Clayton County Public Schools Division of Human Resources

Request for Family Medical Leave (FML) Packet

Dear Employee,

This leave of absence packet will help guide you through the medical leave process. Please fully review the contents of this packet and complete the necessary steps listed below:

Action Steps:

- **Initiate Your Leave:**
  - The employee should complete the Medical Request for Leave Form and submit to his/her immediate supervisor and directly to the Division of Human Resources within thirty (30) days of anticipated need for leave.
  - If the need for leave is unforeseen, the employee must provide notice as soon as practical. If leave is unforeseeable, the employee must notify the Division of Human Resources Benefits Unit: Leave Management as soon as possible.
  - Completed forms should be either submitted to Clayton County Public Schools ("CCPS") Division of Human Resources by email to FamMedLeave@clayton.k12.ga.us or delivered to Clayton County Public Schools, Division of Human Resources Benefits Unit – Ms. Tanya Turnipseed, 1058 Fifth Avenue, Jonesboro, GA 30236.

Instructions for completing the Family Medical Leave Request Form:

Step 1: Employee Information

Please provide your CCPS Employee I.D. Number or Social Security Number, home address, contact number, and email address.

Note: All HR correspondence will be sent to the requesting leave employee via email.

Step 2: Absence Information/ Types of Leave and Definitions

Continuous Leave is defined as leave taken in one long, uninterrupted block of time from start to finish (*For example*, November 1st through November 10th).

Intermittent Leave is defined as leave taken periodically, an hour or two at a time, a day or two at a time over the course of several weeks or months. (*For example*, reduced schedule, one day per week or month for appointments, treatment, therapy, etc.).

List the beginning and ending date of your anticipated leave. If you do not have the exact dates, please provide best estimate.

Step 3: Leave is Required For:

The employee should select the reason for leave (i.e. employee, family member or birth/adoption of a child).

- Supporting documentation is required (i.e. Medical Certification Form, official military identification for the Military Caregiver Request or Military Orders).

Clayton County Public Schools Division of Human Resources

Request for Leave Packet Continued

Step 4: Signatures

- Employee sign and date
- Obtain supervisor's signature and date

Forms are not accepted without BOTH signatures

Complete the Certification of Health Care Provider Form:

- Certification must be completed by a licensed physician and submitted to the Division of Human Resources within 15 calendar days of last day worked.
- Medical certification must include the following:

1. Medical certification substantiating a serious health conditions that requires FML due to the employee inability to work or required to care for a qualified family member;
2. The beginning and estimated ending date of employee's need for leave (or estimated duration of FML Leave);
3. Confirm there is a regiment of treatment; and
4. Health care provider's signature

AND/OR

(Intermittent FML) – Medical certification that the condition has or will cause episodic flare-ups periodically preventing employee or family member from participating in normal daily activities.

5. Based upon medical history and the doctor's knowledge of the medical condition, an estimate of the frequency of flare-ups and duration of related incapacity that may cause the employee to miss work over the next 6 months (such as one episode every 3 months lasting 1-2 days) and
6. Health care provider's signature

Intent to Return and/or Fitness for Duty Form, after doctor release

Step 1

- Enter your name, phone number and email address.
- Please provide authorization by signing and date

Step 2

- Attach your Job Description

Step 3

- Health care provider completes Section III.

Note: It is the employees' responsibility to ensure this form is returned to Clayton County Public Schools at least seven business days prior to returning to work.

Submit forms to the Division of Human Resources either by email to FamMedLeave@clayton.k12.ga.us or delivered to Clayton County Public Schools, Division of Human Resources, Benefits Unit – Ms. Tanya Turnipseed, 1058 Fifth Avenue, Jonesboro, GA 30236.

Clayton County Public Schools Division of Human Resources

FAMILY MEDICAL LEAVE REQUEST FORM

EMPLOYEE INSTRUCTIONS

This form must be completed by the employee to request a medical leave of absence. Please complete the form and forward to the Division of Human Resource Department either by email FamMedLeave@clayton.k12.ga.us or deliver to 1058 Fifth Avenue, Jonesboro, GA 30236.

