**PENN HILLS SCHOOL DISTRICT**
**ADMINISTRATIVE OFFICES-Human Resources**
**260 Aster Street**
**Pittsburgh, Pennsylvania 15235**

412-793-7000 – Telephone
412-712-1009 – Fax
www.phsd.k12.pa.us

# FAMILY AND MEDICAL LEAVE (FMLA)

## EMPLOYEE'S SERIOUS HEALTH CONDITION

## *INFORMATION AND APPLICATION PACKET*

- **Memo to Employee**
- **Fact Sheet #28: The Family and Medical Leave Act**
- **Board Policy No. 335: Family and Medical Leave**
- **Leave of Absence Request Form**
- **WH-380-E Certification of Healthcare Provider for Employee's Serious Health Condition**
- **Fitness for Duty Certification**
- **Intermittent FMLA Tracking Form**

# FMLA
## EMPLOYEE'S SERIOUS HEALTH CONDITION


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Enclosed please find the employee FMLA forms packet. Please read all of the information provided carefully.

Your request requires Board Approval and cannot be placed on the Agenda until all paperwork is received for processing.

**Step 1: Form WH-380-E:** Certification of Health Care Provider for Employee's Serious Health Condition

I. **Section I is to be completed by the District.**
II. **Section II is to be completed by you as the Employee.**
III. **Section III is to be completed by your physician.** Have your physician complete section III then, sign and date Form WH-380-E and return to you. Form WH-380-E is the Certification of Health Care Provider for Employee's Serious Health Condition form that must accompany the following Family & Medical Leave Request Form.

**Step 2: Family & Medical Leave Request Form:** Complete, sign and date then return the **FAMILY & MEDICAL LEAVE REQUEST FORM.** This signed form must accompany the WH-380-E which has been completed by your physician.

Submit both forms to the Human Resource office to begin the processing of your request for leave. Once you submit these forms they will be reviewed and if complete, your request will be placed on the Board Agenda.

**If you have any questions, please do not hesitate to contact me.**


***Dominique Ansani***

**Administrative Asst. – Human Resources**

**Phone: 412-793-7000 ext. 1228 Fax: 412-712-1009 Email: dansan@phsd.org**

WAGE AND HOUR DIVISION
UNITED STATES DEPARTMENT OF LABOR

# Fact Sheet #28D: Employer Notification Requirements under the Family and Medical Leave Act

**January 2024**

The Family and Medical Leave Act (FMLA) provides job-protected leave from work for family and medical reasons. This fact sheet explains employers' obligations to provide employees information about their FMLA rights and responsibilities.

## ABOUT THE FMLA

The FMLA provides eligible employees of covered employers with job-protected leave for qualifying family and medical reasons and requires continuation of their group health benefits under the same conditions as if they had not taken leave. FMLA leave may be unpaid or used at the same time as employer-provided paid leave. Employees must be restored to the same or virtually identical position when they return to work after FMLA leave.

**Eligible employees:** Employees are eligible if they:

- Work for a covered employer for at least 12 months,
- Have at least 1,250 hours of service with the employer during the 12 months before their FMLA leave starts, and
- Work at a location where the employer has at least 50 employees within 75 miles.

**Covered employers:** Covered employers under the FMLA include:

- Private-sector employers who employ 50 or more employees in 20 or more workweeks in either the current calendar year or previous calendar year,
- Public agencies, including Federal, State, and local government employers, regardless of the number of employees, and
- Local educational agencies, including public school boards, public elementary and secondary schools, and private elementary and secondary schools, regardless of the number of employees.

**The FMLA protects** leave for:

- The birth of a child or placement of a child with the employee for adoption or foster care,
- The care for a child, spouse, or parent who has a serious health condition,
- A serious health condition that makes the employee unable to work, and
- Reasons related to a family member's service in the military, including:
  - Qualifying exigency leave – leave for certain reasons related to a family member's foreign deployment, and
  - Military caregiver leave – leave when a family member is a current servicemember or recent veteran with a serious injury or illness.

