YOUR RIGHTS UNDER THE FAMILY AND MEDICAL LEAVE ACT OF 1993

FMLA requires covered employers to provide up to twelve weeks of unpaid, job protected leave to "eligible" employees for certain family and medical reasons. Employees are eligible if they have worked for a covered employer for at least one year, and for 1250 hours over the previous twelve months, and if there are at least fifty employees within 75 miles.

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 medical condition; or
- for a serious health condition that makes the employee unable to perform the employee's job.

Employees shall be required to take any applicable accrued leave such as sick leave as a part of leave pursuant to this policy. These days shall run concurrently with the non-paid leave benefit.

ADVANCED NOTICE AND MEDICAL CERTIFICATION:

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

- The employee ordinarily must provide 30 days advance notice when the leave is "foreseeable".
- An employer may require 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 leave.

UNLAWFUL ACTS BY EMPLOYERS:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge of 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 medical leave rights.

FOR ADDITIONAL INFORMATION:

Contact the nearest office of the Wage and Hours Division, listed in most telephone directories under U.S. Government, Department of Labor.

U.S. Department of Labor, Employment Standards Administration Publication 1120
Wage and Hour Division
Washington, D.C. 20210

June 1993
Revised: 09/03

FAMILY AND MEDICAL LEAVE ACT OF 1993 APPLICATION

At the time an employee gives verbal or written notice of the need for leave pursuant to this Policy to the Personnel Director or a supervisor, the employee will be given written notice of his/her rights under the FMLA in the form of a Department of Labor's FMLA fact sheet or an equivalent document, the required forms and procedure for certification of need for the leave, the deadline for the return of required certification, and the specific consequences of a failure to provide a required certification by the required date. The employee need not cite specifically to this Policy or the FMLA in order to request leave pursuant to this Policy. The Personnel Director will assist an employee in determining whether the FMLA and this Policy applies to his/her specific circumstances.

Employees shall be required to take any applicable accrued leave such as sick leave as a part of leave pursuant to this Policy. The required use of accrued paid leave shall run concurrently with the twelve (12) weeks of unpaid pursuant to this Policy. Employees covered by the overtime provisions of the federal Fair Labor Standards Act are not required to use accrued compensatory time before utilizing leave pursuant to this Policy.

Please refer to the School Board Policy manual for more FMLA details.

1. EMPLOYEE'S NAME:_____

2. STATE REASON FOR TAKING LEAVE:_____

_____

_____

_____

_____

3. STATE THE BEGINNING AND ENDING DATES OF THE LEAVE:_____

_____

_____

EMPLOYEE SIGNATURE: _____

DATE: _____

MSD of WAYNE TOWNSHIP

Employer Response to Employee Request for Family or Medical Leave

To: _____

From: _____

Date: _____

Subject: Request for Family/Medical Leave

On _____ you notified us of your need to take family/medical leave due to:

_____ birth of your child, or the placement of a child with you for adoption or foster care; or

_____ a serious health condition that makes you unable to perform the essential functions of your job; or

_____ a serious health condition affecting you _____ spouse, _____ child, _____ parent, for which you are needed to provide care.

You notified us that you need this leave beginning on _____and that you expect leave to continue until on or about _____.

Except as explained on the reverse side, you have a right under the FMLA (1993), as made applicable by the Congressional Accountability Act of 1995, to up to 12 weeks of unpaid leave in a 12-month period for the reasons listed above. Also, your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work, and you must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and condition of employment on your return from leave. If you do not return to work following FMLA leave for a reason other than: (1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; or (2) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave.

This is to inform you that: (check appropriate spaces; explain where indicated)

1. You are _____ eligible _____ not eligible for leave under the FMLA as made applicable by the CAA.

2. The requested leave _____ will _____ will not be counted against your annual FMLA leave entitlement.

3. You _____ will _____ will not be required to furnish medical certification of a serious health condition. You must furnish the certification by _____

(must be at least 15 days after you are notified of this requirement) or we may delay the commencement of your leave until the certification is submitted.

4. You may elect to substitute accrued leave for unpaid FMLA leave. We _____ will _____ will not require that you substitute accrued paid leave for unpaid FMLA leave. If paid leave will be used, the following conditions will apply: (Explain)

5. (a) If you normally pay a portion of the premiums for your health insurance, these payments will continue during the period of FMLA leave. Arrangements for payment have been discussed with you and it is agreed that you will make premium payments as follows: (Set monthly payment dates.)

(b) You have a minimum 30-day grace period in which to make premium payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse, or, at our option, we may pay your share of premiums during FMLA leave, and recover these payments from you upon your return to work. We _____ will _____will not pay your share of health insurance premiums while you are on leave.

