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Monticello Community School District
711 South Maple Street
Monticello, Iowa 52310
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Phone: (319) 465-3000 Fax: (319) 465-4092
Dr. Brian Jaeger, Superintendent

Family & Medical Leave Act (FMLA) Employee (Family Member) Packet

According to Board Policy #405.0, the district will grant up to twelve (12) weeks per year in *unpaid* family and medical leave pursuant to state and federal laws. For purposes of this policy, a year is defined to begin on July 1 of each year, and to end on June 30 of each year. Requests for family and medical leave shall be made to the superintendent.

Who can take FMLA leave?
In order to be eligible to take leave under the FMLA, an employee must:

- work for a covered employer;
- have worked 1,250 hours during the 12 months prior to the start of leave;
- work at a location where the employer has 50 or more employees within 75 miles; and
- have worked for the employer for 12 months. The 12 months of employment are not required to be consecutive in order for the employee to qualify for FMLA leave. In general, only employment within seven years is counted unless the break in service is (1) due to an employee's fulfillment of military obligations, or (2) governed by a collective bargaining agreement or other written agreement.

Employees may be allowed to substitute paid leave for unpaid family and medical leave by meeting the requirements set out in the family and medical leave administrative rules. Employees eligible for family and medical leave must comply with the family and medical leave administrative rules and the family and medical leave regulations in these policies prior to starting family and medical leave. Please see Board Policy #405.0 for complete policy guidelines.

Information included in this packet:

- **Family and Medical Leave Request Form** *(return to District Office)*

Please fill out the leave request form as soon as you know and return to the district office. If the leave is due to the birth of a child, use the due date as the beginning date. This date can then be adjusted to the date the child was born.

- **Certification of Health Care Provider** *(return to District Office)*

The certification of health care has three sections and needs to be filled out as well. The district office will complete Section I. Section II should be completed by the employee and Section III needs to be completed by your health care provider.

- **Family and Medical Leave Notice to Employees and The Employee's Guide to the Family and Medical Leave Act**

This is information/guidance for you to keep.

Additional information on FMLA can be found in our Board Policies located on our website at: http://www.monticello.k12.ia.us/district-2/board-policies/

Also remember to…

- ✓ Set up an appointment with Business Manager, Marcy Gillmore at the District Office.
- ✓ Return the Family & Medical Leave Request Form & Certification of Health Care Provider Form
- ✓ Talk to your Principal/Supervisor and Building Secretary in regards to your leave.
- ✓ Submit your leave into the Time Management System if possible or have your building secretary input your leave.
- ✓ Obtain a medical release from your doctor stating when you are able to return to work.

If you have any questions, please contact me at extension 5300.

Thank you!

Marcy Gillmore
Business Manager

Form Title: **Family and Medical Leave Request Form** Form #405.0F2

Date: _____

I, _____, request family and medical leave for the following reason: *(check all that apply)*

_____ for the birth of my child;
_____ for the placement of a child for adoption or foster care;
_____ to care for my child who has a serious health condition;
_____ to care for my parent who has a serious health condition;
_____ to care for my spouse who has a serious health condition; or
_____ because I am seriously ill and unable to perform the essential functions of my position.
_____ because of a qualifying exigency arising out of the fact that my ___spouse; ___ son or daughter; ___parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves.
_____ because I am the ___ spouse; ___ son or daughter; ___ parent; ___next of kin of a covered service member with a serious injury or illness.

I acknowledge my obligation to provide medical certification of my serious health condition or that of a family member in order to be eligible for family and medical leave within 15 days of the request for certification.

I acknowledge receipt of information regarding my obligations under the family and medical leave policy of the district.

I request that my family and medical leave begin on _____ and I request leave as follows: *(check one of the three (3) options)*

_____ continuous, and I anticipate that I will be able to return to work on _____.

_____ intermittent leave for the:
- _____ birth of my child or adoption or foster care placement subject to agreement by the district;
- _____ serious health condition of myself, parent, or child when medically necessary;
- _____ because of a qualifying exigency arising out of the fact that my ___spouse; ___ son or daughter; ___parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves.
- _____ because I am the ___ spouse; ___ son or daughter; ___ parent; ___next of kin of a covered service member with a serious injury or illness.

Details of the needed intermittent leave:

_____

_____

_____

I anticipate returning to work at my regular schedule on _____.

_____ reduced work schedule for the:

_____ birth of my child or adoption or foster care placement subject to agreement by the district;

_____ serious health condition of myself, parent, or child when medically necessary;

_____ because of a qualifying exigency arising out of the fact that my ___spouse; ___ son or daughter; ___parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves.

_____ because I am the ___ spouse; ___ son or daughter; ___ parent; ___next of kin of a covered service member with a serious injury or illness.

Details of needed reduction in work schedule as follows:

_____

_____

_____

I anticipate returning to work at my regular schedule on _____.

I realize I may be moved to an alternative position during the period of the family and medical intermittent or reduced work schedule leave. I also realize that with foreseeable intermittent or reduced work schedule leave, subject to the requirements of my health care provider, I may be required to schedule the leave to minimize interruptions to district operations.

While on family and medical leave, I agree to pay my regular contributions to employer sponsored benefit plans. My contributions will be deducted from moneys owed me during the leave period. If no monies are owed me, I will reimburse the district by personal check or cash for my contributions. I understand that I may be dropped from the employer-sponsored benefit plans for failure to pay my contribution.

I agree to reimburse the district for any payment of my contributions with deductions from future monies owed to me or the district may seek reimbursement of payments of my contributions in court.

I acknowledge that the above information is true to the best of my knowledge.

Employee Signature: _____

Date _____

Supervisor Signature: _____

Date _____

Approval: ____ YES, pending medical approval ____ NO

Superintendent Signature: _____

Date _____

Date of Adoption: 4/22/13

Amended: 7/27/15

Reviewed:

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

U.S. Department of Labor
Wage and Hour Division

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

OMB Control Number: 1235-0003
Expires: 5/31/2018

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: Monticello Community School District - Marcy Gillmore

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

CONTINUED ON NEXT PAGE

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):

_____

_____

_____

_____

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: _____

   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**

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 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 Ave., NW, Washington, DC 20210.
DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.

YOUR RIGHTS
UNDER THE
FAMILY AND MEDICAL LEAVE ACT OF 1993

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 Protection

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.

Job 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.

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.

***NOTE*: 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.**

If you have access to the Internet visit FLMA's website: http://www.dol.gov/esa/whd/fmla.

To locate your nearest Wage-Hour Office, phone our toll-free information at 1-866-487-9243 or to the Web site at: http://www.wagehour.dol.gov.

For a listing of records that must be kept by employers to comply with FMLA visit the U.S. Dept. of Labor's website: http://www.dol.gov/dol/allcfr/ESA/Title_29/Part_825/29CFR825.500.htm

U.S. Department of Labor – Revised July 2009