EXTENDED LEAVE OF ABSENCE

This contains the information and forms necessary for requesting an Extended Leave of Absence.

- Extended Leave of Absence 2013/2014
- Important Leave of Absence Information
- Family and Medical Leave Act (FMLA)
- Medical and Optional Insurance Benefits
- Instructions for Leave of Absence
- Application for Extended Leave
- Certification of Health Care Provider (Form WH-380-E)
- Fitness for Duty Certification (Medical Release Form)

For any questions, contact:

DUVAL COUNTY PUBLIC SCHOOLS
Extended Leave Office
1701 Prudential Drive
Jacksonville, Florida 32207

Phone: (904) 390-2065
Fax: (904) 390-2395

Revised October 10, 2013

EXTENDED LEAVE OF ABSENCE
2013/2014

MEDICAL LEAVE OF ABSENCE

- **Family and Medical Leave Act (FMLA)**
  FMLA is federal law which allows an employee to take unpaid, job protected medical leave for their own serious health condition or for the serious health condition of an immediate family member.

- **Personal Health Leave**
  Personal Health leave is used for the illness of an employee who does not qualify for FMLA or who has used all available FMLA, but has not been released by their doctor. Under Personal Health Leave, you would be responsible to pay for your health benefits and your position may be filled.

- **OJI (on the job injury/illness)**
  If you will be out of work due to an injury/illness, it may be necessary for you to be placed on an extended leave of absence. You will need to contact the Extended Leave Office for your options.

PERSONAL LEAVE

- Not available for the 2013/2014 school year.

PROFESSIONAL/EDUCATIONAL LEAVE

- Not available for the 2013/2014 school year.

FMLA/Military Exigency
FMLA/Military Caregiver

- Specialized leave of absence relating to Military issues. Contact the Extended Leave Office for additional information.

MILITARY LEAVE

- See separate paperwork under “Extended Military Leave of Absence”

IMPORTANT LEAVE OF ABSENCE INFORMATION

This information covers the major issues involved in the Extended Leave process.

FIRST CONTACT: Contacting the Extended Leave Office at (904) 390-2065 is your first step. They will answer all questions about extended leave, determine what type of leave that you qualify for and provide the necessary paperwork to apply for leave.

EMPLOYEE BENEFITS: Being on Extended Leave will affect your benefits. You will need to call Employee Benefits at (904) 390-2887 to discuss continuing or dropping any current benefits while you are on leave. When you return to work, you will also contact Employee Benefits to reinstate your benefits and discuss any adjustments that may be necessary.

SICK LEAVE/ANNUAL LEAVE: You will be required to use all available leave before starting extended leave. Not all sick leave is available to be used. You can check with your work location or the Payroll Department for your available leave balance.

DIRECT DEPOSIT: Once you have been placed on extended leave, you will be taken off direct deposit. The final check that you receive will be a “paper” check. Reinstating your direct deposit is part of the return from leave process.

EQUALIZATION: If you are on an equalized pay plan, the balance in your equalization account will be adjusted on the final check. When you return from leave, adjustments may also be necessary to get you back on the proper schedule. Contact the Payroll Department for more information.

OPTIONAL PAY: If you are on the optional pay plan (which pays you additional checks during the summer), the balance in the Equalization account at the time you are placed on leave will be paid out to you on your final check. When you return from leave, you will be placed back on the regular pay plan for the remainder of the school year. At the end of the school year, you MUST sign up for the optional pay plan, if you choose, for the next school year.

SHORT TERM DISABILITY: If you purchased a Short Term Disability Income Protection Policy, you will need to call the UNUM Claim Office at 1-888-857-0157 to file your claim.

RETURN FROM LEAVE: Once you have been released by your doctor to return to work, you **must come to the Extended Leave Office prior to returning to your work location** with the doctor’s release and a voided check to reinstate your direct deposit. Completed paperwork will be sent to HR Staffing for placement.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

The Family and Medical Leave Act of 1993 (FMLA) allows eligible employees of a covered employer to take job-protected, unpaid leave for up to a total of 12 workweeks in any 12 months.

How do I qualify for FMLA?

To be eligible for FMLA, an employee must meet the following qualifications:

- Has worked for DCPS for at least 12 months at the time the leave is to commence
- Has worked at least 1250 hours during the 12 month period prior to leave start date

What can FMLA be used for?

A leave of absence under FMLA can be used for the following reasons:

- Birth of a child and care for the newborn child
- Placement with the employee of a child for adoption or foster care
- Serious health condition of the employee
- Care for employee's spouse, child or parent with a serious health condition
- Qualifying exigency arising out of the fact that the employee's spouse, child or parent is a covered military member on active duty (special paperwork is required)

What rights or protections does FMLA leave offer?

- You have a right under FMLA for up to 12 weeks of unpaid leave in a 12 month period
- Your basic health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work
- You must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA leave.

How do I apply for FMLA leave?

