FAMILY AND MEDICAL LEAVE
INFORMATION SHEET

The Family and Medical Leave Act of 1993 provides up to twelve weeks unpaid leave to eligible employees for certain family and medical reasons, without loss of health insurance benefits as a result of taking a family or medical leave.

The following information is provided to explain the employee's rights and obligations when requesting a family or medical leave. Additional information is available in Board Policy GBRIG.

1. Eligible employees are entitled to:

    Twelve workweeks of leave in a 12-month period for:

    the birth of a child and to care for the newborn child within one year of birth;

    the placement with the employee of a child for adoption or foster care and to care for the newly placed child within one year of placement;

    to care for the employee's spouse, child, or parent who has a serious health condition;

    a serious health condition that makes the employee unable to perform the essential functions of his or her job;

    any qualifying exigency arising out of the fact that the employee's spouse, son, daughter, or parent is a covered military member on "covered active duty;" **or**

   Twenty-six workweeks of leave during a single 12-month period to care for a covered servicemember with a serious injury or illness if the eligible employee is the servicemember's spouse, son, daughter, parent, or next of kin (military caregiver leave).

2. An employee may take a total of 12 work weeks of unpaid leave for the reasons specified above. The **twelve-month period** for purposes of leave entitlement under this policy shall be **the twelve-month** period measured forward from the date any employee's first FMLA leave begins.

3. If an employee is entitled to paid leave under another benefit plan or policy, which includes, but is not limited to, unused paid vacation, sick, family, or personal leave, the employee must take the paid leave first. Such available paid leave will be counted against the FMLA 12-week unpaid leave entitlement. Unless otherwise required, no employee will be entitled to more than a total of 12 weeks, paid and/or unpaid, for leave which qualifies under the FMLA.

4. **To be eligible for leave under this policy an employee must have been employed for at least twelve months in total, and must have worked at least 1250 hours during the twelve-month period preceding the commencement of the leave. To be eligible the employee must also work at a facility with 50 or more employees within a 75-mile radius. Employees with less than one year of service will be eligible for medical leave only.**

5. Employees who are approved for family/medical leave due to a serious health condition of the employee or covered relative will be required to provide medical certification of that serious health condition using the form provided. Failure to provide such certification may result in denial of family/medical leave and may result in the absence being considered unexcused.

6. Employees who are approved for family/medical leave due to their own serious health condition are also eligible to receive earned sick leave providing the employees meet the requirements for sick leave.

7. During an approved family/medical leave, employees are entitled to the same medical insurance they had before the leave began. Employees who pay some or all of their benefit premium will be required to continue to pay premiums in order to continue benefit coverage during the leave period. The employee is responsible for making arrangements to pay any premiums due during the leave period.

8. **Employees who are approved for a family/medical leave due to their own serious health condition will be required to present medical certification upon their return which indicates that they are medically able to return to their job. Failure to provide such information may preclude the employee from returning.**

9. Employees returning from family/medical leave will be returned to the same or an equivalent job upon their return to work as required by law.

10. Other information, such as periodic recertification of the employee's or covered relative's condition, may be required.

11. Employees will be required to advise whether they intend to return to work at the conclusion of the family/medical leave and their expected date of return. Employees who do not return to work following a family/medical leave will be liable for payment of health insurance premiums paid by the employer during unpaid family/medical leave, unless the failure to return to work was due to continuation, recurrence, or onset of a serious health condition or for reasons beyond the employee's control.

12. A key employee is an employee who is among the highest-paid 10% of employees within seventy-five miles. If reinstatement of a key employee at the conclusion of the leave period would result in substantial and grievous economic injury to the employer reinstatement of the key employee can be denied.

    If it is a possibility that reinstatement will be denied to a key employee, that employee will be provided notice that he or she is a key employee and that rights to reinstatement and continued health benefits could be denied if the reinstatement poses a substantial and grievous economic injury to the employer.

13. A Request for Family and Medical Leave form should be completed in detail, signed by the employee and supervisor, and forwarded to Human Resources, along with any medical certification, if required. The form must be submitted thirty (30) calendar days in advance of the effective date of the leave when the need for FMLA leave is foreseeable. When the need for FMLA leave is not foreseeable, this form should be submitted within two days of when the need for FMLA leave becomes known to the employee.

