
ADMINISTRATIVE REGULATIONS**PER-31****SECTION: Personnel****SUBJECT: Family and Medical Leave Act (FMLA)**

04/01/99

An employee who has worked at least 1,250 hours during the previous 12 months for the Nederland Independent School District, will be entitled to take up to 12 weeks (60 days) unpaid leave a year for:

1. The birth of the employee's child;
2. The placement of a child with the employee for adoption or foster care;
3. To care for the employee's spouse, child or parent who has a serious health condition;
4. A serious health condition rendering the employee unable to perform his or her job.

The 12-month period within which employees shall be eligible for 12 weeks of Family and Medical Leave Act (FMLA) shall be defined as July 1 through June 30.

Employees shall be required to use all applicable accumulated sick leave and vacation (if applicable) in the order determined by policy concurrently with family and medical leave. Employees will not be allowed to use sick leave if the employee is on workers' compensation and has selected to take Family and Medical Leave entitlement.

If both spouses are employed by the District, combined family and medical leave for the birth, adoption, or placement of a child may be limited to a combined total of 12 weeks.

The District will continue the employee's health insurance under the same conditions as if the employee were working during the family and medical leave.

Upon request for family and medical leave for the employee's serious health condition or that of a spouse, parent, or child (PER-31F/A and PER 31F/B), and at 30-day intervals thereafter, the employee shall provide medical certification of the illness or disability.

The employee's request for reinstatement shall be accompanied by medical certification of the employee's ability to perform essential job functions.

NEDERLAND INDEPENDENT SCHOOL DISTRICT

Request for Family or Medical Leave

Please print

Request for Family or Medical Leave must be made as soon as possible prior to the date the requested leave is to begin.

Name _____ Date _____

Identification No. _____ School or Department _____

I request family or medical leave for one of the following reasons:

π Birth and care of a newborn child.*

Expected date of birth _____

Leave to start _____ Expected return date _____

π Placement of a child with me for adoption or foster care.+

Date of placement _____

Leave to start _____ Expected return date _____

π Care of my spouse, child, or parent with a serious health condition.*

Leave to start _____ Expected return date _____

π Inability to work, due to serious health condition.*

Describe: _____

Leave to start _____ Expected return date _____

* Physician's Certification will be required for this leave.

+ Copy of placement papers will be required for this leave.

Have you taken a family or medical leave in the past 12 months? ☐ Yes ☐ No

If yes, how many workdays? _____

I understand and agree to the following provisions:

- Currently employed by the Nederland I.S.D. for a minimum of one year and worked a minimum of 1,250 hours in the previous 12 months.
- Required to use state and local sick leave and vacation (if applicable) as part of 12 weeks leave.
- Will receive pay for leave as long as I have sick leave and/or vacation. If I exhaust my sick leave and/or vacation, this leave will be unpaid but the district will continue to pay my medical insurance premium.

Failure to return to work after the leave for reasons other than the continuation, recurrence or onset of a serious health condition that would entitle me to Medical Leave or other circumstances beyond my control, I will be financially responsible for the medical insurance premiums Nederland I.S.D. has paid while I was on leave.

After 12 weeks of leave, if I do not return to work or contact my supervisor or manager on the date intended, it will be considered that I abandoned my job.

Employee Signature _____

Date _____

Leave Approval

(To be completed by Principal or Immediate Supervisor)

Total Number of working days requested for leave: _____

Principal/Supervisor Signature _____

Date _____

Notes _____

Payroll Instructions

(To be completed by Administration)

π With pay from _____ to _____

Number of Days _____

π Without pay from _____ to _____

Number of Days _____

Comments _____

Assistant Superintendent for Personnel Signature _____

Date _____

NEDERLAND INDEPENDENT SCHOOL DISTRICT

220 – N. 17th Street, Nederland, TX 77627
Phone: (409) 724-2391 FAX: (409) 724-4280

PHYSICIAN CERTIFICATION for Family or Medical Leave

Name _____

Date _____

Identification No. _____

School/Department _____

I am requesting family and medical leave from work with the Nederland Independent School District for:

☐ Myself

☐ My Spouse

☐ My Child

☐ My Parent

who is under your care by the name of _____
Patient's Name

I am requesting one of the following leaves:

☐ Full day leave from _____ to _____.

