Human Resources

Request for Medical Leave

(see intructions on page 2)

A. EMPLOYEE INFORMATION

Employee Name: _____ Emp ID # _____
(Last) (First) (Middle Initial)

Location: _____ Position: _____ Original Hire Date: _____

Personal Email: _____ Home Phone: _____

Status: ☐ Full-Time ☐ Part-Time Hours Worked Per Week: _____

B. TYPE OF LEAVE

If this request for leave is due to the employee's own serious health condition or the serious health condition of a family member, a completed Certification of Health Care Provider Form must be forwarded to the FMLA Administrator by the employee or the attending physician/practitioner within twenty (20) days of this request.

☐ **FMLA** (Family/Medical Leave) I have worked for BISD for at least a year and 1,250 hours during the past year. I am requesting FMLA Leave of Absence for one or more of the following reason(s):

- ☐ Serious health condition that makes me unable to work
- ☐ Birth of my child and in order to care for him or her
- ☐ Placement of a child with me for adoption or foster care
- ☐ Care for my spouse, child or parent who has a serious health condition
  - ☐ Spouse ☐ Child Age:____ ☐ Parent

☐ **Temporary Disability leave** (for the employee's own serious health condition and when FMLA is exhausted or employee is not eligible for FMLA)

I do not qualify for Family Medical Leave due to one of the following reasons and would like to request Temporary Disability leave. I am providing medical documentation to support my request.

(Please select one)

- ○ I have not worked for my employer for at least one year.
- ○ I have not worked the needed 1,250 hours.
- ○ I have utilized all FML days and still need to remain on leave.

C. DURATION

Date Leave to Begin: _____ Expected Return to Work Date: _____
(date may change based on doctor documentation)

☐ Consecutive time off ☐ Intermittent Leave or Reduced Leave Schedule (Only available for FMLA)

This request is also my written intent to return to work on the return to work date stated above. I understand that I will need a note from my physician stating that I am able to return to work if this leave of absence is for my own serious health condition. I understand that I am required to keep my supervisor informed and up-to-date of my situation throughout the leave periodically and as agreed upon by my supervisor and myself. If I fail to return by the agreed date without an approved extension and/or re-certification of a serious health condition, I am aware that I may be deemed to have abandoned my job.

_____ _____ _____ _____
Employee Signature Date Principal/Supervisor Signature Date

_____ _____
Employee Print Principal/Supervisor Print

D. TO BE COMPLETED BY HR DEPARTMENT

_____ Sick Days
_____ State Personal Days
_____ Non BISD
_____ Total
_____ Vacation Days

Leave Beginning Date _____
Leave End Date _____
Leave Rtn Date _____
TDL End Date _____

Approval: _____

Business Form: _____

RETURN COMPLETED FORM TO:

Melissa Austin, Human Resources, 6125 E Belknap, Haltom City, TX 76117
Fax No. 817-547-5536 melissa.austin@birdvilleschools.net

Human Resources

INSTRUCTIONS
For employee to retain

GENERAL INFORMATION

Medical Leave is defined as Family Medical Leave (FML) and/or Temporary Disability Leave (TDL). FML and TDL run concurrently if both are necessary.

Medical Leave is only paid if the employee has accrued leave days (Local, State or Vacation) available. Otherwise the Leave will be unpaid.

The first day of Medical Leave may be counted back to the first absence associated with the reported condition. The anticipated return to work date must correspond to the date given by the healthcare provider on the Certification of Healthcare Provider Form.

All requests for leave must be accompanied by one of the following:
- Certification of Healthcare Provider for Employees Serious Health Condition or
- Certification of Healthcare Provider for Family Member's Serious Health Condition

A medical release, is required before the employee may return to duty. The medical release must state:
- Date employee is released back to work
- Any restrictions employee might have

If the employee utilizes the District's health insurance plan, the District will continue to pay its share of the premium for up to 12 weeks. The employee will still be responsible to pay their portion of the premium.

EMPLOYEE INFORMATION:

1. Complete Sections A, B and C of Request for Leave of Absence Form.
2. Return completed Request for Leave of Absence Form to principal/supervisor.
3. Review with principal/supervisor the use of accrued sick, vacation and/or personal time.
4. For leaves of absence due to the employee's own serious health condition or the serious health condition of a family member, the health care provider or the health care provider of the family member must complete the appropriate Certification of Health Care Provider Form (Employee's Serious Health Condition or Family Member's Serious Health Condition).
5. The employee or employee's physician will forward the completed Certification of Health Care Provider Form to Melissa Austin in the Human Resources department via:
   - fax: 817-547-5536
   - email: melissa.austin@birdvilleschools.net.

PRINCIPAL/SUPERVISOR:

1. Sign section C.
2. Melissa Austin in the Human Resources department via fax: 817-547-5536 or email: melissa.austin@birdvilleschools.net.

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

U.S. Department of Labor
Wage and Hour Division

WAGE AND HOUR DIVISION

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

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 protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee'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 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: **Birdville ISD - Melissa Austin** 817-547-5764 fax:817-547-5536 | melissa.austin@birdvilleschools.net 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.)

(4) Employee's job title: _____ Job description (☐ is / ☐ is not) attached.
Employee's regular work schedule: _____
Statement of the employee's essential job functions: _____
_____
(*The essential functions of the employee's position are determined with reference to the position the employee held at the time the employee notified the employer of the need for leave or the leave started, whichever is earlier.)*

SECTION II - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form. Your patient has requested leave under the FMLA. 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 due to the serious health condition of the employee. 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 on page 4.

You 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.

Employee Name: _____

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

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

(3) 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.

(4) Describe the medical facts and/or treatment that meet the criteria of the serious health condition checked above:

_____
_____
_____
_____
_____
_____
_____

Employee Name: _____

(5) 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 FMLA coverage.

(1) 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): _____

_____

(2) 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)

_____

(3) Due to the condition, it is medically necessary for the employee to work a reduced schedule.
Provide your best estimate of the reduced schedule the employee is able to work. From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy) the employee is able to work: (e.g., 5 hours/day, up to 25 hours a week)

_____

(4) 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.

(5) Due to the condition, it (☐ was / ☐ is / ☐ will be) medically necessary for the employee to be absent from work 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.

Employee Name: _____

PART C: Essential Job Functions

If provided, the information in Section I question #4 may be used to answer this question. If the employer fails to provide a statement of the employee's essential functions or a job description, answer these questions based upon the employee's own description of the essential job functions. An employee who must be absent from work to receive medical treatment(s), such as scheduled medical visits, for a serious health condition is considered to be *not able* to perform the essential job functions of the position during the absence for treatment(s).

(1) Due to the condition, the employee (☐was not able / ☐is not able / ☐will not be able) to perform *one or more* of the essential job function(s). Identify at least one essential job function the employee is not able to perform: _____

_____

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.