**WOODSTOCK BOARD OF EDUCATION**

**FAMILY AND MEDICAL LEAVE POLICY**

**REQUEST FOR LEAVE**

**UNDER THE FAMILY AND MEDICAL LEAVE ACT OF 1993**

An employee wishing to request leave may make such request by filling out the information contained in this box at the top of this form. Use of this form by the employee is not mandatory.

|  |
| --- |
| Employee requesting FMLA leave: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (Employee's name)  Please be advised that as of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, I give you notice of my need to take  (Today's date)  family and medical leave due to:  🞎 the birth of a child, or the placement of a child for adoption or foster care; or  🞎 a serious health condition that I need care for, or  🞎 a serious health condition affecting my 🞎 spouse, 🞎 child, 🞎 parent, for which I am needed to provide care.  I need this leave beginning on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, and I expect the leave to  (Date)  continue until on or about \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.  (Date)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Employee Signature |

**WOODSTOCK BOARD OF EDUCATION**

**FAMILY AND MEDICAL LEAVE POLICY**

**RESPONSE TO REQUEST FOR LEAVE**

**UNDER THE FAMILY AND MEDICAL LEAVE ACT OF 1993**

This response should be used in all cases by the Superintendent of Schools or his/her designee(s), charged with FMLA compliance responsibility, even if notice has only been given verbally.

TO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Employee's name)

FROM: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Name of appropriate employer representative)

SUBJECT: Request for Family and Medical Leave

On \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, you notified us of your need to take family and medical leave due to:

(Date)

🞎 the birth of a child, or the placement of a child for adoption or foster care; or

🞎 a serious health condition that you need care for, or

🞎 a serious health condition affecting your 🞎 spouse, 🞎 child, 🞎 parent, for which you are needed to provide care.

You notified us that you need this leave beginning on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, and that you (Date)

expect the leave to continue until on or about \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

(Date)

Except as explained below, you have the right under the FMLA to receive up to 12 weeks of unpaid leave in a 12-month period for the reasons listed above. Your health benefits shall be maintained during any period of unpaid leave under the same conditions as if you continued to work, including your insurance premium share payment obligation, if applicable, and you shall 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 may be required to reimburse us for our share of health insurance premiums paid in your behalf during your FMLA leave.

This is to inform you that: (check appropriate boxes; explain where indicated)

1. You are **🞎eligible** **🞎not eligible** for leave under the FMLA.

2. The requested leave **🞎will** **🞎will not** be counted against your annual FMLA leave entitlement.

3. You **🞎will** **🞎will not** be required to furnish medical certification of a serious health condition. If required, you must furnish certification by \_\_\_\_\_\_\_\_\_\_\_\_ (insert date — must be at least 15 days after you are notified of this requirement) or we may delay the commencement of your leave until the certification is submitted.

4. We **🞎will** **🞎will not** require that you substitute accrued paid leave for unpaid FMLA leave. If paid leave will be used, the following conditions will apply: (Explain)

5. (a). If you normally pay a portion of the premiums for your health insurance, these payments will continue during the period of FMLA leave. Arrangements for payment have been discussed with you and it is agreed that you will make premium payments as follows: (Set forth dates, e.g., the 10th of each month, or pay periods, etc. that specifically cover the agreement with the employee.)

(b). You may have a 30-day grace period in which to make payment. If payment has not been made timely, your group health insurance may be cancelled, or, at our option, we may pay your share of the premiums during FMLA leave, and recover these payments from you upon return to work.

(c). We **🞎will** **🞎will not** pay your share of the premiums for your health insurance while you are on leave.

(d). We **🞎will** **🞎will not** do the same with other benefits (e.g., life insurance, disability insurance, etc.) while you are on FMLA leave. If we do, when you return from leave you will be expected to reimburse us for the payments made on your behalf.

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

7. (a). You **🞎are** **🞎are not** a "key employee as described in §825.218 of the FMLA regulations. If you are a "key employee," restoration to employment may be denied following FMLA leave on the grounds that such restoration will cause substantial and grievous economic injury to us.

(b). We **🞎have** **🞎have not** determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic harm to us. (Explain (a) and/or (b) below.)

8. You **🞎will** **🞎will not** be required to furnish us with periodic reports of your status and intent to return to work every 30 days while on FMLA leave.

9. You **🞎will** **🞎will not** be required to furnish recertification every 30 days relating to a serious health condition. (Explain below, if necessary.)

10. You **🞎are** **🞎are not** an instructional employee.

11. In accordance with the Board's policy re: FMLA leave for instructional employees, your leave request **🞎will** **🞎will not** be modified. If modified, the following conditions or alternatives apply:

WOODSTOCK BOARD OF EDUCATION

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ By

(Name of appropriate employer representative)

**WOODSTOCK BOARD OF EDUCATION**

**FAMILY AND MEDICAL LEAVE POLICY**

**CERTIFICATION OF PHYSICIAN OR PRACTITIONER**

**UNDER THE FAMILY AND MEDICAL LEAVE ACT OF 1993**

**TO**: Woodstock Board of Education

1. Employee's name:

2. Patient's name (if other than employee) and relationship to employee:

3. Diagnosis:

4. Date condition commenced:

5. Probable duration of condition:

6. Regimen of treatment to be prescribed (indicate number of visits, general nature and duration of treatment, including referral to other provider of health services. Include schedule of visits or treatment if it is medically necessary for the employee to be off work on an intermittent basis, or to work less than the employee's normal schedule of hours per day or days per week):

a. By Physician or Practitioner:

b. By another provider of health services, if referred by Physician or Practitioner:

**IF THIS CERTIFICATION RELATES TO CARE FOR THE EMPLOYEE'S SERIOUSLY ILL FAMILY MEMBER, SKIP ITEMS 7, 8 AND 9, AND PROCEED TO ITEMS 10 THROUGH 14. OTHERWISE, CONTINUE BELOW.**

Check Yes or No in the boxes below, as appropriate.

Yes No

7. 🞎 🞎 Is inpatient hospitalization of the employee required?

8. 🞎 🞎 Is the employee able to perform work of any kind? (If "no", skip Item 9).

9. 🞎 🞎 Is the employee able to perform the functions of the employee's position? (Answer after reviewing statement from employer of essential functions of the employee's position, or, if none provided, after discussing it with the employee).

Proceed to Item 15

**IF THIS CERTIFICATION RELATES TO CARE FOR THE EMPLOYEE'S SERIOUSLY ILL FAMILY MEMBER, COMPLETE ITEMS 10 THROUGH 14 BELOW AS THEY APPLY TO THE FAMILY MEMBER, AND PROCEED TO ITEM 15.**

Yes No

10. 🞎 🞎 Is inpatient hospitalization of the family member (patient) required?

11. 🞎 🞎 Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation?

12. 🞎 🞎 After review of the employee's signed statement (see Item 14 below), is the employee's presence necessary, or would it be beneficial for the care of the patient? (This may include psychological Comfort).

13. Estimate the period of time care is needed, or the employee's presence would be beneficial?

ITEM 14 IS TO BE COMPLETED BY THE EMPLOYEE NEEDING FAMILY LEAVE.

14. When Family Leave is needed to care for a seriously ill family member, the employee shall state the care he or she will provide, and an estimate of the time period during which this care will be provided, including a schedule if leave is to be taken intermittently or on a reduced leave schedule:

15. Signature of Physician or Practitioner:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

16. Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

17. Type of Practice (Field of Specialization, if any):

18. Employee signature:

19. Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved: 28 October 1999