REQUEST FOR UNPAID FMLA LEAVE

(to be filed at least thirty (30) days in advance of foreseeable leave; otherwise, as soon as practicable)

Employee's Name: _____ Position: _____

Building: _____

I hereby request FMLA leave from _____ to _____ for (circle one):

A. The birth of a child and/or to care for the newborn child within one (1) year of the child's birth;

B. The placement of an adopted child or foster child with you and/or to care for the newly placed child within one (1) year of the child's arrival;

C. To care for an immediate family member (son, daughter, spouse, or parent) with a serious health condition; or

D. The employee's own serious health condition prevents him/her from performing the functions of his/her job (i.e. the health care provider determines that the employee is unable to work at all or is unable to perform any of the essential functions of the employee's position within the meaning of the Americans with Disabilities Act).

Explain the reason for your request:

_____

_____

Does employee's spouse work for the Educational Service Center? ☐ Yes ☐ No

Would an intermittent or reduced leave schedule meet your needs? ☐ Yes ☐ No
If yes, specify a schedule that would meet your needs:

_____

_____

Note: A FMLA leave request based on the employee's serious health condition or the serious health condition of an immediate family member must be accompanied by Form 3430-01- 4430.01- 2, Medical Certification from Health Care Provider.

I hereby authorize the Board of Education to contact my health care provider to verify the reason for my requested FMLA leave or for any other information concerning said leave.

I understand that a failure to return to work at the end of my FMLA leave may be treated as a resignation unless an extension of FMLA leave has been agreed upon and approved in writing by the Board of Education, or an additional unpaid leave is authorized by the Board and/or State law.

_____ _____
Employee's Signature Date

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Employee's accumulated personal leave, sick leave, and/or vacation leave: _____

Total unpaid leave, with benefits, employee entitled to: _____

Intermittent or reduced leave schedule and alternative position employee assigned to (if applicable):

_____

MEDICAL CERTIFICATION FROM HEALTH CARE PROVIDER
FMLA LEAVE

(to be submitted within fifteen (15) days of employee requesting FMLA leave)

Employee's Name: _____ Position: _____

Building: _____

Reason for employee requesting FMLA leave (circle one):

A. To care for an immediate family member (son, daughter, spouse, or parent) with a serious health condition; or

B. The employee's own serious health condition prevents him/her from performing the functions of his/her job (i.e. the health care provider determines that the employee is unable to work at all or is unable to perform any of the essential functions of the employee's position within the meaning of the Americans with Disabilities Act)

If reason #A has been circled above, indicate the name and relationship of the immediate family member (patient): _____

Name of treating health care provider: _____

Type of medical practice (field of specialization, if any): _____

Approximate date on which the serious health condition commenced: _____

Probable duration of the condition/incapacity: _____

Pages four and five of this form describe what is meant by a "serious health condition." Does the patient's condition (for which the employee is taking FMLA leave) qualify under any of the categories described? If so, please check (✓) the applicable category.

❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 or ❑ None of the above

Describe the medical facts which support your certification, including a brief statement as to how the medical facts meet the criteria of one (1) of these categories:

_____

_____

Will it be necessary for the employee to work intermittently or on a reduced leave schedule as a result of the condition (including, as a result of treatment): ❑ Yes ❑ No
If yes, give the probable duration: _____

If the condition is a chronic condition or pregnancy, state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity:

_____

_____

If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments: _____

If the patient will be absent from work or other daily activities because of treatment on an Intermittent or part-time basis, provide an estimate of the probable number and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any:

_____

_____

If any of these treatments will be provided by another provider of health services (e.g., physical therapist), please state the nature of the treatments:

_____

_____

If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment):

_____

_____

If the employee is taking FMLA leave for reason #8 (including absences due to pregnancy or a chronic condition):

A. Is the employee unable to perform work of any kind? ❑ Yes ❑ No

B. If able to perform some work, is the employee unable to perform anyone (1) or more of the essential functions of the employee's job (the employee or the Board will provide you with information about the essential job functions)? ❑ Yes ❑ No

C. If yes, please list the essential functions the employee is unable to perform:

_____

_____

D. If neither A. nor B. applies, is it necessary for the employee to be absent from work for treatment? ❑ Yes ❑ No

If the employee takes FMLA leave for reason #A:

A. Does the patient require assistance for basic medical or personal needs or safety, or for transportation? ❑ Yes ❑ No

B. If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patients recovery? ❑ Yes ❑ No

C. If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need:

_____

_____

_____ _____

Health Care Provider's Signature Date

_____ _____

Address Telephone Number

To be completed by the employee requesting FMLA leave for reason #A:

State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule:

_____

_____

_____

_____

_____ _____

Employee's Signature Date

MEDICAL RELEASE:

I authorize the release of any medical information necessary to process the above request.

_____ _____

Patient's Signature Date

A " **Serious Health Condition**" means an illness, injury , impairment, or physical or mental condition that involves one of the following:

1. Hospital Care. Inpatient care (i.e. an overnight stay) in a hospital, hospice. or residential medical care facility, including any period of incapacity (e.g., inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom), or any subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment: A period of incapacity (i.e. inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom) of more than three (3) consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:

   a. ***Treatment two or more times*** by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under order of, or on referral by, a health care provider (treatment includes examinations to determine if a serious health condition exists and evaluations of the condition, but it does not include routine physical examinations, eye examinations, or dental examinations); or

   b. ***Treatment by a health care provider on at least one (1) occasion which results in a regimen of continuing treatment*** under the supervision of the health care provider (e.g., a course of prescription medication or therapy requiring special equipment to resolve or alleviate the health condition). A regimen of continuing treatment that includes the taking of over-the-counter medications such as aspirin, antihistamines or salves; or bed rest, drinking fluids, exercise and other similar activities that can be initiated without a visit to a health care provider, is not, by itself, sufficient to constitute a regimen of continuing treatment for purposes of FMLA leave.

3. Pregnancy: Any period of incapacity due to pregnancy or for prenatal care.

4. Chronic Conditions Requiring Treatment: Any period of incapacity or treatment for such incapacity due to a chronic health condition (e.g., asthma, diabetes, epilepsy, etc.). A chronic condition is defined as one (1) which:

   a. Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;

   b. Continues over an extended period of time (including recurring episodes of a single underlying condition); and

   c. May cause episodic rather than a continuing period of incapacity.

5. Permanent/Long-term Conditions Requiring Supervision: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective (e.g., Alzheimer's, a severe stroke or the terminal stages of a disease). The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider.

6. Multiple Treatments (Non-Chronic Conditions): Any period of absence to receive **multiple treatments** (including any period of recovery therefrom) by a health care provider or by a provider of health care services under the orders of, or on referral by, a health care provider, either for **restorative surgery** after an accident or other injury, or for a condition that **would likely result in a period of incapacity of more than three (3) consecutive calendar days in the absence of medical intervention or treatment**, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).

Conditions for which cosmetic treatment are administered (e.g., acne or plastic surgery) are not "serious health conditions" unless inpatient hospital care is required or unless complications develop. Ordinarily, unless complications arise, the common cold, the flu, ear aches, upset stomach, minor ulcers, headaches other than migraine, routine dental or orthodontia problems, periodontal disease, etc., are conditions that do not meet the definition of a serious health condition and do not qualify for FMLA Leave.

Mental illness resulting from stress or allergies may be serious conditions, but only if all the conditions of the above subparagraphs are met.

Substance abuse may be a serious health condition if the conditions stated above are met (i.e. the treatment is by a health care provider or by a provider of health care services on referral by a health care provider). Absence due to an employee's use of the substance, rather than for treatment, does not qualify for FMLA Leave.