DENTON INDEPENDENT SCHOOL DISTRICT
Insurance Department
P. O. Box 1951
Denton, TX 76202
940-369-0028
940-369-4980 - fax

FAMILY MEDICAL LEAVE
GENERAL INFORMATION

ENCLOSURES

- DENTON ISD FML Employee Request for Leave Form
- Use of Leave Authorization Form
- ***Certification of Health Care Provider Form (Employee or Family Members Serious Health Condition) will be issued once the FML Employee Request for Leave Form and Use of Leave Authorization Form have been received and processed in the Insurance Department.***

FAMILY AND MEDICAL LEAVE ACT OF 1993

Federal Family and Medical Leave Act (FMLA) grants to qualified employees a total of 12 work weeks of leave, without loss of any employment benefits, during any 12 month period for one or more of the following reasons: [DISD Board Policy Compensation and Benefits (DEC LOCAL)]

1. The birth or adoption, including placement for foster care, of the employee's child and in order to care for the child, provided the leave is taken within 12 months of the birth, adoption, or placement of the child.
2. To care for the employee's spouse, child, or parent if the spouse, child, or parent has a serious health condition including injury.
3. The employee's serious health condition which causes the employee to be unable to perform the functions of his or her position.

The district shall continue to provide its portion of the employee's health insurance premium for the approved FML period. The employee is required to pay for his/her portion of all health insurance cost during the approved FML period. The District requires the use of all applicable accumulated leave while out on FML.

Military Service FML

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 which may include:

1. Attending certain military events,
2. Arranging for alternative childcare,
3. Addressing certain financial and legal arrangements,

4. Attending certain counseling sessions,
5. Attending post-deployment reintegration briefings.

FML also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member 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 service member medically unfit to perform his or her duties for which the service member is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list. The service member must be the employee's spouse, child, parent, or next of kin.

EMPLOYEE REQUEST FOR LEAVE

An employee shall provide at least 30 days' notice before FML leave is to begin if the need for leave is known (e.g. expected birth, adoption placement, or planned medical treatment for a serious health condition or military). If this is not practicable due to unforeseeable circumstances, notice must be given as soon as feasible. FML can be designated and started before the written forms are turned into the Insurance Department. The employee will receive a notice of eligibility from the Insurance Department once the request is received and processed.

Complete and return the FML Employee Request for Leave Form and Use of Leave Authorization to the Insurance Department.

Certification of Health Care Provider – Will be issued by the Insurance Department once all documents are received and processed. [MUST BE COMPLETED BY LICENSED HEALTH CARE PROVIDER]

Health care provider is defined as a doctor of medicine who is authorized to practice medicine or surgery. A health care provider does include others who are authorized to practice (e.g. podiatrists, clinical psychologists, optometrists, chiropractors, and Christian Science Practitioners). Board policy DEC (LEGAL) fully lists all acceptable practitioners or you may contact the DISD Insurance Department for further assistance.

When the leave is foreseeable and at least **30 days' notice has been provided, the employee will need to provide the medical certification before the leave begins**. When this is not possible, the employee must provide the requested certification to the employer within **15 calendar days after the employee receives the notice of eligibility.**

USE OF LEAVE DESIGNATION FORM

Employees now have a choice how leave will be used. Select the order in which earned leave will be taken during your absence, and decide on the number of days per category to be charged to your leave balances.

Failure to designate the order will result in leave being charged as follows:

1) Local leave;
2) State sick leave (accumulated before the 1995-96 school year);
3) State personal leave;

DENTON ISD reserves the right to request medical certification for any illness or disability by a health care provider at 30 day intervals when an employee is out on FML for the employee's serious health condition or that of a spouse, child or parent.

RETURN TO WORK

When an employee is ready to return to work, it is the employee's responsibility to deliver the medical release form to the Insurance Department. This form must be signed by the doctor stating the return to work date and if there are any restrictions. The Insurance Department will review and determine if the employee is eligible to return to work. If it is determined you can return to work, the employee will be given a ***Return to Work Notice***. A copy will be emailed to the supervisor and the employee. All employees must report to the Insurance Department and receive a ***Return to Work Notice*** prior to returning to his/her campus or department.

