Harford County Public Schools

Leaves

(FMLA, Leaves of Absence and Worker's Compensation)

Information & Application Packet

Benefits Office
102 S. Hickory Ave.
Bel Air, Maryland 21014
Phone: 410-588-5275
Fax: 410-588-5316

Rev. 6/2009 (HR/BEN-1)

Leave of Absence
Application Process

To determine if you qualify for leave under FMLA, please complete Section I (below):

Section I – FMLA Eligibility

A. Have you been employed by Harford County Public Schools for 12 months? □ Yes □ No
- ***If you answered Yes,*** *please continue to "B" below.*
- ***If you answered No,*** *you are not eligible for leave under FMLA.*

B. Are you an employee who has worked 1250 hours within the 12-month period prior to the commencement of the requested FMLA leave? □ Yes □ No
- ***If you answered Yes to both A and B,*** *you are eligible and need to submit a written request for FMLA leave along with all other applicable forms (see Section II below).*
- ***If you answered No,*** *you are not eligible for leave under FMLA.*

Section II – Leave of Absence/Documentation Required

If you wish to take leave for any of the following reasons, you will need to submit a **WRITTEN (*Leave Request Form*)** request for your leave including the dates and reasons for the leave along with the required supporting documentation for your leave. **It is important to notify Human Resources immediately, if the dates change from your original request!**

If you do not request leave under FMLA and it is determined by HCPS that your leave qualifies under one or more of the following FMLA qualified absences, HCPS may automatically designate your leave as FMLA.

Along with a written request (as stated above), please include the additional required documentation for a leave due to:

- **Birth of a child:** medical certification (please use the attached Healthcare Provider Certification Form) indicating the expected date of birth.
- **Placement of a child for adoption or foster care:** a copy of placement papers.
- **A serious health condition of your spouse, child or parent:** medical certification (please use the attached Healthcare Provider Certification Form).
- **Your own serious health condition** (including absence due to Worker's Compensation): medical certification (please use the attached Healthcare Provider Certification From). A serious health condition may include and run concurrently with Worker's Compensation absences.
- **Intermittent leave or a leave on a reduced schedule:** medical certification (please use the attached Healthcare Provider Certification Form) indicating the leave has been determined to be medically necessary.

To return to work from leave for your own personal illness: You must submit a medical release from your healthcare provider (please use the attached "Return to Work Medical Certification Form") prior to reporting for duty.

Section III - Approval

You will be notified as to the approval of your leave request once a determination has been made. Please refer to the attached "Family and Medical Leave Act Procedures" for information on the *retention of your benefits* during your leave.

***If you wish to extend your leave past the 12 weeks allowed under FMLA*, you must submit a revised "Leave Request Form" (available in your school or from the Human Resources Office). Please note that extending your leave beyond 12 weeks may affect the cost of your benefits.**

For further information please contact the Benefits Office at 410-588-5275

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 certain family and medical reasons. Employees are eligible if they have worked for their employer for at least one year, and for 1,250 hours over the previous 12 months, and if there are at least 50 employees within 75 miles. The FMLA permits employees to take leave on an intermittent basis or to work a reduced schedule under certain circumstances.

Reasons for Taking Leave:

Unpaid leave must be granted for *any* of the following reasons:

- 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.

At the employee's or employer's option, certain kinds of *paid* leave may be substituted for unpaid leave.

Advance Notice and Medical Certification:

The employee may be required to provide advance leave notice and medical certification. Taking of leave may be denied if requirements are not met.

- The employee ordinarily must provide 30 days advance notice when the leave is "foreseeable."
- An employer may require medical certification to support a request for leave because of a serious health condition, and may require second or third opinions (at the employer's expense) and a fitness for duty report to return to work.

Job Benefits and Protection:

- For the duration of FMLA leave, the employer must maintain the employee's health coverage under any "group health plan."
- Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.
- The use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

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; or
- 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:

- The U.S. Department of Labor is authorized to investigate and resolve complaints of violations.
- An eligible employee may bring a civil action against an employer for violations.

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.