For more information about the FMLA generally, see Fact Sheet #28.

## REQUIRED NOTICES

Covered employers must provide employees with certain critical notices about the FMLA:

- **General Notice.** All covered employers must display a general notice about the FMLA, the FMLA poster. If a covered employer has any eligible employees, the employer must also provide each employee individually with a general notice containing the same information about the FMLA as contained in the FMLA poster.
- **Eligibility Notice.** When an employee first requests leave for a reason that may qualify for FMLA leave, the employer must notify the employee whether they are eligible for FMLA leave.
- Rights and Responsibilities Notice. If the employee is eligible, the employer must notify the employee in writing about employee rights and responsibilities under the FMLA.
- **Designation Notice.** Once the employer has enough information to know whether a leave request qualifies as FMLA leave, the employer must notify the employee in writing whether the employee's time off from work will be designated FMLA leave, and the amount of time that will count against the employee's FMLA entitlement.

Where a significant portion of the employer's workforce is not literate in English, employers are required to provide certain notices in languages other than English.

Employers are also required to comply with all applicable requirements under Federal or State law for notices provided to sensory-impaired individuals.

## CONSEQUENCES OF NOT PROVIDING REQUIRED NOTICES

Failure to provide required FMLA notices may constitute an interference with, restraint, or denial of the exercise of an employee's FMLA rights. An employer may be liable for compensation and benefits lost by reason of the violation, for other actual monetary losses sustained as a direct result of the violation, for liquidated damages, and for appropriate equitable or other relief, including employment, reinstatement, promotion, or any other relief tailored to the harm suffered.

## REQUIRED GENERAL NOTICES

**FMLA poster.** Every employer covered by the FMLA must display or post an informative general notice about the FMLA. A covered employer must display this poster even if it has no eligible employees.

- The poster must be displayed in plain view where all employees and applicants can readily see it and must have text large enough so it can be easily read.
- The information displayed on the poster must explain the FMLA provisions and provide information on how to file a complaint with the Wage and Hour Division.
- If a significant portion of employees do not read and write English, the employer must provide the general notice in a language in which they can read and write.

English and Spanish language FMLA posters are available free of charge from the U.S. Department of Labor's Wage and Hour Division (WHD). Employers may distribute the information electronically, create their own poster or notice, or use another format However, the material provided to employees must include all the information contained in the WHD FMLA poster, be accessible t applicants for employment and current employees, and fulfill all other requirements.



An employer who willfully violates this posting requirement may be subject to an FMLA civil money penalty, which is adjusted for inflation each year.

**General notice upon hire.** In addition to displaying a poster, if a covered employer has any FMLA eligible employees, it must also provide each employee with a general notice about the FMLA in the employer's employee handbook or other written materials about leave and benefits. If no handbook or written leave materials exist, the employer must distribute this general notice to each new employee upon hire.

This general notice requirement can be met by duplicating the general notice language found on the WHD FMLA poster. Employers may distribute this information electronically, create their own poster or notice, or use another format. The material provided must include all the information contained in the WHD FMLA poster and fulfill all other requirements. If a significant portion of employees do not read and write English, the employer must provide this general notice in a language in which they can read and write.

# REQUIRED SPECIFIC NOTICES

**Eligibility notice.** The employer must provide employees with an eligibility notice the first time the employee requests leave for an FMLA-qualifying reason in the employer's designated 12-month leave year.

The eligibility notice may be either oral or in writing and must:

- Be provided within five business days of the initial request for leave or when the employer acquires knowledge that an employee leave may be for an FMLA-qualifying reason,
- Be provided in a language in which the employee is literate, if a significant portion of the employer's workforce is not literate in English,
- Inform the employee of their eligibility status, and
- If the employee is not eligible for FMLA leave, state at least one reason why.

Once an employee is notified they are eligible, employers are not required to provide a new eligibility notice for FMLA absences for the same qualifying reason during the same leave year. Employers are also not required to provide a new eligibility notice for FMLA absences for a different qualifying reason where the employee's eligibility status has not changed. When an employee needs leave for a different qualifying reason in the same leave year and the employee's eligibility status has changed, however, the employer must notify the employee of the change in eligibility status within five business days.

