LAKELAND REGIONAL HIGH SCHOOL
Restart & Recovery 2020

Minimal Standard as outlined by the NJDOE:
In all stages and phases of pandemic response and recovery, the Centers for Disease Control and Prevention recommends actions, which schools and districts should incorporate into reopening plans:

- Reasonable accommodations should be provided for individuals that the Centers for Disease Control identifies as having a higher risk for severe illness from COVID-19, including older adults (aged 65 years and older) and individuals with disabilities or serious underlying medical conditions, which may include:
    - Chronic lung disease or asthma (moderate to severe)
    - Serious heart conditions
    - Immunocompromised
    - Severe obesity (body mass index, or BMI, of 40 or higher)
    - Diabetes
    - Chronic kidney disease undergoing dialysis
    - Liver disease
    - Medically fragile students with Individualized Education Programs (IEPs)
    - Students with complex disabilities with Individualized Education Programs (IEPs)
    - Students who require accommodations under a Plan in accordance with the Section 504 of the Rehabilitation Act of 1973 (504 Plan).

1. **Disability or CDC High Risk Category Accommodation Request (for Employee's condition only/ secondary disorder that is exacerbated by employee's higher COVID-19 risk may be approved)**
    a. Employee to complete Disability Accommodation Request (Form A on page 4) and submit with Physician's Certification (Form B on Page 6)
    b. If approved, employee granted an accommodation are compensated as governed by the existing CBA.
    c. If not approved due to it causing an undue hardship on the employer, Employee may be eligible for CBA sick leave or NJ Paid Sick leave (if applicable.) Possibly FMLA entitlement (see # 2 below) depending on the seriousness of the health condition. Otherwise job abandonment. Employees are not eligible for unemployment benefits.
    d. Employers are not required to provide a reasonable accommodation if doing so would cause an undue hardship which as defined:* means that an accommodation would be unduly costly, extensive, disruptive or would fundamentally alter the nature or operation of the business
    e. **Requests are due to Cathy Pagana in the Business Office by Friday, August 14.**

2. **Leave Request (FMLA/NJFLA for Employee's own health condition including advisement by healthcare provider or public health authority to quarantine; If not for care of/bond with newborn or seriously injured family member, employee may be eligible for NJ Temporary Disability Insurance.**
    a. Employee to complete FMLA/NJFLA application and submit medical certification. Medical certifications are REQUIRED for all Medical Leave Requests.
    b. If approved, the employee is eligible for up to 80 hrs. Paid leave under the Federal Emergency Paid Sick Leave Act or FEPSL (prorated for PT employees) in ADDITION to regular 12 weeks of FMLA/NJFLA (running consecutively or concurrently depending on CBA or board policy). The FEPSL is payable from day one of employment at the employee's full wage subject to a maximum of $511/day and a total maximum of $5110. An employee can opt to use existing sick leave before or after this FEPSL pay period. Benefits are retained during the leave periods with normal contributions. An employee would apply directly for NJFLI benefits.
    c. Non-represented employees (those ineligible for sick days under 18A) may be eligible for NJ Earned Sick Leave in place of CBA bargained sick leave.

3. **Leave Requests (for Childcare)**
    a. Employee is eligible for Federal Emergency Paid Sick Leave and FMLA Emergency Childcare Leave. NJ Family Leave is not available unless the leave begins within one year of the date the child is born or placed with the employee. Otherwise NJFLA for care of the child is only for the child's serious health condition. FMLA and NJFLA run consecutively or concurrently as applicable. FEPSL is in addition to the other leaves. The employee's initial 10 days of leave would be unpaid, FEPSL at 2/3 of the employee's wages with a maximum of $200/day and a total maximum of $2000, after which point, the employee would be eligible for paid leave under EFMLEA. The Emergency Childcare Leave benefit under FMLA does not extend the maximum 12 weeks and it requires an employee to have been employed for at least 30 calendar days however it does require the employer to pay the employee. The payment under ECL is 2/3 of the employees' wages with a maximum of $200/day or $10,000 maximum. The first two weeks are unpaid under ECL, followed by up to 10 weeks paid. Benefits are retained during the Leave periods with normal contributions.

4. **Leave Requests (For Care of a Covered Family Member with a Serious Health Condition)**
    a. Employee to complete FMLA/NJFLA application and submit medical certification. Certification REQUIRED for all Medical Leave conditions.
    b. If approved, the employee's health condition is related to COVID-19, the employee is eligible for 80 hrs. paid leave under the Federal Emergency Paid Sick Leave Act (prorated for PT employees) in ADDITION to the regular 12 weeks of FMLA/NJFLA (running consecutively or concurrently as applicable). Note: eligible employees are those that have worked in the prior 12 months/1250 hours of employment. The FEPSL is payable from day one at the full wage with a maximum of $511/day and a total maximum of $5110. Benefits are retained

during the leave periods with normal contributions. Employee would apply directly for NJFLI benefits.

