Pemberton Township Schools

IMPORTANT INFORMATION:

Family Care **Intermittent** - Leave of Absence

- A staff member eligible for Family Leave must give at least a thirty-day notice to Human Resources. When it is not possible to give this notice, contact either HR Director, Jannett Pacheco, or HR Specialist, Joshua Bentham. (Please refer to District Policies 1643)
- Complete the Request for Leave of Absence form for any leave equal to or greater than 7 school days. Send to Personnel in advance of the leave for Board approval.
- Have your family member's treating physician complete the included Certification of Health Care Provider Form in accordance with the Family Medical Leave Act.
- It is critical to contact Joshua Bentham at ext. 1019 or jbentham@pemb.org regarding any changes to your intermittent leave of absence.
- If there is an established frequency of appointments or scheduled appointment dates ahead of time, please have your Doctor note that in the Certification of Healthcare Provider form. You will not need Doctor's notes for these appointments.
    - However, if the absences are on an as-needed basis a Doctor's note will be required for the absences.

Please return all completed forms to Joshua Bentham, Human Resources

Phone: (609) - 893 - 8141 ext. 1019
Email: jbentham@pemb.org
Fax: (609) - 564 - 1596

An employee absence without leave (AWOL) will be considered to have breached his or her contract and will be subject to disciplinary action including loss of salary and/or such disciplinary action as may be deemed appropriate by the Board of Education. This includes meeting all deadline dates for Human Resources to receive all required and completed forms.

Revised 10/2025

The Family and Medical Leave Act

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.

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.

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.

District utilizes a “rolling” 12-month period measured backward from the date an employee takes FMLA leave.

Example:

- At Patricia’s workplace, the 12-month period for FMLA leave is a rolling 12-month period measured backward from the date an employee takes leave. When Patricia begins FMLA leave on November 1st, her available FMLA leave is 12 workweeks less any FMLA leave she used in the previous 12 months.

CASH BENEFITS

LEARN MORE AT:
myLeaveBenefits.nj.gov

TO CARE FOR YOUR FAMILY MEMBER OR BOND WITH A NEW CHILD



NJ FAMILY LEAVE INSURANCE

Family Leave Insurance benefits can partially replace your wages when you have to stop working to care for a family member/loved one with a physical or mental health condition, bond with a new child, or to handle certain matters related to domestic or sexual violence.

Most New Jersey employees qualify

To be eligible you must meet earnings requirements in the 18 months prior to the start of your claim; see the current year's requirements at **myleavebenefits.nj.gov.**

Receive 85% of your average weekly wages, up to a maximum

See the current year's max weekly benefit level at **myleavebenefits.nj.gov** and learn about how you'll be paid at **myleavebenefits.nj.gov/yourpayment.**

Length of benefits

You may take one continuous period of leave for up to 12 consecutive weeks (84 days) or you can split your leave into multiple periods (days or weeks at a time) and receive up to a maximum of 56 days (8 weeks).

When to apply

If you're planning ahead, you can start the online application at **myleavebenefits.nj.gov** up to 60 days in advance and save it as a draft. Once your leave begins, you must return to your draft to certify and submit your application. If applying after your leave begins, you have 30 days from your first day of leave to file your application. It can take two to six weeks to approve a claim and pay benefits once we have a complete application.

Family Leave Insurance for caregivers

See the law's generous definition of family and apply for caregiving benefits at: **myleavebenefits.nj.gov/caregiver.** When applying, we'll need information from you and your loved one's medical provider. It is your responsibility to ensure this information is submitted – including the medical provider portion, certifying their need for care.

Family Leave Insurance for bonding with a new child

Family Leave Insurance provides cash benefits for parents who stop working to bond with a newborn, newly adopted, or newly placed foster child. You may apply for Family Leave benefits any time during the first year after the child was born, adopted, or placed in your care. In addition, birthing parents can receive Temporary Disability Insurance benefits when they stop working before giving birth, and while recovering. Learn more at **myleavebenefits.nj.gov.**

Family Leave Insurance for domestic violence victims/survivors and their caregivers

If you need to take time off work to handle certain matters related to domestic or sexual violence, you may be able to collect Family Leave Insurance benefits. Family Leave Insurance supports employees who are victims/survivors or are assisting a victim/survivor. To learn more, visit: **myleavebenefits.nj.gov/survivors.**

If you are currently unemployed

If you must care for a loved one or bond with a new child, it is more than 14 days after your last day of work, and you are not on an employer-approved leave of absence, you may be eligible for Family Leave During Unemployment benefits. For more information, visit: **myleavebenefits.nj.gov/unemployed.**

Covered employers and employees

Employers, including local governments (for example, counties, municipalities, and school districts) must participate in the State Family Leave Insurance plan and deduct your payroll taxes for it, or provide a private plan. The federal government is exempt. Generally, employees that work a significant amount of time outside of NJ are not covered but are encouraged to apply to find out if they are eligible. If you are covered under a private plan, talk to your employer to learn more and to get an application.

