Family and Medical Leave Act (FMLA)
(Up to 12 weeks)

QUALIFYING EXIGENCY
FOR MILITARY FAMILY LEAVE
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MEDICAL LEAVE OF ABSENCE REQUIREMENTS

Request for leave must be made at least thirty (30) days prior to the date the requested leave is to begin, or as soon as practicable under the circumstances. The LRSD may delay FMLA coverage to any employee who fails to provide timely notice of the need for leave.

The employee must complete the appropriate “Request for Medical Leave of Absence, Family and Medical Leave Act (FMLA)” form. Please note, ALL leave types require the completion of an application for leave and any other related forms for the specified leave of absence to be determined for approval.

Upon receipt of the Request for Medical Leave of Absence, Family and Medical Leave Act (FMLA) form, the employee will receive a Notice of Eligibility and Rights & Responsibilities Form. The LRSD will require the employee to complete the appropriate Certification of Healthcare Provider form.

The employee must return a completed Certification of Healthcare Provider form within fifteen (15) calendar days of the LRSD request. Failure to provide the required Certification of Healthcare Provider form within the 15 calendar days notice may result in FMLA coverage being denied until the required certification is provided.

Specific dates (start date and estimated return date) MUST be provided in the Certification of Healthcare Provider form. Statements such as “until further notice”, “undetermined,” or “until next appointment”, etc. will NOT be accepted.

If the Certification of Healthcare Provider form is incomplete or insufficient, Human Resources (HR) will notify the employee in writing of such, stating what information is needed to cure the deficiency. The employee must cure the deficiency within seven (7) calendar days of the notification of the deficiency, unless impracticable under the circumstances despite the employee’s diligent good faith efforts. Failure to provide an adequate Certification of Healthcare Provider form may result in the denial of FMLA coverage.

The LRSD will maintain the coverage under any group health plan for any employee on medical leave on the same conditions as coverage would have been provided if the employee had been continuously employed during the leave period. Any share of group health insurance premiums which had been paid by the employee prior to medical leave must continue to be paid by the employee during the medical leave period.

Prior to returning to work, the employee shall submit a “Medical Leave Return to Work Certification” form completed by the employee's health care provider. The Medical Leave Return to Work Certification may be submitted to HR in-person, by mail or by facsimile at (501) 447-1162. The employee should NOT return to work until he/she makes contact with HR and the employee receives authorization to return to work. HR will notify the employee's supervisor of the employee's return to work.

Employee Name (Print) Employee Signature Date

HUMAN RESOURCES DEPARTMENT
Little Rock School District ● 810 West Markham St. ● Little Rock, AR 72201 ● 501-447-1100 ● (fax) 501-447-1162
REQUEST FOR MEDICAL LEAVE OF ABSENCE
Family and Medical Leave Act (FMLA) (up to 12 weeks)

Date:___________________________________________ Social Security Number____________________________

Employee’s Name (Print):___________________________________________________________________________

Position:________________________________________ Location:___________________________________________

Phone Number:______________________________ Alternate Number:________________________________

Address:________________________________________ Apt:__________________________________________

City: ____________________ State: ______ Zip Code_______ Email Address:_________________________

- I understand that my request for a medical leave of absence must be accompanied by a Certification of Healthcare Provider form, which must be provided within 15 days of the request.
- I also understand that my medical leave will run concurrently with my accrued paid sick leave. Request for Medical Leave must be made 30 days prior to the date requested leave is to begin.

Please initial:  _______

I request a Medical Leave of Absence for one or more of the following reasons:

☐ The birth of a child, or the placement of a child with me for adoption or foster care; or

☐ A serious health condition that makes me unable to perform the essential functions of my job; or

☐ A serious health condition affecting my ☐ spouse ☐ child ☐ parent for which I am needed to provided care; or

☐ Any qualifying exigency arising from my ☐ spouse ☐ child ☐ parent Who is on active military duty, or has been notified of any impending call to active duty status, in support of a contingency operation.

☐ Care for my: ☐ spouse ☐ child ☐ parent or ☐ next of kin who is a covered service member recovering from a serious illness or injury in the line of duty on active military duty, who is a: ☐ current service member ☐ veteran

☐ Military Leave

☐ I am a current service member injured in the line of duty.

Please submit original (not a copy) to:
Human Resources Department
ATTN: Medical Leave

HUMAN RESOURCES DEPARTMENT
Little Rock School District • 810 West Markham St. • Little Rock, Arkansas 72201 • 501-447-1100 • (fax) 501-447-1162
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REQUEST FOR MEDICAL LEAVE OF ABSENCE
Family and Medical Leave Act (FMLA)  (up to 12 weeks)

☐ Intermittent Leave or leave on a reduced leave schedule due to:

☐ My own serious health condition  ☐ Care for an immediate family member

The estimated schedule I am requesting for intermittent leave is:

The reasons for requesting this schedule is:

If my request for medical leave of absence is granted, I understand that I will be required to provide the District with a statement from my Healthcare Provider confirming that I am fully capable of performing the essential duties of my position prior to my return to work.

Please initial: ________
(MUST BE INITIALED)

I UNDERSTAND that I must comply with Little Rock School District procedures for requesting leave and reporting my absences. I also understand that I may be required to provide additional documentation including medical certification as required and as requested by the District.

_____________________________________________________________  ________________________________
Employee’s Signature  Date

For HR District Personnel to Complete:

Please list all previous medical leaves of absence within the last 5 years for this employee.