REQUEST FOR FAMILY AND MEDICAL LEAVE/SABBATICAL

Name: ______________________ Social Security Number: ______________

Date of Employment: ______ / ______ / ________ School/Location: ______________

Position: ____

Is your spouse employed by Pike County Public Schools? ❑ YES ❑ NO If yes SS# ______________

Home Address: ____

(Number and Street) (City)

(State) (Zip Code)

Home Phone Number: ______________ Work Phone Number: ______________

LEAVE IS REQUESTED FOR: A.

Serious illness of:

- ☐ Employee
- ☐ Spouse
- ☐ Child
- ☐ Parent
- ☐ Parent In-Law
- ☐ Birth of a child

ATTACH MEDICAL CERTIFICATION TO THIS FORM FOR LEAVE REQUESTED

- ☐ Adoption of a child
- ☐ Placement of a foster child

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

____

MM DD YY

Leave is requested starting: ______________

Last Day Worked: ______________

Do you intend to return to work after the leave? ❑ YES ❑ NO

If yes, expected date of return: ______________

NOTE: A MEDICAL RELEASE IS NEEDED PRIOR TO RETURNING TO WORK FOR EMPLOYEE ILLNESS ONLY.

Have you taken any other FMLA leave or other leave of absence during the past twelve months? ☐ YES ☐ NO

If yes, From________To______________Reason For Leave______________

NOTE: UNDER THE PIKE COUNTY PUBLIC SCHOOL BOARD POLICIES, AN EMPLOYEE MUST TAKE PAID LEAVE INCLUDING ANY ACCRUED VACATION AND SICK/PERSONAL LEAVE FIRST BEFORE BEGINNING UNPAID LEAVE. UNLESS OTHERWISE REQUIRED, NO EMPLOYEE WILL BE ENTITLED To MORE THAN A TOTAL OF 1 2 WEEKS, PAID AND/OR UNPAID, FOR LEAVE THAT QUALIFIES UNDER THE FMLA.

Signature of Employee: ______________________ Date: __________

Signature of Supervisor: ______________________ Date: __________

PLEASE SEND THIS FORM WITH THE CERTIFICATION OF HEALTH CARE PROVIDER FORM To BENEIITS DEPARTMENL

Certification of Health Care Provider
(Family and Medical Leave Act of 1993)

Pike County Public Schools
P.O. Box 386, 16 Jackson Street
Zebulon, GA 30295

(When completed, this form goes to the employee, ***not to the Department of Labor.)***

OMB No.: 1215-0181 Expires: 06/30/02

1. Employee's Name

2. Patient's Name *(If different from employee)*

3. Page 4 describes what is meant by a **"serious health condition"** under the Family and Medical Leave Act. Does the patient's condition[1] qualify under any of the categories described? If so, please check the applicable category.

   (1) _______ (2) _______ (3)_______ (4)_______ (5) ______ (6) _______ , or None of the above _______

4. Describe the **medical facts** which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories:

5. a. State the approximate **date** the condition commenced, and the probable duration of the condition (and also the probable duration of the patient's present **incapacity**[2] if different):

   b. Will it be necessary for the employee to take work only **intermittently or to work on a less than full schedule** as a result of the condition (including for treatment described in Item 6 below)?

   If yes, give the probable duration:

   c. If the condition is a **chronic condition** (condition #4) or **pregnancy,** state whether the patient is presently incapacitated[2] and the likely duration and frequency of **episodes of incapacity**[2]**:**

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1 Here and elsewhere on this form, the information sought relates **only** to the condition for which the employee is taking FMLA leave.

2 "Incapacity," for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom.

6. a. If additional **treatments** will be required for the condition, provide an estimate of the probable number of such treatments.