5. **Leave Requests (For Care of a Loved one for coronavirus quarantine, illness or symptoms)**
    a. Complete FMLA form. Medical certification or Public Health Authority advisement required.
    b. Employees are eligible for Emergency Paid Sick Leave for up to 80 hrs. The payment under ECL is 2/3 of the employees' wages with a maximum of $200/day or $2,000 maximum available from day one of employment Standard FMLA rules apply for the remainder of the 10 weeks provided the employee is eligible for those weeks. Benefits are retained during the Leave periods with normal contributions.
    c. Note: NJFLA does not currently extend to self-quarantining unless advised by a healthcare provider or public health authority.

6. **Self-Quarantining-** Employees traveling from states with increasing rates of COVID-19 are advised to self-quarantine for 14 days. This includes travel by train, bus, car, plane and any other method of transportation. Such employees are eligible for EPLSA.

The 14-day quarantine travel advisory applies to travel The 14-day quarantine travel advisory applies to travel from certain states identified as those that have a positive COVID-19 test rate higher than 10 per 100,000 residents or have a 10% or higher positivity rate over a seven-day rolling average ("impacted states.")

Lakeland Regional High School
FORM A

Americans with Disabilities Act
Accommodation Request Form

To initiate a request for reasonable accommodations, please complete this form and provide a copy to **Cathy Pagana** and also submit a copy to the **Mr. Hugh Beattie & your area supervisor by Friday, August 14**. Any supporting documentation that would assist in responding to your request should be attached to this form.

Employee Name: _____

Position: _____

1. Identify the condition that requires a reasonable accommodation (e.g., your disability or physical or mental impairment(s) or limitation(s) ("Disability"):

2. Explain how your Disability impairs or limits your ability to perform your assigned job responsibilities:

3. What is the expected duration of your Disability?

4. If known, what accommodation(s) are you requesting?

5. If you are not sure what accommodation is needed, do you have any suggestions that we could explore?

6. Has a specific accommodation been recommended? If so, please describe the recommendation and, if available, attach any supporting documentation.

7. Have you received accommodations in the past for the same Disability? If yes, what were they and how did they help you perform your job responsibilities?

8. Please provide any additional information that might be helpful in processing your accommodation request.

Signature: _____ Date:_____

Lakeland Regional High School
FORM B

Physician Certification for Employee Disability Accommodation

_____ _____
Print Patient Name (last, first, middle) Examination Date

_____ _____
Print Physician Name New Jersey License Number

I certify that the above-named patient is permanently/temporarily disabled and may/may not require accommodation.

Please Check and Complete One of the Following Three Options:

☐ I examined the above-named patient on _____ and certify that the patient has the following permanent/temporary functional limitation(s):

_____

_____

_____

☐ I examined the above-name patient on _____ and I am unable to make a determination without further examination. The patient is scheduled for a follow-up examination on _____ with _____.

☐ I examined the above-named patient on _____ and I have not found any limitations at this time. This patient may return to regular duty without restrictions on _____

Physician Comment:_____

_____

_____

_____

_____
Physician Street Address Suite #

_____
City State Zip Code

Phone Number: _____

Physician Signature: _____ Date: _____

Attach any relevant documentation, reports, or additional information which you believe may be pertinent to the accommodation review process.

Lakeland Regional High School
FORM C

Employee Authorization for Release of Records for Disability Accommodation Request

_____
Print Employee Name (last, first, middle)

_____
Print Physician/Practitioner Name

I,_____, hereby authorize the above-listed physician/practitioner to exchange any of my Protected Health Information ("PHI"), including, but not limited to, confidential medical, psychological and/or sociological information, to Lakeland Regional High School (the "Board") for the purpose of disability accommodation request evaluation. By signing this form, I authorize the release of a copy of my PHI, or a summary or narrative of my protected health information to the Board.

Any information shared will be treated in a professional and confidential manner and will be used for the exclusive purpose of disability accommodation request evaluation. Information received by the Board will be placed in the employee's confidential file. The effect of granting this authorization may be that the PHI used or disclosed may be subject to the re-disclosure by the recipient, in which case it may no longer be protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

The Board, its programs, services, employees, officers, agents and/or assigns are hereby released from any legal responsibility or liability for disclosure of my PHI to the extent indicated and authorized.

This authorization is given voluntarily. The Board will not condition the grant of a disability accommodation on the giving of this authorization.

I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Board. I understand that revocation of this authorization will not affect any action taken by the Board in reliance on this authorization before written notice of revocation was received. If information has already been disclosed in reliance on this authorization, revoking it will only prevent future disclosure.

This authorization expires one year from the date of the employee signature.

I have had a full opportunity to read and consider the contents of this authorization, and I understand that, by signing this form, I am confirming my authorization of the use and/or disclosure of my PHI, as described in this form.

_____ _____
Employee Signature Date