(c) We _____ will _____ will not do the same with other benefits (e.g., life insurance, disability insurance, etc.) while you are on FMLA leave. If we do pay your premiums for other benefits, when you return from leave you _____ will _____ will not be expected to reimburse us for the payments made on your behalf.

6. You _____ will _____ will not be required to present a fitness-for-duty certificate prior to being restored to employment. If such certification is required but not received, your return to work may be delayed until the certification is provided.

7. (a) You _____ are _____ are not a "key employee" as described in Sec. 825.218 of the Office of Compliance's FMLA regulations. If you are a "key employee," restoration of employment may be denied following FMLA leave on the grounds that such restoration will cause substantial and grievous economic injury to us.

(b) We _____ have _____ have not determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous and economic harm to us (Explain if necessary.)

8. While on leave, you _____ will _____ will not be required to furnish us with periodic reports every 30 calendar days of your status and intent to return to work. If circumstances of your leave change and you are able to return to work earlier than the date indicated on the reverse side of this form, you _____ will _____ will not be required to notify us at least two work days prior to the date you intend to return for work.

9. You _____ will _____ will not be required to furnish recertification relating to a serious health condition.

LOA 1

SELECTION OF OPTIONS DURING LEAVE

In order for the Personnel and Business Offices to know your intentions concerning certain benefits during your leave, please indicate below your choice of options and return the original and first copy to the Personnel Office.

1.	Do you wish to continue your group life insurance?	Yes ☐	No ☐
2.	Do you wish to continue your health insurance?	Yes ☐	No ☐
3.	Do you wish to continue your dental insurance?	Yes ☐	No ☐
4.	Do you have a spouse employed by the MSD of Wayne? (If so, your decision may affect his/her deduction for health insurance and/or dental insurance.)	Yes ☐	No ☐
5.	Are you aware that sick and income protection plan days must be used in conjunction with FMLA leave?	Yes ☐	No ☐

Date _____ Signature _____

School _____

Grade/Subject _____

LOA 2

MSD of Wayne Township
1220 S. High School Road
Indianapolis, Indiana 46241

REQUIRED DOCTOR'S STATEMENT FOR EXTENDED DISABILITY

To the Physician:
A teacher in the Metropolitan School District of Wayne Township may be paid through the use of sick days for extended periods of disability. It is the practice of the school corporation to accept informal verification of disability for any disablement of thirty (30) calendar days or less. However, for the teacher to draw upon his or her leave for a period of time that exceeds thirty (30) calendar days, it is necessary that a statement confirming continued disability be filed with the Personnel Office. This statement shall be based upon a timely examination of the patient and be possibly subject to a second opinion as may be required by the school corporation.

_____
Date

_____ is unable to perform his/her duties as a teacher in the MSD
Name of Teacher of Wayne Township due to the following reason(s):

_____

_____

_____

I would expect for him/her physically to be able to resume his/her regular teaching duties on

_____
Date

_____
Physician Signature (no proxy signatures accepted)

_____
Physicians Name Typed or Printed

_____
Address

_____
City State Zip Code

_____
Phone Number

LOA 3

NOTICE OF REQUESTED LEAVE OF ABSENCE DUE TO PREGNANCY

(This notice must, by law, be filed at least 30 days prior to the start of the leave)

DATE: _____

In accordance with provisions of Indiana law, notice is hereby given that the undersigned desires to start her leave of absence due to pregnancy on _____. She intends to continue
(First day of leave)
on leave until she returns to work on _____ (the beginning of a new semester, grading
(Date)
period or school year, if convenient).

A physician statement certifying pregnancy and/or a copy of the birth certificate is attached.

_____
Teacher

_____
School

_____
Grade/Subject

Received this day of _____, 20___.

Director of Personnel Services
The Metropolitan School District of
Wayne Township, Marion County, Indiana

LOA 4

MSD of Wayne Township
1220 S. High School Road
Indianapolis, Indiana 46241

REQUIRED DOCTOR'S STATEMENT
PREGNANCY CONFIRMATION

_____, a teacher in the Metropolitan School
(Name)
District of Wayne Township, is interested in applying for a leave of absence for maternity reasons. In accordance with the state law and the requirements of the school corporation, it is necessary that her pregnancy be confirmed by a physician.

_____
(*Date)*

I verify that _____ is pregnant and has an expected date of
(Name)
confinement of _____
(Date)

_____
Physician Signature (no proxy signatures accepted)

_____
Physicians Name Typed or Printed

_____
Address

_____
City State Zip Code

_____
Phone Number