison National Life Insurance in connection with my claim(s).I understand that the information used or released as a result of this authorization may no longer be protected by federal privacy laws. I am aware my medical information may be redisclosed when necessary as part of the review process performed by Madison National Life Insurance at any point during the review of my claim or during any appeals that may take place as explained above. I understand that I have the right to receive a copy of this authorization upon request. I agree that a photocopy of this authorization is valid as the original. Treatment, payment, enrollment or eligibility of benefits may not be conditioned on obtaining my authorization, however I understand if I do not sign this authorization or if I alter its content in any way, Madison National Life Insurance may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s).

I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to each of my health care providers. I understand that, by signing this form, I am confirming my authorization that my health care provider may disclose to Madison National Life Insurance Company the protected health information described in this form.

Signature____ **Date**______________________

Madison National Life

Insurance Company, Inc.

P.O. BOX 2865 CLINTON, IA 52733-2865

Telephone: 800-356-9601 Extension 2410 Fax: 608-830-2701

ATTENDING PHYSICIAN'S STATEMENT

THIS IS A TIME SENSITIVE DOCUMENT

Thorough completion of this form will provide the information necessary to allow us to work closely with your patient and his/her employer to develop a plan which will promote a return to work. This form must be completed by a physician.

Name of patient:________________________ Date of birth:________________

Address:____

Street City State Zip

A. DIAGNOSIS / HISTORY

Primary diagnosis:________________________ ICD-9 code:________________

Secondary diagnosis:________________________ ICD-9 code:________________

Other diagnoses and ICD codes related to this claim:________________________

DSM IV Axis I – V (GAF):________________________

Symptoms:________________________

Is the condition primarily related to: ☐ Employment ☐ Illness ☐ Mental Disorder ☐ Alcohol or Drug Dependence ☐MVA ☐Pregnancy ☐ Injury

Date patient became unable to work due to this impairment? Month________ Day________ Year________

Date your patient can return to work: Part time:________________ Full time:________________

OR unable to determine, due to:________________________ Follow up in: ________________

Patient's Height: ________Patient's Weight: ________ BP:________ Patient's Dominant Hand: ☐ Right ☐ Left

Date symptoms first appeared:________________ Date of first visit to you for this condition:________________

Date of most recent visit:________________ Date of next visit:________________

Has your patient ever had the same or similar condition? ☐ No ☐ Yes If yes, indicate when and describe:________________

B. TREATMENT PLAN

Planned course of treatment (please include expected duration, surgeries, therapy, etc.):________________

Treatment complicated by: ☐ Employer / Employee conflict ☐ Significant emotional or behavioral disorder

☐ Alcohol or Drug Dependence ☐MVA ☐Other ________________

Medications prescribed (dosage, frequency and date of prescriptions (please feel free to use a separate sheet of paper):________________

Frequency with which you see your patient: ☐ Weekly ☐ Monthly ☐ PRN ☐ Other:________________

Has your patient been referred to other doctors or therapy programs (P.T., O.T., psychotherapy)? ☐ No ☐ Yes If yes please indicate to whom and dates:

If your patient is not working now, does the treatment plan include a definitive strategy for his/her return to work? For example, have you had contact with the patient's employer regarding possible job modifications or gradual return to work? ☐ No ☐ Yes If yes please describe the return to work plan:________________

C. HOSPITALIZATION: (If not hospitalized please proceed to next section.)

If patient was hospitalized, please provide dates: Admitted________________ Discharged________________

Admitting diagnosis:________________________ ICD-9 code:________________

Discharge diagnosis:________________________ ICD-9 code:________________

Name of hospital:________________________ Name of doctor seen at hospital:________________

Address:____

Street City State Zip Code

D. SURGERY: (If surgery was not performed or is not anticipated to be necessary in the future please proceed to next section.)

Was surgery performed? ☐ No ☐ Yes If yes indicate procedure and date of surgery: ________________

Is surgery planned? ☐ No ☐ Yes If yes indicate planned procedure and anticipated date:________________

Name of Patient:______________________________ Date of Birth______________________

E. PREGNANCY: (If patient is not pregnant please proceed to next section.)

If disability is related to pregnancy, please provide the following: LMP________________ First obstetric visit:________________
Expected date of delivery________________ Actual date of delivery________________ Type: ☐ C-Section ☐ Vaginal
Have there been complications resulting in disability prior to delivery? ☐ No ☐ Yes If yes indicate the type of complication:________________

