REQUEST FOR FAMILY MEDICAL LEAVE
HOUSTON INDEPENDENT SCHOOL DISTRICT

Complete all attached Family Medical Leave (FML) forms (Request Form and Certification for Health Care Provider) to begin the FML application process. Submit completed forms to HISD Human Resources by fax at 713-556-7384 or email scanned copy to FML@houstonisd.org. Upon receipt of all completed forms, Human Resources will respond to your FML request and determine eligibility within five (5) business days.

PLEASE PRINT

Employee's Name: _____ Employee ID: _____

Phone: _____ Personal E-mail address: _____

Job Title/Position: _____ Location: _____

Mailing Address: _____ City, State and Zip: _____

Select your communication preference: **The indicated selection is my preference on how the district will communicate status updates or request, information related to my FML.** ☐ Email ☐ Letter (U.S. Mail)

If you do not make a selection all communications will be sent by letter.

I request Family and Medical Leave for the following reason:

☐ Birth/Adoption of a child ☐ Care for Family Member ☐ Self Serious Health Condition ☐ Military Service Care

☐ Continuous (consecutive absences) OR ☐ Intermittent

Estimated Leave Start Date: _____ Estimated Return to Work Date: _____

I understand and agree to the following:

I have met the requirement of working 12 months and worked at least 1,250 hours in the previous 12 months.

I understand that FML is taken concurrently with any other leave pursuant to the HISD Board Policy. I understand that FML is an unpaid leave, and I am required to substitute personal leave time (state sick, state, local and vacation) as indicated in DEC(Legal). I will continue to receive a paycheck until all leave time is exhausted. My benefits coverage at the time of FML will remain intact unless I choose to change or discontinue benefits. I am responsible for premium deduction. Arrears due to benefit deductions and escrow will be collected from my paycheck upon returning to work or I may submit premium health insurance deductions to minimize benefit arrears. Contact HR Employee Services at 713-556-7384 or email FML@houstonisd.org, if you have eligibility concerns or for more information regarding arrears.

Employee Signature: _____ **Date**: _____

Fax Completed Form to HISD Human Resources at 713-556-7384 or email scanned copy to FML@houstonisd.org

For questions, please e-mail FML@houstonisd.org.

Houston Independent School District
Certification for Health Care Provider: Maternity

SECTION I: For completion by the EMPLOYEE **Employee ID: _____**

Last Name: _____First Name: _____Middle Initial: ____
Employee Signature: _____ Date: _____

SECTION II: For completion by the HEALTH CARE PROVIDER

Instructions for the Health Care Provider: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. 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 employee is seeking leave. Please be sure to sign the form.

Provider's name *(Print)* _____
Type of practice/medical specialty _____
Provider's business address _____
Telephone ( ) _____ Fax ( ) _____

PART A: AMOUNT OF LEAVE NEEDED
When answering these questions, keep in mind that your patient's need for care may include assistance with basic medical hygienic; nutritional, safety, or transportation needs; or the provision of physical or psychological care.

1. Will the patient be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment/recovery? __ *Yes* __ *No*
   a. *If so, estimate the beginning and ending dates for the period of incapacity.*
   _____

2. Will the patient need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the patient's medical condition? __ *Yes* __ *No*
   a. *If so, are the treatments or the reduced number of hours of work medically necessary?* __ *Yes* __ *No*
3. Estimate treatment schedule, if any, including dates of any scheduled appointments and the time required for each appointment, including any recovery period.
   _____
   _____

PART B: MEDICAL FACTS
1. Approximate patient's date condition commenced __/__/____ (MM/DD/YYYY)
2. Probable duration of condition _____

Mark below as applicable:
3. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? __ *Yes* __ *No*
   a. *If so, dates of admission* _____
   b. Date(s) you treated the patient for condition _____ _____
   c. Was medication, other than over-the-counter medication, prescribed? __ *Yes* __ *No*
4. Will the patient need to have treatment visits at least twice per year due to the condition? __ *Yes* __ *No*
5. Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? __ *Yes* __ *No*
   a. If *so, state the nature of such treatment(s) and expected duration of treatment(s).*
   Nature: _____

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Duration: _____

SECTION II cont'd.

6. Is the medical condition pregnancy? __*Yes* __ *No*
   a. *If so, expected delivery date* __ /__ / ____ (MM/DD/YYYY)
7. Answer these questions based upon the patient's own description of his/her job functions. Is the patient unable to perform any of his/her job functions due to the condition? __*Yes* __ *No*
   a. *If so, identify the job functions the patient is unable to perform.*
   _____
   _____
8. Describe other relevant medical facts, if any, related to the condition for which the patient seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment): _____
   _____
9. Estimate part-time or reduced work schedule patient needs, if any: _____ hour(s) per day; _____days per week from __ /__ / ____ (MM/DD/YYYY) through __ /__ / ____ (MM/DD/YYYY).
10. Will the condition cause episodic flare-ups periodically preventing the patient from performing his/her job functions? __*Yes* __ *No*
    a. Is it medically necessary for the patient to be absent from work during the flare-ups? __*Yes* __ *No*
    If so, explain _____
    _____
    b. 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

Additional Information

_____
_____
_____

_____ _____

Health Care Provider Signature *Date*

Return completed forms to one of the following contacts
Fax: 713-556-7384
Email: FML@houstonisd.org