**Rights and responsibilities notice.** Each time employers are required to provide the eligibility notice, they must also provide employees with a rights and responsibilities notice, notifying employees of their rights under the FMLA, their obligations concerning the use of FMLA leave, and the consequences of failing to meet those obligations.

The rights and responsibilities notice must be in writing and must explicitly state all the following information, as applicable:

- Notice the leave may be counted as FMLA leave – A statement that leave may be designated and counted against the employee's FMLA leave entitlement;
- FMLA leave year – The 12-month period or leave year the employer uses to track FMLA leave usage;
- Certification requirements – Whether the employee will be required to provide certification of the need for leave, and the consequences of failing to do so;Substitution of leave – The employee's right to use paid leave, whether the employer will require the substitution of paid leave, any conditions related to the substitution, and the employee's right to take unpaid FMLA leave if the employee does not meet the conditions for paid leave;
- Key employee notice – The employee's status as a "key employee," i.e., a salaried FMLA-eligible employee who is among the highest paid 10% of all employees, both eligible and ineligible, within 75 miles of the worksite, and potential restoration consequences, if any;
- Job restoration and maintenance of benefits – The employee's right to job restoration and maintenance of benefits; and
- Group health insurance premium payment requirements – Whether the employee will be required to make premium payments to maintain health benefits and any arrangements for doing so, the consequences of failing to make payments on a timely basis, and the employee's potential liability for premium payments made by the employer if the employee fails to return to work.



The rights and responsibilities notice may be distributed electronically provided all other requirements are met, and it may be combined with and provided to the employee at the same time as the eligibility notice. Employers can use WHD Form WH-381, Notice of Eligibility and Rights and Responsibilities, which is available at no cost, or create their own version as long as it meets all legal requirements. If a significant portion of an employer's workforce is not literate in English, the rights and responsibilities notice must be provided in a language in which employees are literate.

Employers must be responsive in answering questions from employees concerning rights and responsibilities under the FMLA.

If information provided in the rights and responsibilities notice changes, the employer must notify the employee of the changes in writing within five business days of the first time, after the changes, that the employee requests leave. For example, if the initial leave period was paid leave and the subsequent leave period would be unpaid leave, notice of new arrangements for making health insurance premium payments may be required.

**Designation notice.** Once the employer has enough information to determine that the employee's requested leave qualifies as FMLA leave, the employer must provide the employee with a written designation notice within five business days, absent extenuating circumstances. The designation notice informs the employee that the requested leave will be designated as FMLA leave and sets out the requirements applicable while the employee is on leave.

The designation notice must include:

- Whether the employee is required to substitute paid leave for unpaid FMLA leave,
- Whether the employee will be required to submit a fitness-for-duty certification to return to work, andThe amount of leave that will count against the employee's FMLA leave entitlement, if known. If the exact amount of leave is not known at the time of the designation, the employer must provide this information in writing upon the employee's request, but no more often than once in a 30-day period and only if leave is taken in that period.

If the leave does not qualify as FMLA leave, the employer must notify the employee in writing that the leave is not FMLA-protected and will not be counted as FMLA leave. This notice can be a simple written statement.

The employer is required to provide the employee with one designation notice for each FMLA-qualifying reason for leave in the 12-month leave year, regardless of whether the leave is taken in a continuous block or intermittently or on a reduced schedule. If the employee requests leave and the information provided in the designation notice changes, the employer must provide the employee written notice of the change. This notice must occur within five business days of the first leave request from the employee that follows any changes.

Employers may use WHD Form WH-382, Designation Notice, or create their own version of this notice, provided it meets all legal requirements.

If an employer is unable to determine whether a leave request should be designated as FMLA-protected because a submitted certification is incomplete or insufficient, the employer is required to state in writing what additional information is needed. The employer may use the designation notice to inform the employee that a certification is incomplete or insufficient and identify what information is needed to make the certification complete and sufficient. For more information about medical certification, see Fact Sheet #28G.