EMPLOYEE INFORMATION

SSN/EMP ID _____ First Name_____ MI ___ Last Name _____

Complete Address _____ City _____ Zip Code _____

Phone Number _____ Alt. Phone Number _____

Email Address _____

(All correspondence will be sent via email only)

School/Department _____ Position_____

Employee's Supervisor/Manager _____ Phone Number _____

ABSENCE INFORMATION

Type of Leave Requested: ☐ **Continuous Days** ☐ **Intermittent** ☐ **Paid Parental Leave**

I am requesting Family and Medical Leave for the following dates (*maximum of 60 days per rolling calendar year*)

_____ _____ _____

Beginning Date **Ending Date** **Anticipated Return to Work Date**

Prior to processing request, employee must provide anticipated (estimated) leave dates as request above.

I am requesting Paid Parental Leave for the following dates (*maximum of 15 days*)

_____ _____

Beginning Date **Ending Date**

LEAVE IS REQUIRED FOR:

Serious Health Condition; Check one:

___ Employee
OR
___ Spouse (*name*) _____ OR

___ Parent (*name*) _____ OR

___ Child (*name*) _____ AGE _____

___ Birth of Child
OR
___ Adoption of a Child

___ Placement of a Child
(Must provide supporting documentation)

Date (or expected date) of birth, adoption, or placement of a foster child: _____

Military:
___ Qualifying Exigency (call to active duty) ___To care for a covered service member with a qualified serious injury or illness

____ Self ____Spouse ____ Son ____ Daughter ____ Parent (do not include in-laws) ___ Next of Kin

(Supporting documentation is required (i.e. copy of official orders)

Signature of Employee : _____ Date: _____

Signature below indicates knowledge of leave and that employee is applying for FML:

Signature of Principal/Supervisor: _____ Date: _____

Print Principal/Supervisor name: _____

Return completed FML application to: Clayton County Public Schools Division of Human Resources Department at: 1058 Fifth Avenue, Jonesboro, GA 30236 or email to FamMedLeave@clayton.k12.ga.us

Certification of Health Care Provider for Family Member's Serious Health Condition under the Family and Medical Leave Act

U.S. Department of Labor
Wage Hour Division

WAGE AND HOUR DIVISION

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR.
RETURN TO THE PATIENT.

OMB Control Number: 1235-0003
Expires: 6/30/2023

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave to care for a family member with a serious health condition to submit a medical certification issued by the family member's health care provider. 29 U.S.C. §§ 2613, 2614(c)(3); 29 C.F.R. § 825.305. The employer must give the employee **at least 15 calendar days** to provide the certification. If the employee fails to provide complete and sufficient medical certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

SECTION I - EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, this form asks the health care provider for the information necessary for a complete and sufficient medical certification, which is set out at 29 C.F.R. § 825.306. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308**. Additionally, you **may not** request a certification for FMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care.

Employers must generally maintain records and documents relating to medical information, medical certifications, recertifications, or medical histories of employees or 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.

(1) Employee name: _____
First *Middle* *Last*

(2) Employer name: _____ Date: _____ *(mm/dd/yyyy)*
(List date certification requested)

(3) The medical certification must be returned by _____ *(mm/dd/yyyy)*
(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee's diligent, good faith efforts.)

SECTION II - EMPLOYEE

Please complete and sign Section II before providing this form to your family member or your family member's health care provider. The FMLA allows an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of your family member. If requested by your employer, your response is required to obtain or retain the benefit of the FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). **You are responsible for making sure the medical certification is provided to your employer within the time frame requested, which must be at least 15 calendar days.** 29 C.F.R. §§ 825.305-825.306. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA leave request. 29 C.F.R. § 825.313.

(1) Name of the family member for whom you will provide care: _____

(2) Select the relationship of the family member to you. The family member is your:

☐ Spouse ☐ Parent ☐ Child, under age 18
☐ Child, age 18 or older and incapable of self-care because of a mental or physical disability

Spouse means a husband or wife as defined or recognized in the state where the individual was married, including in a common law marriage or same-sex marriage. The terms "child" and "parent" include *in loco parentis* relationships in which a person assumes the obligations of a parent to a child. An employee may take FMLA leave to care for an individual who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave to care for a child for whom the employee has assumed the obligations of a parent. No legal or biological relationship is necessary.

