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)

FAMILY MEMBER'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-F Certification of Healthcare Provider for Family Member's Serious Health Condition**
- **Intermittent FMLA Tracking Form**

FMLA
FAMILY MEMBER 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-F: Certification of Health Care Provider for Family Member'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 family member's physician.** Have your physician complete section III then, sign and date Form WH-380-F and return to you. Form WH-380-F is the Certification of Health Care Provider for Family Member'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-F which has been completed by your family member's 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

Human Resources Manager

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

The Penn Hills School District does not discriminate on the basis of age, race, color, national or ethnic origin, sex, or handicap in employment practices or in administration of any of its educational programs and activities in accordance with applicable federal statutes and regulations. Dominique Ansani has been identified as the Title VI/Title IX/Section 504/AMD Coordinator, Penn Hills School District, 260 Aster Street, Pittsburgh, PA 15235, (412) 793-7000 email: dansan@phsd.org.

WAGE AND HOUR DIVISION
UNITED STATES DEPARTMENT OF LABOR

Fact Sheet #28: The Family and Medical Leave Act

Revised March 2025

The Family and Medical Leave Act (FMLA) provides job-protected leave from work for family and medical reasons. This fact sheet explains FMLA benefits and protections.

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.

Download "The Employee Guide to the Family and Medical Leave Act" for more information about the FMLA, including how to request FMLA leave.

USING FMLA LEAVE

Eligible employees may take:

- Up to 12 workweeks of leave in a 12-month period for any FMLA leave reason except military caregiver leave, and

- Up to 26 workweeks of military caregiver leave during a single 12-month period.

Examples:

- Sheila works 32 hours a week at a shoe store. When Sheila needs to take FMLA leave for 12 weeks, she may use up to 32 hours of FMLA leave a week for 12 weeks.
- Chester works 40 hours a week as an administrative assistant. When Chester needs to take FMLA leave for 12 weeks, he may use up to 40 hours of FMLA leave a week for 12 weeks.
- Kayden works 50 hours a week as a cook at a restaurant. When Kayden needs to take FMLA leave for 12 weeks, he may use up to 50 hours of FMLA leave a week for 12 weeks.

Intermittent or reduced schedule leave. Employees have the right to take FMLA leave all at once, or, when medically necessary, in separate blocks of time or by reducing the time they work each day or week. Intermittent or reduced schedule leave is also available for military family leave reasons. However, employees may use FMLA leave intermittently or on a reduced leave schedule for bonding with a newborn or newly placed child only if they and their employer agree.

Examples:

- Sheila has a daughter who serves in the Armed Forces and was seriously injured during deployment overseas. Sheila needs FMLA leave for one-half of her usual workweek (16 hours) over the next six months to assist with her daughter's care.
- Chester has a serious mental health condition that sometimes affects his ability to work. Occasionally, when Chester is unable to work because of his mental health, he takes FMLA leave, usually for one to three weeks at a time. Chester also takes FMLA leave every now and then for an hour or two when he has an appointment to see his doctor or attend therapy to treat his condition.
- Kayden, a cook, works Tuesday through Saturday. His father, Emile, has a serious health condition. Kayden and his wife, Maeve, take turns bringing Emile to dialysis during the week. Every other Friday evening Kayden uses five hours of FMLA leave to help his father. Even though his wife helps, Kayden also occasionally uses five hours of FMLA leave on other evenings to help his father.

Paid leave. FMLA is job-protected, unpaid leave. Employees may use employer provided paid leave at the same time that they take FMLA leave if the reason they are using FMLA leave is covered by the employer's paid leave policy. An employer may also require employees to use their paid leave during FMLA leave.

Examples:

- Sheila works for a shoe store that provides her with one week of paid vacation time every year. The store always requires employees to use their paid vacation time when they take time off from work for any reason, even if they are not taking a vacation. When Sheila takes 16 hours of FMLA leave because of her daughter's deployment with the Armed Forces to a foreign country, her employer pays her for her FMLA time off and deducts 16 hours from her one week of vacation time.
- When Chester needs FMLA leave for his own serious health condition, he uses paid sick leave that is part of his job benefits.
- The restaurant where Kayden works provides him paid sick leave that he can use for his own health needs but not for family care. Kayden also has other paid time off (PTO) that he uses when he takes leave to care for his father who has a serious health condition.

Requesting FMLA leave. Employees do not have to specifically ask for FMLA leave but do need to provide enough information so the employer is aware the leave may be covered by the FMLA. Employees must provide notice to their employer as soon as possible and practical that they will need to use FMLA leave. For example, if an employee knows that he or she has a procedure for a serious medical condition scheduled in three weeks, the employee needs to provide notice to the employer as soon as the procedure is scheduled. Employers may as for information from the health care provider before approving FMLA leave and must allow 15 calendar days to provide the information. In some circumstances, such as when the employee's health care provider is not able to complete the certification information timely, employees must be allowed additional time.

FMLA LEAVE BENEFITS AND PROTECTIONS

Job protection. Employees who use FMLA leave have the right to go back to work at their same job or to an equivalent job that has the same pay, benefits, and other terms and conditions of employment at the end of their FMLA leave. Violations of an employee's FMLA rights may include changing the number of shifts assigned to the employee, moving the employee to a location outside of his or her normal commuting area, or denying the employee a bonus for which the employee qualified before taking FMLA leave.

An employer cannot threaten, discriminate against, punish, suspend, or fire an employee because he or she requested or used FMLA leave. Violations of an employee's FMLA rights may include actions such as writing up the employee for missing work when using FMLA leave, denying a promotion because the employee has used FMLA leave, or assessing negative attendance points for FMLA leave use.

Group health plan benefits. Employers are required to continue group health insurance coverage for an employee on FMLA leave under the same terms and conditions as if the employee had not taken leave. For example, if family member coverage is provided to an employee, family member coverage must be maintained during the employee's FMLA leave.

SPECIAL FMLA RULES FOR SOME WORKERS

FMLA Leave and Teachers. Special rules apply to employees of elementary schools, secondary schools, and school boards. Generally, these rules apply when an employee needs intermittent leave or leave near the end of a school term.

FMLA Eligibility for Flight Crews. Airline flight crew employees have special hours of service eligibility requirements. For more information about the special rules for flight crew employees, see Fact Sheet #28J.

FMLA Eligibility for Servicemembers under the Uniformed Services Employment and Reemployment Rights Act (USERRA)

Returning servicemembers are entitled to receive all rights and benefits of employment that they would have obtained if they had been continuously employed. Any period of absence from work due to USERRA-covered service counts toward an employee's months and hours of service requirements for FMLA leave eligibility.

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

FMLA is a federal worker protection law. Employers are prohibited from interfering with, restraining, or denying the exercise of, or the attempt to exercise, any FMLA right. Any violations of the FMLA or the FMLA regulations constitute interfering with, restraining, or denying t 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.

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

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 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 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:

- 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.

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

Signature: _____ Date: _____

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 exact 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