# ADDITIONAL PROTECTIONS

## State Laws

Some States have their own family and medical leave laws. Nothing in the FMLA prevents employees from receiving protections under other laws. Workers have the right to benefit from all the laws that apply.

## Protection from Retaliation

The FMLA is a federal worker protection law. Employers are prohibited from interfering with, restraining, or denying the exercise o or the attempt to exercise, any FMLA right. Any violations of the FMLA or the FMLA regulations constitute interfering with, restraining, or denying the exercise of rights provided by the FMLA. For more information about prohibited employer retaliation under the FMLA, see Fact Sheet #77B and Field Assistance Bulletin 2022-2.

## Enforcement

The Wage and Hour Division is responsible for administering and enforcing the FMLA for most employees. If you believe that your rights under the FMLA have been violated, you may file a complaint with the Wage and Hour Division or file a private lawsuit against your employer in court. 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.

## Where to Obtain Additional Information

**For additional information scan the QR Code, visit the Wage and Hour Division FMLA website https://www.dol.gov/agencies/whd/fmla, and/or call our toll-free information and helpline, available 8 a.m. to 5 p.m. in your time zone, 1-866-4-USWAGE (1-866-487-9243)**

This publication is for general information and is not to be considered in the same light as official statements of position contained in the regulations.

| | |
|---|---|
| Book | Policy Manual |
| Section | 300 Employees |
| Title | Family and Medical Leaves |
| Code | 335 |
| Status | Active |
| Adopted | August 25, 2014 |
| Last Revised | June 22, 2020 |
| Last Reviewed | June 29, 2020 |

## Authority

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.[1][2]

Employee requests for FMLA leave shall be processed in accordance with law, Board policy and administrative regulations.

## Delegation of Responsibility

The Superintendent shall develop and disseminate administrative regulations to implement FMLA leave for eligible employees.

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.[3]

Employee requests for leave, both FMLA and non-FMLA, shall be submitted in writing on a district form to the Superintendent of designee.

## Guidelines

Employees' eligibility for FMLA leave shall be based on the criteria established by law.[4][5]

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.[5]

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.[5]

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. [6]

Instructional employees may be required to continue FMLA leave to the beginning of a grading period or term if conditions or leave are those specified in the FMLA.

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 is required to utilize such paid leave concurrent with the FMLA leave.[5]

In addition, employees on an approved FMLA leave are not permitted to hold employment outside the district.

Legal

1. 29 U.S.C. 2601 et seq
2. 29 CFR Part 825
3. 29 U.S.C. 2619
4. 29 U.S.C. 2611
5. 29 U.S.C. 2612
6. 29 CFR 825.200

Pol. 813

# Penn Hills School District

# EMPLOYEE LEAVE OF ABSENCE FORM

DATE:_____ EMPLOYEE NUMBER:_____

NAME:_____ BUILDING:_____

POSITION:_____ CERTIFICATION:_____

LEAVE START DATE:_____ LEAVE END DATE:_____

ANTICIPATED DATE OF RETURN:_____

TYPE OF LEAVE:
- [ ] Maternity
- [ ] Medical
- [ ] Sabbatical
- [ ] F.M.L.A.

PLEASE INDICATE NUMBER OF BENEFIT DAYS TO USE FOR PAYROLL AND ATTENDANCE RECORDS:

_____ Sick
_____ Personal
_____ Emergency
_____ Vacation
_____ Leave Without Pay
_____ Income Protection

_____ TOTAL NUMBER OF DAYS

Is substitute required for coverage during your leave?
- [ ] Yes
- [ ] No

Substitute Shadow Day Date(s): ____/____/____ Before Leave
____/____/____ After Leave

Information above subject to change if necessary.