Employee Name: _____

(3) Briefly describe the care you will provide to your family member: (*Check all that apply)*

☐ Assistance with basic medical, hygienic, nutritional, or safety needs ☐ Transportation

☐ Physical Care ☐ Psychological Comfort ☐ Other: _____

(4) Give your **best estimate** of the amount of leave needed to provide the care described: _____

_____

(5) If a **reduced work schedule** is necessary to provide the care described, give your **best estimate** of the reduced schedule you are able to work. From _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy),* I am able to work _____ (*hours per day*) _____ (*days per week).*

Employee Signature _____ **Date** _____ *(mm/dd/yyyy)*

SECTION III - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form below. A family member of your patient has requested leave under the FMLA to care for your patient. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a family member with a serious health condition. For FMLA purposes, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that *involves inpatient care* or *continuing treatment by a health care provider*. For more information about the definitions of a serious health condition under the FMLA, see the chart at the end of the form.

You also may, but are **not required** to, provide other appropriate medical facts including symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment. Please note that some state or local laws may not allow disclosure of private medical information about the patient's serious health condition, such as providing the diagnosis and/or course of treatment.

Health Care Provider's name: *(Print)* _____

Health Care Provider's business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____) _____ Fax: (____) _____ E-mail: _____

PART A: Medical Information

Limit your response to the medical condition for which the employee is seeking FMLA leave. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. **After completing Part A, complete Part B to provide information about the amount of leave needed.** Note: For FMLA purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

(1) Patient's Name: _____

(2) State the approximate date the condition started or will start: _____ *(mm/dd/yyyy)*

(3) Provide your **best estimate** of how long the condition lasted or will last: _____

(4) For FMLA to apply, care of the patient must be medically necessary. Briefly describe the type of care needed by the patient (*e.g., assistance with basic medical, hygienic, nutritional, safety, transportation needs, physical care, or psychological comfort).*

_____

_____

Employee Name: _____

(5) Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

- ☐ **Inpatient Care**: The patient (☐ has been / ☐ is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): _____

- ☐ **Incapacity plus Treatment**: *(e.g. outpatient surgery, strep throat)*
  Due to the condition, the patient (☐ has been / ☐ is expected to be) incapacitated for *more than* three consecutive, full calendar days from _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*.

  The patient (☐ was / ☐ will be) seen on the following date(s): _____

  _____

  The condition (☐ has / ☐ has not) also resulted in a course of continuing treatment under the supervision of a health care provider *(e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment)*

- ☐ **Pregnancy**: The condition is pregnancy. List the expected delivery date: _____ *(mm/dd/yyyy)*.

- ☐ **Chronic Conditions**: *(e.g. asthma, migraine headaches)* Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

- ☐ **Permanent or Long Term Conditions**: *(e.g. Alzheimer's, terminal stages of cancer)* Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

- ☐ **Conditions requiring Multiple Treatments**: (*e.g. chemotherapy treatments, restorative surgery)* Due to the condition, it is medically necessary for the patient to receive multiple treatments.

- ☐ **None of the above**: If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed. Go to page 4 to sign and date the form.

(6) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. *(e.g., use of nebulizer, dialysis)* _____

_____

PART B: Amount of Leave Needed

For the medical condition(s) checked in Part A, complete all that apply. 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 if the benefits and protections of the FMLA apply.

(7) Due to the condition, the patient (☐ had / ☐ will have) **planned medical treatment(s)** (scheduled medical visits) *(e.g. psychotherapy, prenatal appointments)* on the following date(s): _____

_____

(8) Due to the condition, the patient (☐ was / ☐ will be) **referred to other health care provider(s)** for evaluation or treatment(s).

State the nature of such treatments: *(e.g. cardiologist, physical therapy)* _____

Provide your **best estimate** of the beginning date _____ *(mm/dd/yyyy)* and end date _____ *(mm/dd/yyyy)* for the treatment(s).

Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery

_____ *(e.g. 3 days/week)*

Employee Name: _____

(9) Due to the condition, the patient (☐ was / ☐ will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.