For Additional Information

If you have access to the Internet, visit our FMLA website: http://www.dol.gov/esa/whd/fmla. To locate your nearest Wage-Hour Office, telephone our Wage-Hour toll-free information and help line at 1-866-4USWAGE (1-866-487-9243): a customer service representative is available to assist you with referral information from 8am to 5pm in your time zone; or log onto our Home Page http://www.wagehour.dol.gov

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division
Washington, D.C. 20210

WH Publication 1420
Revised August 2001

NOTICE

Military Family Leave

On January 28, President Bush signed into law the National Defense Authorization Act for FY 2008 (NDAA), Public Law 110-181. Section 585(a) of the NDAA amended the FMLA to provide eligible employees working for covered employers two important new leave rights related to military service:

(1) **New Qualifying Reason for Leave.** Eligible employees are entitled to up to 12 weeks of leave because of "any qualifying exigency" arising out of the fact that the spouse, son, daughter, or parent of the employee is on active duty, or has been notified of an impending call to active duty status, in support of a contingency operation. By the terms of the statute, this provision requires the Secretary of Labor to issue regulations defining "any qualifying exigency." In the interim, employers are encouraged to provide this type of leave to qualifying employees.

(2) **New Leave Entitlement**. An eligible employee who is the spouse, son, daughter, parent, or next of kin of a covered servicemember who is recovering from a serious illness or injury sustained in the line of duty on active duty is entitled to up to 26 weeks of leave in a single 12-month period to care for the servicemember. This provision became effective immediately upon enactment. This military caregiver leave is available during "a single 12-month period" during which an eligible employee is entitled to a combined total of 26 weeks of all types of FMLA leave.

Additional information on the amendments and a version of Title I of the FMLA with the new statutory language incorporated are available on the FMLA amendments Web site at http://www.dol.gov/esa/whd/fmla/NDAA_fmla.htm.

WHD
U.S. Wage and Hour Division

Harford County Public Schools

Benefits Office, 102 S. Hickory Avenue, Bel Air, MD 21014 * Phone (410) 588-5275 * Fax (410) 588-5316

Leave Request Form

Complete all information below and attach appropriate verification documentation and ***submit to the Benefits Office*** 30 days prior to the start of leave date. Refer to the negotiated agreements for policies regarding qualified leaves of absence. Family/Medical leave (FMLA) will run concurrently with all qualified paid and unpaid leave requested.

☐ New Request ☐ Revised Request ☐ A&S ☐ Teacher / Instructional Staff ☐ Support Staff

Employee Name: _____ Employee #: _____ SS #: _____

Location/School: _____ Job Title: _____

☐ Part-time employee ☐ Full-time employee Date of Hire: _____

Member of Sick Leave Bank: ☐ Yes ☐ No Phone # *(while on leave)*: _____

Requested Leave Dates: _____/_____/_____ thru _____/_____/_____ *or # of weeks:* _____ Requesting Intermittent Leave: ☐ Yes ☐ No

Reason(s) for leave – please check all that apply: Email *(while on leave):* _____

☐ **Family/Medical Leave Act (FMLA)** *[1, 3]

☐ **Disability Due to Childbirth** *[1, 2]

☐ **Short-Term Childcare Leave** *[1, 2] (leave without pay immediately following a birth or adoption of a child for 12 weeks or less, as allowed under FMLA)

☐ **Long-Term/Extended Childcare Leave** *[2] (leave without pay immediately following the birth/adoption of a child lasting ***longer*** than 12 weeks, but less than 1 year)

☐ **Personal Illness** *[1, 3] (including complications due to pregnancy) Reason: _____

☐ **Family Illness** *[1, 3] **to care for a seriously ill** ☐ **Spouse** ☐ **Child** ☐ **Parent** Name: _____

☐ **Military Leave** (attach orders) ☐ **Bereavement** ☐ **Study** ☐ **Other** Reason: _____

*[1] A physician's statement verifying diagnosis with start and end dates of disability period must be attached to this request.

*[2] If you wish your child to be covered under any healthcare coverage, proof and application must be completed within 30 days of adoption or birth of the child.

*[3] Employees who are seeking leave because of family or personal illness must provide medical certification (please use the "Healthcare Provider Certification Form" attached) within 15 days of your request or as soon as practical. I understand that failure to provide medical certification may result in denial of FMLA leave until such certification is provided.

I understand, if I am eligible, I may take unpaid FMLA leave for up to 12 weeks on a rolling 12-month basis. I have read and understand all material on FMLA sent with this form. I am also aware that I am responsible for my normal contribution for health, dental and life insurance benefits while on FMLA. Further, I understand that failure to return to employment at the conclusion of FMLA leave may result in my being required to reimburse Harford County Public Schools for all premiums paid by the Board to maintain my benefits while on unpaid FMLA Leave. All missed health, dental and life insurance deductions (*missed during the 12-week FMLA period*) will be deducted from the first pay upon return to active employment. For additional information contact Debbie Moore in the Payroll Office at 410-588-5254.