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

U.S. Department of Labor
Wage and Hour Division

WAGE AND HOUR DIVISION

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

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

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

## SECTION I - EMPLOYER

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

Employers must generally maintain records and documents relating to medical information, medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

(1) Employee name: _____
First Middle Last

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

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

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

Employee's regular work schedule: _____

Statement of the employee's essential job functions:

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

## SECTION II - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form. Your patient has requested leave under the FMLA. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of the employee. For FMLA purposes, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves **inpatient care** or **continuing treatment by a health care provider**. For more information about the definitions of a serious health condition under the FMLA, see the chart on page 4.

You also may, but are **not required** to, provide other appropriate medical facts including symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment. Please note that some state or local laws may not allow disclosure of private medical information about the patient's serious health condition, such as providing the diagnosis and/or course of treatment.

**Employee Name:** _____

Health Care Provider's name: (Print) _____

Health Care Provider's business address: _____

Type of practice / Medical specialty: _____

Telephone: _____ Fax: _____ E-mail: _____

**PART A: Medical Information**

Limit your response to the medical condition(s) for which the employee is seeking FMLA leave. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. **After completing Part A, complete Part B to provide information about the amount of leave needed.** Note: For FMLA purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

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

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

(3) Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

☐ **Inpatient Care**: The patient (☐ has been / ☐ is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): _____

☐ **Incapacity plus Treatment**: (e.g. outpatient surgery, strep throat)

Due to the condition, the patient (☐ has been / ☐ is expected to be) incapacitated for **more than** three consecutive, full calendar days from: _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy).

The patient (☐ was / ☐ will be) seen on the following date(s): _____

_____

The condition (☐ has / ☐ has not) also resulted in a course of continuing treatment under the supervision of a health care provider (e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment).

☐ **Pregnancy**: The condition is pregnancy. List the expected delivery date: _____ (mm/dd/yyyy).

☐ **Chronic Conditions**: (e.g. asthma, migraine headaches) Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

☐ **Permanent or Long Term Conditions**: (e.g. Alzheimer's, terminal stages of cancer) Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

☐ **Conditions requiring Multiple Treatments**: (e.g. chemotherapy treatments, restorative surgery) Due to the condition, it is medically necessary for the patient to receive multiple treatments.

☐ **None of the above**: If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed. Go to page 4 to sign and date the form.

**Employee Name:** _____

(4) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. (e.g., use of nebulizer, dialysis)

_____

**PART B: Amount of Leave Needed**

For the medical condition(s) checked in Part A, complete all that apply. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage.

(5) Due to the condition, the patient ( ☐ had / ☐ will have) **planned medical treatment(s)** (scheduled medical visits) (e.g.psychotherapy, prenatal appointments) on the following date(s): _____

_____

(6) Due to the condition, the patient ( ☐ was / ☐ will be) **referred to other health care provider(s)** for evaluation or treatment(s).

State the nature of such treatments: (e.g. cardiologist, physical therapy) _____

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

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

_____

(7) Due to the condition, it is medically necessary for the employee to work a **reduced schedule**.

Provide your **best estimate** of the reduced schedule the employee is able to work. From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy) the employee is able to work: (e.g., 5 hours/day, up to 25 hours a week)

_____

(8) Due to the condition, the patient ( ☐ was / ☐ will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.

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

(9) Due to the condition, it (☐ was / ☐ is / ☐ will be) medically necessary for the employee to be absent from work on an intermittent basis (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, episodes of incapacity are estimated to occur _____ times per ( ☐ day ☐ week ☐ month) and are likely to last approximately _____ ( ☐ hours ☐ days) per episode.

**Employee Name:** _____

**PART C: Essential Job Functions**

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

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

_____

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

**Definitions of a Serious Health Condition** (See 29 C.F.R. §§ 825.113-.115)

**Inpatient Care**

- An overnight stay in a hospital, hospice, or residential medical care facility.
- Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.

**Continuing Treatment by a Health Care Provider (any one or more of the following)**

**Incapacity Plus Treatment**: A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either:

- o Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or,
- o At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.