Provide your **best estimate** of the beginning date: _____ *(mm/dd/yyyy)* and end date _____ *(mm/dd/yyyy)* for the period of incapacity.

(10) Due to the condition it, (☐ was / ☐ is / ☐ will be) medically necessary for the employee to be absent from work to provide care for the patient on an **intermittent basis** (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, episodes of incapacity are estimated to occur _____ times per (☐ day / ☐ week / ☐ month) and are likely to last approximately _____ (☐ hours / ☐ days) per episode.

Signature of Health Care Provider _____ **Date** _____ *(mm/dd/yyyy)*

Definitions of a Serious Health Condition *(See 29 C.F.R. §§ 825.113-.115)*
Inpatient Care
• An overnight stay in a hospital, hospice, or residential medical care facility. • Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.
Continuing Treatment by a Health Care Provider (any one or more of the following)
Incapacity Plus Treatment: A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either: o Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or, o At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.
Pregnancy: Any period of incapacity due to pregnancy or for prenatal care.
Chronic Conditions: Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.
Permanent or Long-term Conditions: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.
Conditions Requiring Multiple Treatments: Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.

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 C.F.R. § 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 15 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 Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR. RETURN TO THE PATIENT.

Important Information Regarding Your Benefits

The Clayton County Benefits Unit is here to assist you while you are out on a leave of absence. Please review this important information.

Medical Insurance Premiums

While on leave, you are responsible for paying for your insurance premiums. Insurance deductions will continue to be deducted through CCPS payroll from any accrued sick, personal or annual leave you have available.

If your accrued leave is exhausted and you have to go into a leave without pay status, you will have to pay your State Health Benefit Plan (SHBP) medical premiums directly to the Benefits Unit in Human Resources by the 1st of every month. This payment can be in the form of a check or money order payable to Clayton County Public Schools. Failure to submit payments will result in loss of coverage.

Flexible Benefits

All flexible benefits can be continued, if your payroll check is in a leave without pays status. To avoid loss of coverage when you receive a direct bill/invoice from Ga Breeze please make payments. If you fail to make payments to GaBreeze while out leave, you will loose coverage and benefits will be terminated. They will not be reinstated upon your return to work. *To re-enroll once you loose coverage can only be done during annual enrollment alone with a Statement of Heatlh*

Newborn Coverage

If you are having a baby or adopting a child, you MUST add your newborn and/or child within 90 of the birth or adaptation as a dependent by SHBP. When submitting your verification form tp SHBP please include in your social security number (SSN) or other tax identification number (TIN). Also you may have to change plan tiers.

Short Term Disability

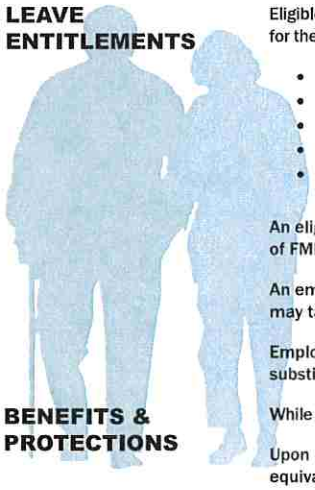
If you enrolled in short term disability insurance offered through GaBreeze by *The Standard*, you may be able to file a claim for this insurance benefit, if your leave is related to a serious health condition, injury or illness covered by the policy. This will offer you some peace of mind and allow, *The Standard* to begin its review of the claim and issue a timely payment if appropriate. You may report a claim up to four weeks in advance of a planned disability absence, such as surgery or childbirth. To file a claim you may do so at http://www.standard.com or 888-641-7186

CCPS Benefit Unit Contact Information

ccps.benefits@clayton.k12.ga.us

EMPLOYEE RIGHTS
UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION



LEAVE ENTITLEMENTS

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within one year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

BENEFITS & PROTECTIONS

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

ELIGIBILITY REQUIREMENTS

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

REQUESTING LEAVE

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

EMPLOYER RESPONSIBILITIES

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

ENFORCEMENT

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division

WHD WAGE AND HOUR DIVISION

WH1420 REV 04/16