INSTRUCTIONS FOR USE OF REQUEST FOR LEAVE OF ABSENCE FORM

1. The employee completes the appropriate sections of the form and forwards it to his/her principal/supervisor. If the request is for a renewal of leave, extenuating circumstances must be explained completely. If the request is due to illness, a disabling condition, childbirth or family illness, the Certification of Health Care Provider form is to be completed by the physician and returned to Human Resources within three weeks of the Leave Request form being completed. If certification is not received within three weeks, continued sick leave may be denied.

2. The principal/supervisor acknowledges the request, signs, and forwards the form to Human Resources.

3. Human Resources approves or denies the request, and returns copies to the employee and the principal/supervisor. Responses to the questions by the physician on the Certification of Health Care Provider portion of the leave form will be reviewed by Human Resources. An independent medical examination review may be required for requests exceeding 12 weeks. Based on the independent review, it may be necessary to have the employee examined by an independent provider.

4. **For extended leaves, the school/site must hold the employee's position for his/her return.**

5. **Requests for extension of leave must also be submitted on this leave form.**

6. **Time and Attendance Reports should show approved leaves.**

Additional Information

7. The employee may be eligible for certain benefits under the Family and Medical Leave Act (FMLA) of 1993. FMLA entitles eligible employees to take up to 12 weeks of unpaid, job-protected leave in a 12-month period for specified family and medical reasons. The law has provisions of employer coverage; eligibility for the law's benefits; leave entitlement; health benefits maintenance during the leave; job restoration after the leave; notice and certification of the need for FMLA leave; and protection for those who request or take FMLA leave. More information on FMLA leave can be found at the Department of Labor website by clicking the link http://www.dol.gov/dol/esa/public/regs/compliance/whd/whdfs28.htm, or requested from Human Resources.

8. If the employee has unpaid days, s/he should be aware that if s/he wishes to continue to participate in the group medical insurance program, s/he should notify the Risk Management Office of his/her intention to do so. If the employee does not elect to continue in the group insurance program while on a leave of absence, s/he will not be eligible for group insurance coverage until s/he returns to the District. Questions regarding insurance coverage should be directed to the Risk Management Office at 348-0235.

9. If a request for an **extension** of an approved leave is denied, the employee will receive written instructions to return to the position or submit a letter of resignation.

10. **Specific provisions regarding the various leaves are contained in the Negotiated Agreement or the Administrative Regulations. Questions concerning leaves should be directed to the supervisor and to Human Resources, if needed.**

WASHOE COUNTY SCHOOL DISTRICT
Human Resources Division

REQUEST FOR LEAVE OF ABSENCE – ALL EMPLOYEES
(Must be submitted for absences over five (5) days)

I hereby request a leave of absence for the length of time and reason(s) indicated below:

TYPE OF LEAVE REQUESTED: (You may be eligible for certain benefits under the Family & Medical Leave Act (FMLA) of 1993. Please review the information on the following page.)

◆SHORT TERM LEAVES (Less Than One Semester): Please note number of days below.

☐ Personal Illness/Disability* ☐ I am a member of the Sick Leave Bank
☐ Family Illness* (Relationship: _____) ☐ Bereavement (Relationship: _____)
☐ Child Rearing (Please contact Risk Management within 31 days of the baby's birth to add to District insurance.)
☐ Worker's Compensation (Please report to Risk Management to complete appropriate forms.)
☐ Other: _____
☐ Extension of previously approved Leave (Explain extenuating circumstances below.)
EXPLANATION : _____

◆EXTENDED LEAVES ☐ One Semester ☐ One Year (Check box below) Please note number of days below.

☐ Personal Illness/Disability* ☐ Family Illness* ☐ Child Rearing ☐ Pursuit of additional education

☐ With Pay: #_____ Working days from _____ to _____ inclusive
(Using accrued sick leave or personal days. Payment of sick days is based on days available at time of leave.)
Sick leave _____Vacation _____ Comp time _____
Classified and Professional-Technical employees may use accrued vacation days.

☐ Without Pay: #_____ Working days from _____ to _____ inclusive
(Unpaid days can result in a loss of accrued sick days for Certified/Pro-Tech and Administrative employees.)

***If reason is illness, disabling condition, childbirth or family illness, a Certification of Health Care Provider form is required. See Instruction 1 on the following page.**

Please note: For Classified employees on leave for more than 90 days, written notification must be submitted to your supervisor stating if you will or will not return to work. This must be submitted no later than 60 calendar days prior to the expiration of your leave. For Certified/Pro-Tech and Administrative employees on extended leave of absence, written notification must be filed with the Human Resources Division by March 1 of the year in which leave is effective, stating whether or not you plan to return the following school year. Failure to submit this notification will result in forfeiture of your employment with WCSD.

Employee Name (Please Print):_____ Emp. Number/SSN: _____

Employee Signature: _____Date:_____

School or Location _____ Position Title: _____

ADMINISTRATOR'S ACKNOWLEDGEMENT OF LEAVE OF ABSENCE

☐ I acknowledge this Leave of Absence request. *If this is a request for an extended leave of absence and, if it is approved, I will hold a position for the employee when s/he returns.*

Administrator's Signature: _____ Date: _____

HUMAN RESOURCES APPROVAL/DENIAL OF REQUEST FOR EXTENDED LEAVE OF ABSENCE:

☐ Approved

☐ Denied for the following reason(s):

_____

Human Resources Administrator: _____ Date: _____

FOR HUMAN RESOURCES USE ONLY
Hire Date _____ ☐ Probationary ☐ Post-Probationary ☐ Sick Days Available _____

CERTIFICATION OF HEALTH CARE PROVIDER

1. Employee's Name (Please Print): _____

2. Patient's Name (if different from employee): _____

3. The attached sheet describes what is meant by a "serious health condition." Does the patient's condition[1] qualify under any of the categories described? If so, please check the applicable category.

   1) Hospital Care ☐
   2) Absence plus Treatment ☐
   3) Pregnancy ☐
   4) Chronic Condition Requiring Treatment ☐
   5) Permanent Long-Term Condition Requiring Supervision ☐
   6) Multiple Treatments (Non-Chronic Conditions ☐ 7) 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 _____

   b. State the approximate date of probable duration of the condition _____,
   and state the probable duration of the patient's present incapacity[2] if different:

   _____
   _____

   c. 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)? ☐ Yes ☐ No

   If yes, give the probable duration:

   _____
   _____

   d. If the condition is a chronic condition (condition #4) or pregnancy (condition #3), state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity:

   _____
   _____

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 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:

[1]Here and elsewhere on this form, the information sought relates only to the condition for which the employee is requesting leave.

[2]"Incapacity" is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery therefrom.

_____
_____
_____

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?
☐ Yes ☐ No

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 (if necessary, the employee or the employer can supply you with information about the essential job functions)? ☐ Yes ☐ No 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? ☐Yes ☐ No

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?
☐ Yes ☐ No

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:
_____

9. 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

_____ _____
Name of Health Care Provider (Please Print) Signature of Health Care Provider

_____ _____
Type of Practice Date

_____ _____
Address Telephone Number

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 or subsequent treatment in connection with or consequent to such impatient care.

2. **Absence Plus Treatment:**

   (a) A period of incapacity of **more than three consecutive calendar days** (including any subsequent treatment period of incapacity 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:** Chronic condition which:

   (a) 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;

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

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

5. **Permanent/Long-Term Condition Requiring Supervision:** A period of **incapacity** 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 therefrom) 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 of more than three consecutive calendar days in the absence of medical intervention or treatmen**t, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).

[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.