HARFORD COUNTY
PUBLIC SCHOOLS
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Leave Requests

(FMLA, Leave 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. 3/2013 (HR/BEN-1)

EMPLOYEE RIGHTS AND RESPONSIBILITIES
UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- 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.

Military Family Leave Entitlements

Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

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;
- 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

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

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.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.

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 an* ***electronic*** *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 an ***electronic*** leave request for your absence including the dates and reasons for the leave along with the required supporting documentation for your leave. **It is important to notify the HR-Benefits Office 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 the ***electronic*** request (as stated above), please submit the additional required documentation for your 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 Form). 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.
- **Military Leave:** form WH-384 or form WH-385 – see Leave Request Checklist attached.

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") at least two business days **prior** to reporting for duty.

Section III - Approval

You will be notified as to the approval of your leave request via email 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 *electronic* leave request. 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.

Rev. 3/2013

Leave Request Checklist

☐ Submit an electronic leave request via SharePoint:

SharePoint can be accessed from all HCPS networked computers or from home via http://my.hcps.org; click on Human Resources, then Benefits and scroll down to the blinking yellow arrows pointing to "Leave Request Login".

Click Here to Login and Fill out a Request!

☐ Have the healthcare provider complete and submit the Healthcare Provider Certification Form to the Benefits Office within 15 days of your leave request submission.

☐ If the absence is due to your own personal illness, please make sure your doctor completes the Return To Work Medical Certification Form and that it is submitted to the Benefits Office at least two business days PRIOR to your return to work date.

☐ **MILITARY ONLY**: If absence is due to Qualifying Exigency or Military Caregiver Leave, please complete the appropriate form.

- Form WH-384: Certification of Qualifying Exigency For Military Family Leave
- Form WH-385: Certification for Serious Injury or Illness of Covered Servicemember - -for Military Family Leave

IMPORTANT: Correspondence regarding your request will be sent via email; all employees should regularly check their HCPS email account (and personal email account if provided by employee on the leave request).

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's 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 Dates: _____

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 Dates: _____

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 ✧ HR-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 this form to the Benefits Office at least two business days PRIOR to your scheduled return to work date.**

To be completed by EMPLOYEE:

Employee Name: _____ Employee #: _____

Location/School: _____ Job Title: _____

Date leave began: _____/_____/_____ Returning to work on: _____/_____/_____
(the actual date that you will return to work)

Employee's Signature: _____ Date: _____

All questions below to be completed by HEALTHCARE PROVIDER:

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

essential functions of his/her job: **without** restrictions effective _____/_____/_____.

with restrictions effective _____/_____/_____.

If restrictions apply – describe limitations (including, but not limited to, weight bearing, lifting, any assistive devices such as a walker, scooter and/or other supports such as cast, sling, post-op shoe, cast boot, etc.):

_____

_____

_____

Restriction(s) are to be in place from: _____/_____/_____ to _____/_____/_____

Healthcare Provider's Name: _____

Telephone: _____ Address: _____

Signature:_____ Date: _____
Healthcare Provider's Signature - Stamp or designee signature NOT ACCEPTABLE.