For questions on FMLA, Leaves, and Insurance contact the Insurance Dept. at 940-369-0028.

For payroll questions contact the Payroll Department at 940-369-0026.

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Request for Family Medical Leave

Must be submitted at least 30 days, if possible, prior to the date the requested leave is to begin.

Last Name	First Name	Employee ID #	
Address	City	State	Zip
Home Phone	Home Email Address	Date of Hire	
Job Title	Home Campus/Department		

Check the type of leave you are requesting:

☐ **Serious illness/injury that affects:**

☐ Employee ☐ Spouse ☐ Child ☐ Parent

Requested # of weeks:__________ (Between 1 and 12 work weeks) or # of days:__________(60 work days maximum)

Date leave to start: ____________________ Anticipated date of return:____________________

(Employees seeking leave due to a serious illness/injury must provide a medical certification within 15 days of approval)

☐ **Birth or Adoption of Child:**

Expected date of birth: __________

Requested # of weeks:__________ (Between 1 and 12 work weeks) or # of days:__________(60 work days maximum)

Date leave to start: ____________________ Anticipated date of return:____________________

☐ **Intermittent Leave:** To be used when leave in not in consecutive days. Please provide a schedule of your anticipated absences.

I understand that the leave I am requesting is an unpaid leave except where use of sick leave, personal days, vacation days and compensatory time are required. Any days taken where leave is unavailable are taken without pay. I understand that the District requires use of all accumulated state sick leave, local sick leave, state personal leave, vacation and compensatory time during leave. I understand that the leave begins on the date specified and shall run concurrently with Family Medical Leave (FML) and Temporary Disability Leave (TDL) as it applies. I understand that while I am on FML, the District will continue to pay its contribution toward my medical insurance premium for a maximum of twelve weeks as covered under the Family Medical Leave Act, and I am responsible for continued payment of my portion of the medical premium. I understand that I will not be permitted to resume my position with the District until I provide a doctor's medical release, specifying the date that I am released to return to work. I understand that if I do not return to work after I exhaust my 12 weeks of leave under FML, I may have to resign. I have read and understand ***District Policy DEC (LOCAL) and CRD (LOCAL).*** I attest that the above information is true and correct. I have read and understand the terms and conditions of my leave.

Employee's Signature ____________________________________ Date________________________

Insurance Department Use Only

Signature:____________________________ Date Appvd:________________

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USE of LEAVE AUTHORIZATION

Employee Name____ Employee ID #__________________
(Please Print)

Job Title___________________________ Campus________________ Department_____________________

Employee Signature____ Date Signed____________________

Check Appropriate Box Indicating Type of Leave Requested:

❒ Family Medical Leave ❒ Workers' Compensation ❒ Temporary Disability Leave

Select the order in which earned leave will be taken during your absence. You may also decide on the number of days/hours per category to be charged to your leave balances.

Failure to designate the order will result in your leave being charged as follows:

1) Local leave;
2) State sick leave (accumulated before the 1995-96 school year)
3) State personal leave;
4) Other (vacation, compensatory, etc)

Use of sick leave bank days shall be permitted only after all available state and local leave has been exhausted.

Please circle the order you would like to use your leave and fill in the number of days/hours per category.

1 2 3 I choose to use ______ days/hours. of Local leave**.**

1 2 3 I choose to use _______ days/hours. of State sick leave (accumulated before the 1995-96 school year)**.**

1 2 3 I choose to use _______ days/hourrs. of State leave**.**

1 2 3 I choose to use _______ days/hourrs. of Other (vacation, compensatory, etc)

FAILURE TO RETURN THIS FORM WILL RESULT IN LEAVE CHARGED AS STATED ABOVE. YOUR SELECTIONS ARE FINAL.

FORM MUST BE RETURNED TO THE INSURANCE DEPARTMENT