**Pregnancy**: Any period of incapacity due to pregnancy or for prenatal care. _____

**Chronic Conditions**: Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.

**Permanent or Long-term Conditions**: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.

**Conditions Requiring Multiple Treatments**: Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.

**PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT**

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 15 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

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

## FITNESS FOR DUTY TO RETURN FROM LEAVE CERTIFICATION

An employee on Family and / or Medical Leave because of his/her own medical condition must present this release to his/her supervisor prior to or on the day he/she returns to work.

TO: Health Care Provider

Our employee, _____, began a period of medical care leave for his/her serious health condition on _____.
(date employee commenced leave)

As a condition of return to work, the employee must have a signed medical release. This form must be completed by his/her health care provider, before the employee is allowed to resume his/her job duties.

1. Employee Name: _____

1. Employer and Job Title: _____

1. Date of Medical Examination: _____

4. Date employee may return from leave

_____

5. Please indicate with a check mark the status of the employee's release for duty.

   A copy of this employee's job description is attached. Please review prior to completion of work status.
   Please note: Should employee not be released to his/her full duty position, the employer is not required to modify the position he/she was originally hired to perform.

   _____ Full, unrestricted duty (Skip question 6 and proceed to item 7.)
   _____ Modified duty (Complete question 6.)
   _____ Not released for any type of duty (Go to item 7.)

6. If you are releasing the employee to modified duty, you must complete the following:

   a. Estimated date that employee will be able to return to full, unrestricted duty:
      _____.
   b. Date of your next medical evaluation of the employee:
      _____.
   c. Indicate the <u>exact</u> work restrictions which apply to the employee at this time on the following chart.

**Employee's Name:**_____

**(Complete this section if the employee is being released to modified duty.)**

| PHYSICAL EXAMINATIONS | FULL RESTRICTIONS | PARTIAL RESTRICTIONS | NO RESTRICTIONS |
|---|---|---|---|
| Sedentary-Lifting 0 to 10 pounds | | | |
| Light-Lifting 10 to 20 pounds | | | |
| Moderate-Lifting 20 to 50 pounds | | | |
| Heavy-Lifting 50 to 100 pounds | | | |
| Pulling/Pushing, Carrying | | | |
| Reaching or working above shoulder | | | |
| Walking (hrs) | | | |
| Standing (hrs) | | | |
| Sitting (hrs) | | | |
| Stooping (hrs) | | | |
| Kneeling (hrs) | | | |
| Repeated Bending (hrs) | | | |
| Climbing (hrs) | | | |
| Operating a motor vehicle, crane, tractor, etc. | | | |
| Other: | | | |
| Exposure Limitation (Specify): | | | |

7. **I hereby certify that the foregoing facts are true and correct.**

_____ _____

Signature of Health Care Provider Date

_____ _____

Print Name of Health Care Provider Phone Number

_____

Type of Practice

_____

Address

_____

City State Zip

# Intermittent FMLA Tracking Form

Employee Name: _____ Month/Year: _____

Building: _____ Position Title: _____

You have requested the need for intermittent leave under the Family and Medical Leave Act.

You are eligible for up to 12 weeks of leave per 12 month rolling period under the Family Medical Leave Act and you will be reinstated to your job after your leave. Penn Hills School District will continue your health insurance during your leaves as per the regulations and your union contract. When a health care provider certifies a need for intermittent FMLA leave for a period exceeding 30 days, PHSD may not require additional certifications during that period unless a request is made to extend the leave, circumstances change significantly or PHSD receives information that casts doubt on the need for leave.

In order to document the dates and times that you are utilizing your leave, it is necessary that you complete the following form with each occurrence during each month.

Please submit the completed form by the end of each month to the Human Resource Office.
Please direct any questions that you may have to the Human Resource Office.
If your leave situation changes, you will need to submit a revised letter indicating the changes.

| DATE | TIME PERIOD OFF | FMLA TIME TAKEN (minimum ½ day pay per contract) | COVERAGE REQUIRED |
|---|---|---|---|
| Ex. 1/15/10 | 11:45 – 3:15 | 3.5 hours | Substitute required |
| | | | |
| | | | |
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| | | | |

Signature: _____ Date: _____