F. ASSESSMENT

Describe your patient's condition since onset of symptoms: ☐ Recovered ☐ Improved ☐ Unchanged ☐ Regressed
Has your patient reached maximum medical improvement? ☐ No ☐ Yes
If your patient has not reached maximum medical improvement, when do you expect a fundamental or marked change in his/her condition?
☐ Never ☐ Condition expected to regress ☐ Condition expected to improve, State anticipated date____________ ☐ Unable to determine
Is confinement to bed or home medically required? ☐ No ☐ Yes. If yes, please indicate duration of confinement. ________________

G. RESTRICTIONS AND LIMITATIONS

If physical or psychiatric limitations exist, how long do you feel that these limitations will last?________________
Has your patient provided a self-report of his/her job tasks? ☐ No ☐ Yes
Based on your knowledge of your patient's job, what reasonable work or job site modifications could the employer make to assist him/her to return to work?

Level of functional impairment:

In a work day, given two breaks and a meal break, your patient can:
Lift (in pounds) ☐ 1 – 10 ☐ 11 – 20 ☐ 21 – 50 ☐ 51 – 75 ☐ 76+
Carry (in pounds) ☐ 1 – 10 ☐ 11 – 20 ☐ 21 – 50 ☐ 51 – 75 ☐ 76+
Bend/Stoop: ☐ Never ☐ Occasionally ☐ Frequently (how frequently)__________

If allowed positional changes, patient can: (please circle one for each)
Sit: 8 7 6 5 4 3 2 1 0 (hrs)
Stand: 8 7 6 5 4 3 2 1 0 (hrs)
Walk: 8 7 6 5 4 3 2 1 0 (hrs)
Alternately sit/stand : 8 7 6 5 4 3 2 1 0 (hrs)

If the total number of days that the patient can work during a week is limited, please specify the number of days the claimant can work per week. ____________

Patient can work with arms in the following positions:
Right arm: Above shoulder ☐ No ☐ Yes Below shoulder ☐ No ☐ Yes
Left arm: Above shoulder ☐ No ☐ Yes Below shoulder ☐ No ☐ Yes

Patient can use arms/hands for repetitive action such as:
Right arm: Gross movements ☐ No ☐ Yes Pushing& pulling ☐ No ☐ Yes Fine movements ☐ No ☐ Yes
Left arm: Gross movements ☐ No ☐ Yes Pushing& pulling ☐ No ☐ Yes Fine movements ☐ No ☐ Yes

Patient can use his/her head and neck in:
Flexion ☐ Not at all ☐ Occasionally ☐ Frequently ☐ Continuously
Extension ☐ Not at all ☐ Occasionally ☐ Frequently ☐ Continuously
Rotation ☐ Not at all ☐ Occasionally ☐ Frequently ☐ Continuously

Mental Impairment (if applicable)

Please define "stress" as it applies to this claimant: ________________
What stress and problems in interpersonal relations has this claimant had on the job? ________________

☐ Class 1 - Patient is able to function under stress and engage in interpersonal relations. (No limitations.)
☐ Class 2 - Patient is able to function in most stress situations and engage in most interpersonal relations. (Slight limitations.)
☐ Class 3 - Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations. (Moderate limitations.)
☐ Class 4 - Patient is unable to engage in stress situations or engage in interpersonal relations. (Marked limitations.)
☐ Class 5 - Patient has significant loss of psychological, physiological, personal and social adjustment. (Severe limitations.)

Remarks: ________________
What obstacles prevent a return to work?________________
If no, would you like assistance in developing a return to work plan? ☐ No ☐ Yes
Would you recommend vocational rehabilitation services (assignment of a case manager to assist your patient and the employer in return to work planning, or to provide assistance in finding a new job, or in designing a retaining plan which would allow a return to work)? ☐ No ☐ Yes
Comments:________________

PLEASE READ CAREFULLY

MEDICAL RECORDS ARE REQUIRED IN ORDER FOR A PROPER REVIEW OF THIS CLAIM. WE ASK THAT YOU ATTACH COPIES OF LABORATORY DATA, RESULTS OF DIAGNOSTIC TESTS, OFFICE VISIT NOTES, PATIENT SURGICAL REPORTS, HOSPITALIZATION RECORDS, CHART NOTES AND NARRATIVE REPORTS FROM THREE MONTHS BEFORE DISABILITY THROUGH PRESENT DATE. LACK OF MEDICAL RECORDS WILL RESULT IN A DELAY IN THE REVIEW OF THIS CLAIM AND A DELAY IN POSSIBLE PAYMENT OF BENEFITS.

I have received and read the fraud warning statements provided with this form.