(See reverse side for additional information – signature required on page 2)

Additional information: _____

I agree and understand the following:

- Maryland State Retirement Agency (MSRA) deductions will not be taken from my paycheck for a period of unpaid leave and it is my responsibility to submit a MSRS-46 Form to protect my retirement benefits while on qualified leave. If I fail to complete this form, I may be precluded from receiving retirement credit for this leave. The MSRA-46 form will be sent to you after you submit this form for review and approval.
- It is my responsibility to ***immediately*** notify my Principal/Supervisor and the Human Resources Office of any change(s) in connection with this request (including an address change) while I am on leave.
- Leave is without pay unless the situation qualifies me to use my own accrued sick, personal or annual leave. If I am a member of any Sick Leave Bank (SLB) and I run out of my own leave, it is my responsibility to contact the Sick Bank to request and submit a SLB request for the days I am unable to work due to an illness or accident.
- I understand that while I am on leave I may not work for Harford County Public Schools in any capacity.
- I understand that upon my physician's clearance to return to work, I will be returned to a position for which I am qualified. I also understand that this means that I may not necessarily be returned to the position that I was in when I requested my leave.
- It is my responsibility to complete an Insurance Enrollment Change Form, any necessary paperwork and notify the Benefits Office, ***in writing,*** of my decision to continue or change any of my benefits. Changes in benefits, including the addition of a newborn or adopted child, must be made within 31 days of the childbirth, adoption or family status change for coverage to be effective. ***Insurance premiums will be increased if you are placed on an unpaid leave of absence - contact the Benefits Office at 410-588-5275 for the adjusted premium rates and information.***

_____ _____

Signature of Employee Date

To be completed by the Benefits Office

Employee: _____ Employee #: _____ School/Location: _____

This leave request has been reviewed for the period of absence listed above. The decision to approve/disapprove this request is as follows:

☐ Approve Comments: _____

☐ Disapprove _____

☐ Qualifies for FMLA ☐ Copy sent to Payroll Office ____/____/____

_____ _____

Signature of Benefits Representative Date

Leave Balances in Hours – Effective Date (Lawson): _____ Member of Sick Leave Bank (Y / N): _____

Sick Leave: _____ Personal Business: _____ Annual Leave: _____ Total FMLA Days: _____

Total Paid Leave: _____ Unpaid Leave Beginning: _____ (*approximate date -> actual date to be determined by the Payroll Office*)

CONFIRMATION FROM PAYROLL -> Unpaid Leave Beginning: _____ Payroll Clerk: _____ Date: _____

Effective Dates of Leave: _____/_____/_____ thru _____/_____/_____ Return to Work Date: _____

Family/Medical Leave
Healthcare Provider Certification Form

NOTE: The information sought on this form pertains **only** to the condition for which the employee is requesting leave under FMLA.

To be completed by the Employee

Employee Name:	Employee #:
Patient Name (if not employee)	Relation to Employee: ☐ Spouse ☐ Child ☐ Parent
State the nature of the care you will provide if Family Leave is requested to care for a family member with a serious health condition:	
State/estimate the time period for which such care will be provided. Include a schedule if requesting leave on an intermittent or reduced schedule.	
Employee Signature	**Date**

To be completed by the Healthcare Provider

Physician/Practitioner Name:	Specialization/Type of Practice:
Address:	Phone:

Under which category of "Serious Health Condition" does the patient's condition qualify? (see back for description of codes)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ None of those listed

Describe the medical facts that support your certification, including a brief statement as to how the medical facts meet the criteria of one of the above categories.

_____

_____

If Pregnancy > projected date of delivery: _____

Illness – Date condition commenced:	**Probable duration of condition:**	**Expected return to work date:**

Certified to return to work without restrictions: ☐ **Yes** ☐ **No** **If yes, return date:**

Will it be medically necessary for the employee to work on an intermittent/reduced schedule due to the condition (including for treatment)? ☐ Yes ☐ No
If employee will miss work because of treatment on an intermittent or reduced schedule, please provide:

1. Probable # of treatments: _____
2. Interval between treatments: _____
3. Dates of treatments if known: _____
4. Period of recovery (if any): _____

A. If absence from work is required due to the employee's own medical condition, including absences related to pregnancy or a chronic condition, is the employee able to perform work of any kind?
☐ Able to perform some types of work ☐ Unable to perform work of any kind