Job protection

New Jersey Family Leave Insurance is a wage replacement program, not job protection. However, your job may be protected under the Family and Medical Leave Act (FMLA), New Jersey Family Leave Act (NJFLA) or the New Jersey Security and Financial Empowerment (SAFE) Act.

Additionally, if an employer retaliates against you for taking Family Leave Insurance benefits, you have the right to take private legal action.

Learn more at **myleavebenefits.nj.gov/jobprotection.**

For further assistance

T: 609-292-7060

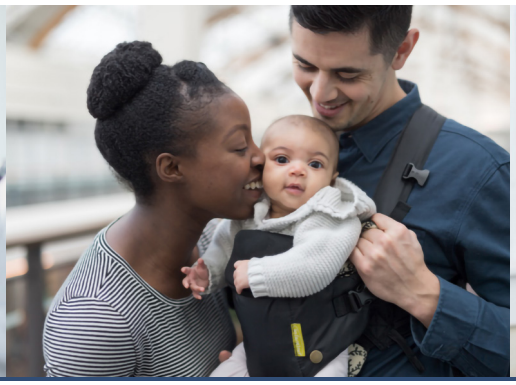
MONDAY-FRIDAY
8:00 am – 4:30 pm

F: 609-984-4138

Temporary Disability and Family Leave Insurance

PO Box 387 | Trenton | NJ | 08625

Hearing-impaired individuals may inquire about their claim via the Telecommunication Device for the Deaf **(TDD): 609-292-8319,** or the NJ Relay Service at **1-800-852-7899.**


5 Things You Should Know About Job-Protected Family Leave

1 **The New Jersey Family Leave Act (NJFLA) is New Jersey's state family leave law** that allows eligible employees to take up to 12 weeks of job-protected leave during a 24-month period to care for a family member or someone who is the equivalent of family.

2 **Under the NJFLA, you generally can take leave if you** (1) work for a company or organization with 15 or more employees worldwide, or a state or local government agency; (2) have been employed by the employer for at least 3 months; and (3) have worked at least 250 hours for the employer in the past 12 months.

3 **If you are eligible, you can generally take up to 12 weeks of job-protected leave—as a block of up to 12 weeks or on an intermittent or reduced schedule—for one of the following reasons:**

- To care for or bond with your child, as long as the leave begins within 1 year of the child's birth or placement with you for adoption or foster care;
- To care for a family member, or someone who is the equivalent of family, with a serious health condition (including a diagnosis of a communicable disease) or who has been isolated or quarantined because of suspected exposure to a communicable disease during a state of emergency; or
- To provide required care or treatment for your child during a state of emergency if their school or place of care is closed by order of a public official due to an epidemic of a communicable disease or other public health emergency.

4 **When you return to work, you are generally entitled to return to the same position** you held before leave, and your employer may not retaliate against you because you took or attempted to take leave under the NJFLA.

5 **NJFLA leave is not the same as leave under the federal Family Medical Leave Act (FMLA),** which covers leave for your own serious medical condition. If you are pregnant or just had a baby, however, you may be able to take up to 12 weeks under the FMLA if you have a pregnancy-related condition that causes a disability requiring time off from work. You then would retain the right to take an additional 12 weeks of NJFLA leave to bond with or care for your baby once you are fit to return to work or you have exhausted your FMLA leave (whichever is earlier).

To find out more or to file a complaint, go to **NJCivilRights.gov**, visit the **NJFLA webpage**, review the **NJFLA Frequently Asked Questions**, or call **1.833.NJDCR4U** (833-653-2748)

NJ Office of the Attorney General
NJCivilRights.gov

NJ DIVISION ON CIVIL RIGHTS
@CivilRightsNJ #CivilRightsNJ #StandUpAgainstHate

The Division on Civil Rights (DCR) enforces the NJFLA, which affords job-protected leave to eligible NJ employees regardless of citizenship or immigration status. To learn more, click here.

The NJFLA protects you against retaliation. No one can retaliate against you for reporting possible NJFLA violations; filing a family leave complaint internally, with DCR, or in court; or exercising any other rights under the NJFLA.

07/17/26

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: 8/31/2029

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: PTBOE 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.