If the patient will be absent from work or other daily activities because of **treatment** on an **intermittent** or **part-time** basis, also provide an estimate of the probable number of and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any:

b. If any of these treatments will be provided by **another provider of health services (e.g.,** physical therapist), please state the nature of the treatments:

c. **If a regimen of continuing treatment** by the patient is required under your supervision, provide a general description of such regimen *(e.g.,* prescription drugs, physical therapy requiring special equipment):

7. a. If medical leave is required for the employee's **absence from work** because of the **employee's own condition** (including absences due to pregnancy or a chronic condition), is the employee **unable to perform work** of any kind?

b. If able to perform some work, is the employee **unable to perform any one or more of the essential functions of the employee's job** (the employee or the employer should supply you with information about the essential job functions)? If yes, please list the essential functions the employee is unable to perform:

c. If neither a. nor b. applies, is it necessary for the employee to be **absent from work for treatment?**

8. a. If leave is required to **care for a family member** of the employee with a serious health condition, **does the patient require assistance** for basic medical or personal needs or safety, or for transportation?

b. If no, would the employee's presence to provide **psychological comfort** be beneficial to the patient or assist in the patient's recovery?

c. If the patient will need care only **intermittently** or on a part-time basis, please indicate the probable **duration** of this need:

Signature of Health Care Provider | Type of Practice

Address | Telephone Number

Date

To be completed by the employee needing family leave to care for a family member:

State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule:

Employee Signature | Date

A **"Serious Health Condition"** means an illness, injury impairment, or physical or mental condition that involves one of the following:

1. Hospital Care

   Inpatient care *(i.e.,* an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity[2] or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

   (a) A period of incapacity[2] of **more than three consecutive calendar days** (including any subsequent treatment or period of incapacity[2] relating to the same condition), that also involves:

   (1) **Treatment**[3] **two or more times** by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services *(e.g.,* physical therapist) under orders of, or on referral by, a health care provider; or

   (2) **Treatment** by a health care provider on **at least one occasion** which results in a **regimen of continuing treatment**[4] under the supervision of the health care provider.

3. Pregnancy

   Any period of incapacity due to **pregnancy,** or for **prenatal care.**

4. Chronic Conditions Requiring Treatments

   A **chronic condition** which:

   (1) Requires **periodic visits** for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;

   (2) Continues over an **extended period of time** (including recurring episodes of a single underlying condition); and

   (3) May cause **episodic** rather than a continuing period of incapacity[2] *(e.g.,* asthma, diabetes, epilepsy, etc.).

5. Permanent/Long-term Conditions Requiring Supervision

   A period of **Incapacity**[2] which is **permanent or long-term** due to a condition for which treatment may not be effective. The employee or family member must be **under the continuing supervision of, but need not be receiving active treatment by, a health care provider.** Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

6. Multiple Treatments (Non-Chronic Conditions)

   Any period of absence to receive **multiple treatments** (including any period of recovery there from) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for **restorative surgery** after an accident or other injury, **or** for a condition that **would likely result in a period of Incapacity**[2] **of more than three consecutive calendar days in the absence of medical intervention or treatment,** such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), and kidney disease (dialysis).

This optional form may be used by employees to satisfy a mandatory requirement to furnish a medical certification (when requested) from a health care provider, including second or third opinions and recertification (29 CFR 825.306).

Note: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

3 Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

4 A regimen of continuing treatment includes, for example, a course of prescription medication *(e.g.,* an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

Public Burden Statement

We estimate that it will take an average of 10 minutes 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 of information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, Department of Labor, Room S-3502, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE; IT GOES TO THE EMPLOYEE.

PIKE COUNTY PUBLIC SCHOOLS
PHYSICIAN'S RELEASE TO RETURN TO WORK

The completion of this form by your physician will be necessary for your clearance to return to work. This should document the entire period of your absence.

Employee: ______________________________ Last Day Worked: _____/______/ _____

Social Security Number: ______________________________

Occupation: ______________________________ Location: ______________________________

ATTENDING PHYSICIAN'S RELEASE STATEMENT

Date first treated for this illness/injury: ______________________________

Date release to:

( ) Date Released To Regular Work: ______________________

( ) Date Released To Limited Work: ______________________

Restrictions:

☐ None

☐ Weight On Lifting: ____________ Length Of Time Restricted: ______________

☐ Other: ______________________________

Medications presently on:

____

Comments: ____

____

____

____

Date: ____________________

BEFORE RETURNING TO WORK DELIVER COMPLETED FORM TO:

Human Resources
Pike County Public Schools
P.O. Box 386
16 Jackson Street
Zebulon, Georgia 30295
Phone: 770-567-8489
Fax: 770-567-8349

Attending Physician: ______________________________

Address: ______________________________

Phone Number: ______________________________