VANCE COUNTY SCHOOLS

REQUEST FOR FAMILY MEDICAL LEAVE (FMLA) for an Immediate Family Member

Employee Section: The employee must complete this form and attach appropriate documentation for the type of leave requested. Any employee absent for 5 or more consecutive days due to illness of self and/or family member must request a FMLA Leave and provide medical documentation. (Certification of Health Care Provider next page)

Name:	**Last 4 digits of SSN:**
School/Department:	**Job Assignment:**
Home Address:	**Phone Number:**

Leave Period Requested

I am requesting a leave of absence for the following length of time:	**From:**	**To:**

Type of Leave Requested

(*See statement below regarding Family and Medical Leave Act. *Certification of Health Care Provider required Form WH-380-E)

***☐ FMLA – serious health condition of an immediate family member _____**
(relationship to you)

Leave Usage

I am requesting to use the following benefits in accordance with the State Board of Education guidelines:

☐ **Sick Leave**	☐ **Personal Leave (Teachers Only)** **($50 deduction per day for substitute)**
☐ **Annual Leave (if applicable)**	☐ **Bonus Leave (if applicable)**
☐ **Leave without pay**	☐ **Comp Time (if applicable)**

Voluntary Shared Leave

Special request can be made for the donation of Voluntary Shared Leave if the employee, as a result of a serious medical condition of self or his/her immediate family member, is on an approved FMLA leave and faces a prolonged absence or frequent absences from work, resulting in a potential financial hardship of the employee.

I understand that I must exhaust all my earned leave prior to receiving any donated leave. I also understand that voluntary shared leave can only be used while on an approved FMLA leave certified by a medical provider. _____ (Initial here)

Voluntary Donated Leave Request (Only available upon exhaustion of all sick and annual leave (if applicable)

- ☐ **I will request donated leave on my own behalf**
- ☐ **I request Human Resources to make a request on my behalf for donated leave**

LICENSED EMPLOYEES: **I understand that for the purpose of computing time as a probationary teacher, I must work not less than 120 workdays as a full-time permanent employee in a normal school year.**

ALL EMPLOYEES: I understand that if I go off payroll, I am responsible for all miscellaneous deductions made through payroll deduction (hospitalization, dental, life and cancer insurance, loan payments, etc.**) and that I will make arrangements with the Finance Department. State reporting procedures require an employee on "12 month installment pay" to be paid a lump sum of earned pay when taking a leave of absence without pay. I also understand that my requested Family or Medical will count against my FMLA entitlement and I must provide the HR Dept a "Return to Work" statement from my physician prior to my return to work.**

Employee's Signature Date Principal/Immediate Supervisor Date

***According to the Family and Medical Leave Act (FMLA), employees who are taking leave with or without pay because of a serious health condition of self or immediate family member, birth/placement of an adopted or foster child, are eligible for up to 12-workweeks of leave. During those 12-workweeks, Vance County Schools will pay the employee's hospitalization insurance premium for full-time permanent employees. The employee is still responsible for the employee cost to cover dependents. The only stipulation is that the employee must have been employed with Vance County Schools for at least one year and have worked at least 1250 hours during the previous 12 months. The employee must also return to work at the end of his/her approved leave for at least 30 days. If the employee fails to return at the end of the FMLA leave, the employee shall be required to reimburse Vance County Schools for all health benefits coverage paid during the unpaid portion of the FMLA leave if certain conditions are not met.**

Approved _____ Executive Director, HRM Date_____

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

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division

OMB Control Number 1215-0181
Expires: XX/XX/XXX

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.

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

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. 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**

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.