Your Employee Rights Under the Family and Medical Leave Act

What is FMLA leave?

The Family and Medical Leave Act (FMLA) is a federal law that provides eligible employees with **job-protected leave** for qualifying family and medical reasons. The U.S. Department of Labor's Wage and Hour Division (WHD) enforces the FMLA for most employees.

Eligible employees can take **up to 12 workweeks** of FMLA leave in a 12-month period for:

- The birth, adoption or foster placement of a child with you,
- Your serious mental or physical health condition that makes you unable to work,
- To care for your spouse, child or parent with a serious mental or physical health condition, and
- Certain qualifying reasons related to the foreign deployment of your spouse, child or parent who is a military servicemember.

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

You have the right to use FMLA leave in **one block of time**. When it is medically necessary or otherwise permitted, you may take FMLA leave **intermittently in separate blocks of time, or on a reduced schedule** by working less hours each day or week. Read Fact Sheet #28M(c) for more information.

FMLA leave is **not paid leave**, but you may choose, or be required by your employer, to use any employer-provided paid leave if your employer's paid leave policy covers the reason for which you need FMLA leave.

Am I eligible to take FMLA leave?

You are an **eligible employee** if **all** of the following apply:

- You work for a covered employer,
- You have worked for your employer at least 12 months,
- You have at least 1,250 hours of service for your employer during the 12 months before your leave, and
- Your employer has at least 50 employees within 75 miles of your work location.

Airline flight crew employees have different "hours of service" requirements.

You work for a **covered employer** if **one** of the following applies:

- You work for a private employer that had at least 50 employees during at least 20 workweeks in the current or previous calendar year,
- You work for an elementary or public or private secondary school, or
- You work for a public agency, such as a local, state or federal government agency. Most federal employees are covered by Title II of the FMLA, administered by the Office of Personnel Management.

How do I request FMLA leave?

Generally, **to request FMLA leave you must**:

- Follow your employer's normal policies for requesting leave,
- Give notice at least 30 days before your need for FMLA leave, or
- If advance notice is not possible, give notice as soon as possible.

You **do not have to share a medical diagnosis** but must provide enough information to your employer so they can determine whether the leave qualifies for FMLA protection. You **must also inform your employer if FMLA leave was previously taken** or approved for the same reason when requesting additional leave.

Your **employer may request certification** from a health care provider to verify medical leave and may request certification of a qualifying exigency.

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.

State employees may be subject to certain limitations in pursuit of direct lawsuits regarding leave for their own serious health conditions. Most federal and certain congressional employees are also covered by the law but are subject to the jurisdiction of the U.S. Office of Personnel Management or Congress.

What does my employer need to do?

If you are eligible for FMLA leave, your **employer must**:

- Allow you to take job-protected time off work for a qualifying reason,
- Continue your group health plan coverage while you are on leave on the same basis as if you had not taken leave, and
- Allow you to return to the same job, or a virtually identical job with the same pay, benefits and other working conditions, including shift and location, at the end of your leave.

Your **employer cannot interfere with your FMLA rights** or threaten or punish you for exercising your rights under the law. For example, your employer cannot retaliate against you for requesting FMLA leave or cooperating with a WHD investigation.

After becoming aware that your need for leave is for a reason that may qualify under the FMLA, your **employer must confirm whether you are eligible** or not eligible for FMLA leave. If your employer determines that you are eligible, your **employer must notify you in writing**:

- About your FMLA rights and responsibilities, and
- How much of your requested leave, if any, will be FMLA-protected leave.

Where can I find more information?

Call **1-866-487-9243** or visit **dol.gov/fmla** to learn more.

If you believe your rights under the FMLA have been violated, you may file a complaint with WHD or file a private lawsuit against your employer in court. **Scan the QR code to learn about our WHD complaint process**.

WAGE AND HOUR DIVISION
UNITED STATES DEPARTMENT OF LABOR

SCAN ME

FAMILY MEDICAL LEAVE FORM

This form must be used by any employee requesting continuous or intermittent leave due to a qualifying event under the Family Medical Leave Act ("FMLA"). When the need for leave is foreseeable, employees should notify Human Resources at least 30 days prior to the commencement of leave. If unable to provide a 30 day notification due to unforeseen circumstances, the employee should notify Human Resources as soon as possible. Annette Weeks is the primary contact for certified employees and Tammy Roberts is the primary contact for classified employees.