Physician's signature:________________ **Date:**________________

Physicians name (please print):________________ Specialty:________________

Address:________________ City________________ State:________ Zip code:________

Phone number:________________ **Medical record department fax number:**________________

Fraud Warnings

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines, confinement in prison and/or denial of insurance benefits. This warning applies to the following states: Alabama, Alaska, Arkansas, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, West Virginia, Wisconsin, Wyoming.

ARIZONA WARNING: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

CALIFORNIA WARNING: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO WARNING: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damage. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DISTRICT OF COLUMBIA WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

FLORIDA WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

KENTUCKY WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

NEW HAMPSHIRE WARNING: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NEW JERSEY WARNING: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

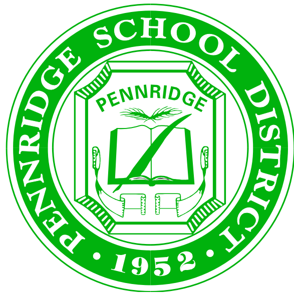
NEW YORK WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

OREGON WARNING: Any person who knowingly and with intent to defraud or solicit another to defraud an insurer by submitting an application, or by filing a claim containing a false statement as to any material fact, may be violating state law.

PENNSYLVANIA WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

WASHINGTON WARNING: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Signature: ____ Date:__________________________________



PENNRIDGE SCHOOL DISTRICT
DISTRICT ADMINISTRATION OFFICE
1200 North Fifth Street ● Perkasie, Pennsylvania 18944

Human Resources

HEALTH INSURANCE COVERAGE DURING LEAVE

Name: ______________________ **EEID:** ________ **Job Class:** ________

Building: ______________ **Coverage with IBX:** ________

Start Date of Leave: ______________ **End Date of Leave:** ________

I understand that as long as I am receiving a paycheck from the district my premium share will continue to be paid through payroll deduction.

I also understand that as soon as I stop receiving a paycheck I will be home billed for my insurance premiums according to my choice below.

PLEASE CHECK ONE:

☐ I intend to maintain my insurance coverage through the end of my FMLA at the premium share outlined in your CBA (to be paid 3 months in advance); I intend to cancel my insurance coverage after FMLA runs out through the end of my leave.

OR

☐ I intend to maintain my insurance coverage through the end of my FMLA at the premium share outlined in your CBA (to be paid 3 months in advance). I understand that should I not qualify under disability maintaining my insurance coverage after FMLA ends through the end of my leave will be at 100% of the premium cost (to be paid 3 months in advance).

______________________________ ______________________
Signature Date

PLEASE NOTE: It is the employee's responsibility to notify Human Resources in writing of any change to the above information.

FMLA FAQs

Q. How do I know if I am eligible for FMLA?

A. If you have been employed with Pennridge for 12 months AND have worked at least 1250 hours in the 12-month period prior to applying for the leave, then yes, you are FMLA eligible.

Q. How much FMLA time am I entitled to?

A. You are entitled to up to 12 weeks of FMLA leave per year (or 26 weeks for to care for a member of the Armed Forces). Time taken in less than full-week increments will be proportionately calculated based on the amount of time taken off, as compared to the employee's normal work-week. For example, if you normally work 5 days per week, and you take one day off, it would count as 1/5 of a week of your FMLA entitlement. A holiday occurring within a week of FMLA as no effect – the week is still counted as a week of FMLA leave. However, for 10-month employees, during the Winter and Summer breaks, FMLA leave is not counted against your 12-week entitlement. Your entitlement is counted as a rolling twelve (12) month period measured backward from the last date you used FMLA.

Q. If I start a leave at the end of the school year- How many sick days are deducted before maternity leave starts? Do I have to use all my sick days?

A. You have to use all of your sick days from the time you go out until the doctor clears you post-partum or until you elect to participate in short/long term disability compensation. Once you are cleared by your health care professional you are no longer eligible to use sick days; nor are you eligible for disability compensation. ***This is when unpaid leave begins.***

Q. When does my leave start?

A. Your leave starts on the day your doctor states in the Certification of Health Care Provider form, or before that date as indicated by you on the application for leave. If you request time prior to your doctor initiating your leave, you will be required to use personal time (as you may not use sick time until you are under a doctor's care).

Q. What if my baby comes early? Or late?

A. If your baby comes early, your leave will begin on the first day you are out of work. If your baby comes after your due date, your leave starts on the date the board approved your leave to begin as stated in the doctor's paperwork.

