Little Rock School District

MEDICAL LEAVE PACKET

Family and Medical Leave Act (FMLA)

(Up to 12 weeks)

FAMILY MEMBER’S
SERIOUS HEALTH CONDITION

Name: ___________________________________
Location: _________________________________
REQUEST FOR FAMILY MEDICAL LEAVE OF ABSENCE (FMLA)
(up to 12 weeks)

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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
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 provide 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 or veteran

☐ Military Leave

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

<table>
<thead>
<tr>
<th>PRIOR FMLA DAYS USED</th>
<th>#FMLA DAYS ELIGIBLE</th>
<th>#FMLA DAYS REQUESTED</th>
<th>#SICK LEAVE DAYS AVAILABLE</th>
<th>ADDITIONAL COMMENTS</th>
</tr>
</thead>
</table>

[A FAMILY MEDICAL LEAVE OF ABSENCE IS:]

_____Approved for Dates: _____________ to _____________ (_____ days)

_____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 protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Please complete Section I before giving this form to your employee. Your response is voluntary. 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 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of 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.

Employer name and contact: ________________________________

SECTION II: For Completion by the EMPLOYEE
INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your family member or his/her medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a covered family member with a serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Your name: ____________________________

First   Middle   Last

Name of family member for whom you will provide care: ________________________________

First   Middle   Last

Relationship of family member to you: ________________________________

If family member is your son or daughter, date of birth: ________________________________

Describe care you will provide to your family member and estimate leave needed to provide care:

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

Employee Signature ____________________________ Date ____________________________
SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. 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 FMLA coverage. Limit your responses to the condition for which the patient needs leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e).

Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider’s name and business address: ____________________________________________________________

Type of practice / Medical specialty: ____________________________________________________________

Telephone: (_______)____________________________ Fax: (_______)______________________________

PART A: MEDICAL FACTS

1. Approximate date condition commenced: ______________________________________________________
   Probable duration of condition: _________________________________________________________________
   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
   ___No ___Yes. If so, dates of admission: _____________________________________________________
   Date(s) you treated the patient for condition: __________________________________________________
   Was medication, other than over-the-counter medication, prescribed? ___ No ___Yes.
   Will the patient need to have treatment visits at least twice per year due to the condition? ___No ___Yes.
   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
   ___No ___Yes. If so, state the nature of such treatments and expected duration of treatment:
   ________________________________________________________________________________________
   ________________________________________________________________________________________

2. Is the medical condition pregnancy? ___No ___Yes. If so, expected delivery date: ____________________

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):
   ________________________________________________________________________________________
   ________________________________________________________________________________________
   ________________________________________________________________________________________

2
PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient’s need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery?  ___No  ___Yes.

   Estimate the beginning and ending dates for the period of incapacity (statements such as “unknown”, “in definite”, “until next appointment”, etc will not be accepted):
   Beginning date: __________________________ Ending date: ______________________________

   During this time, will the patient need care?  ___No ___Yes.

   Explain the care needed by the patient and why such care is medically necessary:

   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

5. Will the patient require follow-up treatments, including any time for recovery?  ___No ___Yes.

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   __________________________________________________________
   Explain the care needed by the patient, and why such care is medically necessary:______________________________
   __________________________________________________________

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery?  ___No ___Yes.

   Estimate the hours the patient needs care on an intermittent basis, if any:
   ______ hour(s) per day; ______ days per week  from __________ through__________

   Explain the care needed by the patient, and why such care is medically necessary:

   __________________________________________________________
   __________________________________________________________
7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ____ No ____ Yes.

   Based upon the patient’s medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

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

   Duration: _____ hours or ___ day(s) per episode

   Does the patient need care during these flare-ups? ____ No ____ Yes.

   Explain the care needed by the patient, and why such care is medically necessary:

   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________

   ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________

   Signature of Health Care Provider ____________________________ Date ____________
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:

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________
TREATING HEALTH CARE PROVIDER (continued):

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

Comments:

Employee 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 child birth;
- 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 to care 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.

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 employee’s 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.