Please check the correct area:	
□ Classified Employee (No license required for position.)	□ Certificated Employee (No License required for position.)
□ Classified Employee (License required for position.)	□ Certificated Employee (License required for position.)

Employee Name (Print):_____

Last Four Digits of SS#: _____

Phone Number:_____ Email: _____

Home Address: _____

School(s):_____Position:_____Grade(s)/Subject(s): _____

Were you a certificated employee last year, and if so what school system? _____

Reason for Requesting Leave:

I am requesting leave for the following reason [check one]:

□ for incapacity due to pregnancy, prenatal medical care, childbirth or still birth.

□ to care for my child after birth, or placement for adoption or foster care.

□ to care for my □ spouse, □ son or daughter, or □ parent who has a serious health condition.

□ for my own serious health condition that makes me unable to perform the essential functions of my job.

□ for a qualifying military exigency arising out of the fact that my □ spouse, □ son or daughter, or □ parent is on covered active duty or call to active duty status with the Armed Forces.

□ to care for a covered servicemember with a serious injury or illness who is my □ spouse, □ son or daughter, □ parent, or □ next of kin.

□ **I am requesting continuous leave beginning: _____ and ending: _____**

□ **I am requesting intermittent leave. My proposed intermittent work schedule that me and my principal have agreed on is attached to this document. Please indicate proposed days working and proposed days on leave. The director of schools has the final approval.**

For payroll purposes I will be requesting the following days during my leave:

Paid Maternity/Paternity Days:_____Sick Days:_____ Personal Days:_____Vacation Days:_____Days Without Pay:_____

Total number of leave days requesting: _____

This document must be signed by your principal and daily scheduled attached before it can be reviewed for approval.

Principal's Signature:	**Date:**

Note: Intermittent or reduced schedule leave is only available when medically necessary due to pregnancy, a serious health condition, the serious illness or injury of a covered service member, or a qualifying military exigency. Leave may not be taken on an intermittent basis after the birth of a child or the placement of an adopted child unless the Director of Schools or designee approves such leave.

Professional Development (Certified Teachers Only):

□ I intend to complete/or have completed 30 hours of professional development per my 200 day contract for this school year.

□ I plan to complete the following number of professional development hours: _____

□ I do not intend to complete 30 hours of professional development per my 200 day contract for this school year and understand this will be deducted from my last paycheck.
□ Professional development is not required in my position.

Please initial to confirm your understanding of each of the following:

_____ I understand that depending on the type of leave requested, I may be required to submit a complete and sufficient certification form to support my need for FMLA leave prior to approval of this leave or any request for extension of leave. I understand that if I fail to provide any requested certification, my request for FMLA leave may be delayed or denied.

_____ I have been provided a written Rights and Responsibilities Notice under the FMLA. I understand that I will be responsible for my medical insurance premium at the end of twelve weeks FMLA leave and that I am to contact Bonnie Head at the Robertson County Finance Office (615-384-0202) to make arrangements regarding payment of my insurance premiums should my leave extend beyond twelve weeks of FMLA.

_____ I understand that in the event I am taking leave for my own serious health condition, I must submit a completed Physician's Fitness for Duty Certification Form signed by a qualified health care provider before I may return to work. **The completed form must be submitted to Human Resources <u>before</u> the employee can return to work.**

_____ I understand that I have an obligation to respond to any questions from the District designed to determine whether my absence is potentially FMLA qualifying. Furthermore, I understand that If I fail to respond to any reasonable inquiry by my employer regarding this leave request, the District may deny my leave request if the District is unable to determine whether the leave is FMLA qualifying.

_____I understand if I have a life changing event, I am responsible for contacting Bonnie Head/Finance Office (615-384-0202) regarding any insurance changes within 30 days of the event.

<u>Employee Statement:</u>
I certify that the statements made above are true and correct. I understand that if I fail to return to work following my FMLA leave, I will be responsible to reimburse Robertson County Schools for the amount of the medical insurance premium the district paid on my behalf during the period of my FMLA leave.

_____ _____

Employee **Date**

Payroll Department:

Employment Date:_____

Leave Days Available for Use for Leave of Absence as of Last Pay Period (Month/Day/Year)_____:

Sick Days:_____Vacation Days:_____Personal Days:_____ per Sheila Clinard on _____(Month/Day/Year).

Human Resources:

□ Employee is eligible for Family Medical Leave requested. □ Employee is eligible for Leave of Absence requested.

_____ _____

Human Resources Signature **Date**

APPROVAL STATUS: **□ Leave Request is Approved** **□ Leave Request is Not Approved**