



CLAYTON COUNTY PUBLIC SCHOOLS

"Building a Better Tomorrow, Today!"

8 - STEPS TO FAMILY AND MEDICAL LEAVE (FML)

START HERE STEP 1

Eligible employees should be employed full-time with Clayton County Public Schools at least 1250 hours in the last 12 months.

STEP 2

Employee must complete the FML Request Form in its entirety and submit via email to FamMedLeave@clayton.k12.ga.us or by fax to 770-603-5767.

STEP 3

If all required documents are received, the employee will receive an email notification from the Division of Human Resources & Strategic Improvement (DHR & SI) Federal Leave Staff notifying of their leave eligibility, start date of leave, employee's rights and responsibilities, time period of the leave, and Return-to-Work requirements. In addition, employees will be notified on how to maintain their current benefits.

STEP 4

Employee must submit a Certification of Health Care Provider Form completed by the physician via email to FamMedLeave@clayton.k12.ga.us or by fax to 770-603-5767 as soon as possible.

STEP 5

Employee will receive an email which includes the FML Request Determination: Approved or Denied, Type of Leave (continuous or intermittent), Duration of FML weeks requested, and Return-to-Work requirements. A copy of the Job Description (JD) will be provided with a continuous leave request.

STEP 6

Employee must submit a Medical Release Intent to Return-to-Work Form completed by the physician 15 days prior to their Return-to-Work date. Please Note: If all required documents are not received in a timely manner, this will result in a delay of clearance to Return-to-Work.

STEP 7

Employee will receive an email releasing them to Return-to-Work. The supervisor and bookkeeper will be copied on the Return-to-Work email.

FINAL STEP STEP 8

Employee will Return-to-Work on the first business day after the end date of their leave.



Clayton County Public Schools

Division of Human Resources and Strategic Improvement

FAMILY AND MEDICAL LEAVE REQUEST FORM

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

EMPLOYEE INFORMATION

Emp ID _____ First Name _____ MI ____ Last Name _____

Complete Address _____ City _____ Zip Code _____

Phone Number _____ Alt. Phone _____

Personal Email Address _____ @ _____

(All Correspondence will be sent via email only.)

School/Department _____ Position _____

Employee's Supervisor/Manager _____ Phone Number _____

FAMILY AND MEDICAL LEAVE INFORMATION:

Type of Leave Requested: Continuous Days Intermittent Paid Parental Leave

(I am requesting Family and Medical Leave for the following dates (maximum of 12 weeks rolling calendar year))

Beginning Date _____ Ending Date _____ Anticipated Return to Work Date _____

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

I am requesting Paid Parental Leave for the following dates (maximum of 30 days)

Beginning Date _____

Ending Date _____

LEAVE REQUIRED FOR:

Serious Health Condition Check One:

- | | |
|---|--|
| <input type="checkbox"/> Employee: OR | <input type="checkbox"/> Birth of Child: OR |
| <input type="checkbox"/> Spouse (name) _____ OR | <input type="checkbox"/> Adoption of a Child: OR |
| <input type="checkbox"/> Parent (name) _____ OR | <input type="checkbox"/> Placement of Child |
| <input type="checkbox"/> Child (name) _____ Age _____ | (Must provide supporting documentation) |

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

Signature of Employee: _____ Date: _____

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

Print Principal/Supervisor name: _____

Signature of Principal/Supervisor: _____ Date: _____

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

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



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

SECTION I – To be completed by EMPLOYEE/PATIENT

First Name _____ MI _____ Last Name _____

Phone Number _____ Personal Email Address _____

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

Employee's Signature: _____ Date: _____

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

SECTION II – Instructions for EMPLOYEE

SECTION III: To be completed by HEALTH CARE PROVIDER

Name of Health Care Provider _____

Address _____

Phone Number _____

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

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

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

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

No Yes Yes, with restrictions

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

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

4. The forgoing restrictions are

Permanent
 Temporary, until _____ [Indicate date]

Print Health Care Provider Name _____

Health Care Provider Signature _____ Date: _____

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

This form is protected by HIPPA

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.