Q. When does maternity leave end and FMLA begin?

A. They are one and the same. FMLA begins on the first day you are out and continues for 12 weeks. This time can be used all at once or intermittently over 12 months. Sick time begins the first day you are out and runs concurrently with the 12 weeks of FMLA as long as you are under a doctor's care. You may also choose to use your personal days before your sick time is used.

Q. Can you take any amount of FMLA?

A. FMLA rules stipulate a maximum of 12 weeks in a 12 month period. You can come back as soon as the doctor clears you. The exception to this is a maternity leave; professional staff must wait until the next marking period break to return to the classroom. In certain cases, and with supporting medical documentation, leave may be taken intermittently, or on a reduced schedule, if due to the serious health condition of either yourself, or a family member. However, you are requested to make an effort to plan intermittent leave so at to mitigate disruption to the functions of the school/classroom/department in which you are employed.

Q. When do you have to summit a request for FMLA?

A. All leaves must be board approved. The CBA indicates a notification period of 60 days prior to the leave. This helps in the approval process, as well as finding a substitute for your position while you are out. As a 10 month employee, if your leave occurs after school is out for the year and you intend to come back at the beginning of the next school year you are not required to submit leave paperwork. Once sick time or unpaid leave starts being used, FMLA paperwork must be completed and submitted by the employee.

Q. Do you get paid during FMLA?

A. You get paid for any sick time you use. If you are out long enough you may be eligible for disability compensation. Please contact Madison Life for more information about your qualification for this benefit.

Q. How much does insurance cost on FMLA? Will HR notify me and send a bill?

A. As long as you are within the FMLA window, insurance will be reflective of your monthly premium share – which is what your payroll deductions are currently based on. Once FMLA runs out, you're responsible for 100% of the cost of coverage. Typically this is when families will switch to another insurance plan if one is available to them. You have the option of doing that and coming back to our plan when you return to work. As long as you maintain a paycheck with the district, we will take your deductions through payroll. Once you are no longer receiving a paycheck from the district, we will issue a home bill for the cost of your premiums. The CBA requires employees to pay these bills **three months in advance**. This School District cannot be responsible however, for the continuation of payment(s) for insurance(s) if reimbursement(s) are not made when due, or if insurance carriers refuse to reinstate coverage.

Q. When I return from leave will my health benefits become active again?

A. Full participation in all of the benefits of employment shall also be restored to the employee, once ***all documentation necessary to re-establish benefits is completed and submitted by the employee*** to Human Resources prior to their return. Benefits will be reinstated as of the first of the month following receipt of the re-enrollment documents.

Q. Do I get PSERS retirement service credit while on leave?

A. You will only earn retirement service credit while on district-paid sick or personal leave. Disability payments and unpaid time off will not earn you PSERS retirement service credit.

Q. How does my Short/Long Term Disability play into my leave?

A. Disability insurance covers you while you are still under a doctor's care **and are no longer receiving sick time pay**. You may contact Madison life directly for more information regarding your eligibility for this benefit.

Q. Am I entitled to benefits while I'm out on leave?

A. Employees granted leave under the Family Medical Leave Act shall be allowed, for the duration of FMLA, to remain a member of the district group insurance plans in the same manner and under the same terms as if the employee had continued to work (i.e. employee pays contribution toward premium as stated in collective bargaining agreement). Employees on authorized leave of absence ***without pay***, shall not be entitled to any benefits granted active, full time employees (i.e. annual step increment, accumulation of paid leave and district paid health benefits) unless otherwise stipulated by FMLA. Employees granted an unpaid leave outside of the FMLA shall be allowed to remain a member of the district group insurance plans on condition that they prepay their monthly premium as it is home billed to them by Pennridge School District and stated in the collective bargaining agreement (i.e. employee pays 100% of premium, **three months in advance**).

Q. A colleague at my school told me she was allowed to use all her sick time, plus short-term disability, she didn't have to contribute towards her benefits premium, and she was allowed to return from leave in the middle of a marking period. Why is my situation different?

A. Well meaning colleagues may not understand all the nuances of FMLA and district policy. Every person's situation plays out differently, based on factors such as amount of sick time available, due date, how long the Mom works before deliver, C-section, and lots of other variables. In addition, the rules change over time. These FAQ's were created to help you understand how FMLA and district policies apply to YOU under the currently existing rules.

Q. Can I continue my part-time second job while using FMLA?

A. You cannot work at another job for pay while on extended unpaid sick leave from the district.

Please be reminded that it is the employee's responsibility to provide HR with updated information as it becomes available. Additionally, as soon as your physician has determined that you are no longer disabled, he or she will need to submit written verification of the same to the HR department. This information is necessary to allow you to return to employment with the District.