B. If able to perform some work, is employee unable to perform any one or more essential functions of the job, based on description of essential functions provided by the employer, if any (or, if none, by the employee)? ☐ Yes ☐ No
- If yes, please describe: _____

C. If neither "A" or "B" above, is it necessary for the employee to be absent from work for treatment? ☐ Yes ☐ No

D. If leave is required to care for a family member with a serious health condition, does the patient require assistance for basic medical or personal needs, safety, or transportation? ☐ Yes ☐ No _____

E. If "D" above is "No", would the employee's presence provide psychological comfort and be beneficial to the family member or assist in recovery? ☐ Yes ☐ No _____

F. If intermittent care is necessary, probable duration of need: _____

_____ _____
Healthcare Provider's Signature (Do not use stamp or designee signature) **Date**

COMPLETE AND RETURN ORIGINAL FORM TO
HARFORD COUNTY PUBLIC SCHOOLS - BENEFITS OFFICE
102 S. Hickory Avenue, Bel Air, MD 21014
Phone: 410-588-5275 ✧ Fax: 410-588-5316

Definition of Terms

A "Serious Health Condition" is defined as an illness, 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[1] or subsequent treatment in connection with or consequent to such inpatient care.

(2) **ASBSENCE PLUS TREATMENT**
A period of incapacity[1] of more than three consecutive calendar days (including any subsequent treatment relating to the same condition), which also involves:

- Treatment[2] two or more times by a healthcare provider, by a nurse or physician's assistant under the direct supervision of a healthcare provider, or by a provider of healthcare services (e.g., physical therapist) under orders of or on referral by a healthcare provider; or
- Treatment by a healthcare provider on at least one occasion which results in a regimen of continuing treatment[3] under the supervision of a healthcare provider.

(3) **PREGNANCY**
Any period of incapacity[1] due to pregnancy or for prenatal care.

(4) **CHRONIC CONDITION REQUIRING TREATMENT**
A condition which

- Requires periodic visits for treatment by a healthcare provider, or by a nurse or physician's assistant under direct supervision of a healthcare provider, *and*
- Continues over an extended period of time (including recurring episodes of a single underlying condition); *and*
- May cause episodic rather than a continuing period of incapacity[1] (e.g., asthma, diabetes, epilepsy, etc.)

(5) **PERMANENT/LONG-TERM CONDITION REQUIRING SUPERVISION**
A condition, which is permanent or long-term due to a condition for which treatment may not be effective. The individual must be under the continuing supervision of, but need not be receiving active treatment from, a healthcare provider (e.g., Alzheimer's, severe stroke or terminal stages of a disease).

(6) **MULTIPLE TREATMENT (Non-Chronic Conditions)**
A period of absence to receive multiple treatments (including any period of recovery there from) by a healthcare provider or by a provider of services under orders or referral of a healthcare provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity[1] 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) or kidney disease (dialysis).

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[1] "Incapacity" for purposes of FMLA, is defined to mean an inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment there from or recovery there from.

[2] "Treatment" includes examinations to determine if a serious health condition exists and evaluations of an existing condition. Treatment *does not* include routine physical examinations, eye examinations or dental examinations.

[3] "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 over-the-counter medications such as aspirin, antihistamines or salves; or bed-rest, drinking fluids and other similar activities that can be initiated without a visit to a healthcare provider.

Please complete and return to:

Harford County Public Schools ✧ Benefits Office
102 S. Hickory Avenue, Bel Air, MD 21014
Phone: 410-588-5275
Fax: 410-588-5316

Return to Work Medical Certification Form

This form is to be completed when you have been released by your physician to return to work from your medical leave. You must have your healthcare provider certify that you are able to return to work and the effective date. You will **not** be permitted to resume work until your healthcare provider certifies that you are able to perform the essential functions of your job. Return the form to the Benefits Office **prior** to your request to return to work.

To be completed by EMPLOYEE:

Employee Name: _____ Employee #: _____

Location/School: _____ Job Title: _____

Date leave began: _____/_____/_____

Returning to work on: _____/_____/_____ *(list the actual date that you will return)*

Employee's Signature: _____ Date: _____

To be completed by HEALTHCARE PROVIDER:

I certify that _____ is able to perform the essential
Employee's Name

functions of his/her job without restrictions effective _____/_____/_____.

If restrictions apply – describe limitations: _____

_____

_____

Actual return to work date: _____/_____/_____

Comments: _____

Healthcare Provider's Name: _____

Address: _____

Telephone: _____

Healthcare Provider's Signature **(Do NOT use stamp or designee signature)**

_____ Date: _____