☐ Intermittent leave for the following dates: _____

To Be Completed by Physician

Please assist the Nederland Independent School District in reaching their decision for granting this leave by providing the following information:

1. As a duly authorized medical care provider, I verify that I am currently

treating _____
Name of Patient

2. The Patient has been diagnosed and is receiving treatment for the following condition:

The relevant medical facts regarding the Patient's condition include the following:

4. The condition began on_____.

5. In my opinion, that condition will last until (provide date if possible)_____

6. As a result of that condition, it is my opinion that:

☐ The Employee is currently unable to perform his/her employment functions.

☐ The Employee is currently needed to care for the Patient.

☐ Intermittent leave is medically necessary for the Employee, or to care for the Patient.

☐ None of the above.

7. In my opinion, the Employee will not be able to return to work until (provide date if possible)

_____.

8. If the Patient requires treatment of the medical condition that necessitates intermittent leave, please describe the treatments to be administered:

As a result of the Patient's condition and/or necessary treatments, it is my opinion that the Employee will be unable to perform his/her employment functions, or is needed to care for the Patient, and therefore unable to work during the following intermittent periods:

From_____ Until_____ From_____ Until_____

From_____ Until_____ From_____ Until_____

From_____ Until_____ From_____ Until_____

Physician's signature

Date

Physician's printed name

Phone No. ()_____

Office mailing address_____

Physician's Comments_____

NOTICE OF PLACEMENT ON FAMILY AND MEDICAL LEAVE

Date: _____
To: _____
From: Michael Laird, Asst. Supt. for Personnel
Subject: **Request for Family and Medical Leave**

On _____, we became aware of your need to take family and medical leave for:

- ☐ the birth of your child, or the placement of a child with you for adoption or foster care; or
- ☐ a serious health condition that makes you unable to perform the essential functions of your job; or
- ☐ a serious health condition affecting your ☐ spouse ☐ child ☐ parent, for which you are needed to provide care.

This is to inform you that you are eligible and π have been π will be placed on FMLA leave beginning on _____. This leave will be counted against your annual family and medical leave entitlement. We understand that your anticipated date of return to work is _____.

If the circumstance of your leave change and you are able to return to work sooner than the anticipated date, you ☐ **will** ☐ **will not** be required to notify the district at least two workdays prior to the date you intend to report for work.

You have the right under FMLA to take up to 12 weeks of unpaid leave in 12-month period for the reasons listed above. Your health benefits will be maintained during FMLA leave under the same conditions as if you continued to work, and you must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from leave. If you do not return to work following FMLA leave for a reason other than (1) the continuation, recurrence or onset of a serious health condition which would entitle you to FMLA leave; or (2) other circumstances beyond your control, you will be required to reimburse the district for its share of health insurance premiums paid on your behalf during your FMLA leave.

You ☐ **will** ☐ **will not** be required to furnish medical certification of a serious health condition. If required, you must furnish certification by _____ (*date no sooner than 15 days after being given notice of this requirement*) or the district may delay the commencement of your leave until the certification is submitted.

You ☐ **will** ☐ **will not** be required to furnish periodic medical certification of a serious health condition every _____ (*indicate interval of periodic reports, as appropriate for the particular leave situation*) during this period of family and medical leave.

You ☐ **will** ☐ **will not** be required to present a fitness-for-duty certification prior to being restored to employment. If such certification is required but not received, your return to work may be delayed until the certification is provided.

You ☐ **will** ☐ **will not** be required to use all applicable and available paid leave concurrently with FMLA leave.

If you normally pay a portion of the premiums for your health insurance, you must continue to pay for these premiums just as you did before FMLA leave. Arrangements for payment have been discussed with you and it is agreed that you will make premium payments as follows: *The 10th and 25th of each month.*

You have a 30-day grace period in which to make premium payments. If payment is not made in a timely manner, your group health insurance may be cancelled, provided the district notifies you in writing at least 15 days before the date that your health coverage will lapse; or, at its option, the district may pay your share of premiums during FMLA leave and recover these payments from you upon your return to work. The district ☐ **will** ☐ **will not** do the same with other benefits (e.g., life insurance, disability insurance, etc) while you are on FMLA leave. If the district does pay your premiums for other benefits, when you return from leave you ☐ **will** ☐ **will not** be expected to reimburse it for the payments made on your behalf.