<table>
<thead>
<tr>
<th>Leave Date</th>
<th>Return Date</th>
<th>Length of Leave</th>
<th>Reason</th>
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A FAMILY MEDICAL LEAVE OF ABSENCE IS:

_______Approved for Dates: __________________________TO___________________________

_______Not approved due to: _______________________________________________________

_____________________________________________________________  ________________________________
Designated Administrator  Date
SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a qualifying exigency to submit a certification. Please complete Section I before giving this form to your employee. Your response is voluntary, and while you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 CFR 825.309.

Employer name: ____________________________________________________________

Contact Information: _________________________________________________________

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II fully and completely. The FMLA permits an employer to require that you submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a qualifying exigency. Several questions in this section seek a response as to the frequency or duration of the qualifying exigency. Be as specific as you can; terms such as “unknown,” or “indeterminate” may not be sufficient to determine FMLA coverage. Your response is required to obtain a benefit. 29 CFR 825.310. While you are not required to provide this information, failure to do so may result in a denial of your request for FMLA leave. Your employer must give you at least 15 calendar days to return this form to your employer.

Your Name: ________________________________________________________________

First   Middle    Last

Name of military member on covered active duty or call to covered active duty status:

____________________________________________________________________________

First   Middle    Last

Relationship of military member to you: ____________________________________________

Period of military member’s covered active duty: ________________________________

A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes written documentation confirming a military member’s covered active duty or call to covered active duty status. Please check one of the following and attach the indicated document to support that the military member is on covered active duty or call to covered active duty status.

☐ A copy of the military member’s covered active duty orders is attached.

☐ Other documentation from the military certifying that the military member is on covered active duty (or has been notified of an impending call to covered active duty) is attached.

☐ I have previously provided my employer with sufficient written documentation confirming the military member’s covered active duty or call to covered active duty status.
PART A: QUALIFYING REASON FOR LEAVE

1. Describe the reason you are requesting FMLA leave due to a qualifying exigency (including the specific reason you are requesting leave):
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

2. A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes any available written documentation which supports the need for leave; such documentation may include a copy of a meeting announcement for informational briefings sponsored by the military; a document confirming the military member’s Rest and Recuperation leave; a document confirming an appointment with a third party, such as a counselor or school official, or staff at a care facility; or a copy of a bill for services for the handling of legal or financial affairs. Available written documentation supporting this request for leave is attached. 
Yes ☐ No ☐ None Available ☐

PART B: AMOUNT OF LEAVE NEEDED

1. Approximate date exigency commenced:

Probable duration of exigency:

2. Will you need to be absent from work for a single continuous period of time due to the qualifying exigency? 
Yes ☐ No ☐

If so, estimate the beginning and ending dates for the period of absence:

3. Will you need to be absent from work periodically to address this qualifying exigency? Yes ☐ No ☐

Estimate schedule of leave, including the dates of any scheduled meetings or appointments:

Estimate the frequency and duration of each appointment, meeting, or leave event, including any travel time (i.e., 1 deployment-related meeting every month lasting 4 hours):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours ___ day(s) per event.
PART C:

If leave is requested to meet with a third party (such as to arrange for childcare or parental care, to attend counseling, to attend meetings with school, childcare or parental care providers, to make financial or legal arrangements, to act as the military member’s representative before a federal, state, or local agency for purposes of obtaining, arranging or appealing military service benefits, or to attend any event sponsored by the military or military service organizations), a complete and sufficient certification includes the name, address, and appropriate contact information of the individual or entity with whom you are meeting (i.e., either the telephone or fax number or email address of the individual or entity). This information may be used by your employer to verify that the information contained on this form is accurate.

Name of Individual: ______________________________ Title: ______________________________
Organization: _________________________________________________
Address: __________________________________________________________________________________________
Telephone: (________) ___________________________ Fax: (_______) ______________________________________
Email: ____________________________________________________________________________________________
Describe nature of meeting: ___________________________________________________________________________
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__________________________________________________________________________________________________
PART D:
I certify that the information I provided above is true and correct.

Signature of Employee ___________________________________________ Date _______________________________

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 CFR 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 20 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 A.V., NW, Washington, DC 20210. DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE EMPLOYER.
MEDICAL LEAVE RETURN TO WORK CERTIFICATION

EMPLOYEE:

Employee Name (Print):________________________________________

Position:________________________________________ Location:________________________________________

Phone Number:________________________________ Email address:_____________________________________

Employee Signature:________________________________________ Date:________________________________

TREATING HEALTH CARE PROVIDER:

Please review the attached job description. Based on your review of the attached job description is the above employee able to perform the essential functions of the position?

☐ Yes  ☐ No  ☐ Yes, with restrictions or accommodations

Please list any restrictions/limitations or describe accommodations which LRSD should consider:
MEDICAL LEAVE RETURN TO WORK CERTIFICATION

TREATING HEALTH CARE PROVIDER (continued):

Are the restrictions/limitations: □ Permanent □ Temporary, until (Date): ____________________________

Comments:

Employer is released to return to work effective (Date): ____________________________

Treating Healthcare Practitioner Name (Print): ____________________________

Treating Healthcare Practitioner Signature: ____________________________

Specialty: ____________________________

Address: ____________________________

Phone number: ____________________________

Date: ____________________________ Contact Phone Number: ____________________________
Basic Leave Entitlement
FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or childbirth;
- To care for the employee’s child after birth, or placement for adoption or foster care;
- To care for the employee’s spouse, son or daughter, or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee’s job.

Military Family Leave Entitlements
Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave for caring for a covered servicemember during a single 12-month period. A covered servicemember is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections
During FMLA leave, the employer must maintain the employee’s health coverage under any “group health plan” on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee’s leave.

Eligibility Requirements
Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition
A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee’s job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave
An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer’s operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave
Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer’s normal paid leave policies.

Employee Responsibilities
Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer’s normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities
Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees’ rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee’s leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers
FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement
An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.