- Complete an extended leave application
- Submit the "Certification of Health Care Provider" form completed by your physician

For more information on the Family and Medical Leave Act, go to www.dol.gov

MEDICAL AND OPTIONAL INSURANCE BENEFITS

PLEASE CONTACT EMPLOYEE BENEFITS AT 390-2887 FOR THE FOLLOWING:

- Employees can continue all benefits while on Leave of Absence (LOA) or terminate some or all benefits while on LOA. An enrollment form must be completed in the Employee Benefits Dept.
- To add a new dependent or drop your benefit coverage's while on LOA, please contact the Employee Benefits Dept. to complete an enrollment form.
- A new enrollment form must be completed **WITHIN 30 DAYS** of the qualifying event.
- If you are enrolled in Short/Long Term Disability and want to file a claim, you must contact UNUM Insurance Company at 800-633-7479. To file claim using the telephonic claim process call 1-888-857-0157. REMEMBER: SHORT TERM DISABILITY INCOME IS NOT CONSIDERED INCOME FROM DCPS.
- You **MUST** notify Employee Benefits upon your return to work.

PAYING FOR BENEFITS WHILE ON LOA:

Fringe Benefits Management Company (FBMC) will bill for all benefits while on LOA. Once they are notified of your LOA, they will mail out coupons billing for any benefits you chose to continue. The coupons will list the amount due and due date.

- All payments are due on the first of the month with the exception of a partial month that may be billed for the first payment after you go on LOA. This date will be on that coupon.
- If payment is not made by 5th of month, benefits will be termed back to the last day of the prior month.
- Employees on FMLA and in the Contributory Medical Plan must pay the employee portion of the premium to keep the medical coverage effective. If the employee portion is not paid, the medical coverage will be terminated at the end of the prior month payment was not made.
- If you request to term your benefits or they are termed due to non-payment while on LOA, you must contact Employee Benefits Dept. on your return to work to have those benefits reinstated. **They will not automatically be restarted.**
- Employees who do not notify the Benefits department upon their return to work and have termed benefit coverages while on LOA will be enrolled in the same medical plan at employee only, Basic life coverage ($10,000) and Flex dollars going to MFSA account.
- Employees with Voluntary Individual benefit plans* that are terminated due to non payment, will not have these benefits restarted by DCPS. Employees must pay the provider company directly to have benefit reinstated and may request through them to have their premium restarted through payroll deduction.

  *Trustmark Cancer
  *Trustmark Universal Life
  *AHL Critical Illness (all plans)
  *Trustmark Premier Select
  *Trustmark Accident Plan
  *UNUM Whole Life

- FBMC will not bill for TSA Deductions, Union Dues, Garnishments and Student Loans.
- FBMC customer service number is 1-800-342-8017
- Payments will be made directly to: **Drop Box 24**
  FRINGE BENEFITS MANAGEMENT COMPANY
  PO Box 1878, Tallahassee, FL 32302

DUVAL COUNTY PUBLIC SCHOOLS

Instructions for Leave of Absence

STEP ONE: Who to Contact

- **Contact Extended Leave Office (904) 390-2065**
  To answer all questions about Extended Leave, to determine what type of leave that you will qualify for and to receive the necessary paperwork for applying for leave

- **Contact Employee Benefits (904) 390-2887**
  To maintain and continue any necessary benefits while you are on extended leave

- **Contact Payroll Department (904) 390-2022 or Payroll Contact at work location** for leave balances. You will be required to use all available sick and annual leave before any medical leave of absence.

- **Contact UNUM Claims at 1-888-857-0157** if you purchased a Short Term Disability policy and need to file a claim.

STEP TWO: Complete Paperwork

- Complete Extended Leave Application and have signed by Principal or Supervisor

- Medical documentation is required for all medical extended leave

  FMLA requires Certification of Health Care Provider (WH-380-E) completed by physician

  Personal Health/OJI requires a doctor's statement which covers the reason for leave, start date and approximate duration of leave

- Other types of leave may require additional documentation

STEP THREE: Submit Paperwork

Return completed application and required documentation to:

US Mail:
Duval County Public Schools
Extended Leave 1st Floor
1701 Prudential Drive
Jacksonville, FL 32207

SCHOOL MAIL:
Bldg #3001
1st Floor Extended Leave

Fax: (904) 390-2395

DUVAL COUNTY PUBLIC SCHOOLS

APPLICATION FOR EXTENDED LEAVE

PLEASE PRINT:

Name ____________ Work Location # ____________ Personnel # ____________ Date ____________

Position ____________ Principal/Supervisor ____________ School Name **or** Work Location ____________

Home Address ____________ ☐ New ☐ Temporary ☐ Home

City ____________ State ____________ Zip ____________ Home Phone ____________ Cell Phone ____________

TYPE OF LEAVE: ***FOR ALL MEDICAL LEAVE, A DOCTOR'S STATEMENT MUST BE INCLUDED***

☐ FAMILY & MEDICAL LEAVE ACT (FMLA)

- ☐ Illness of Employee
- ☐ Illness of Family Member
- ☐ Maternity/**due date** ____________

☐ PERSONAL HEALTH

☐ MILITARY **(include a copy of official orders)**

☐ ON THE JOB INJURY (OJI) **Date of Injury:** ____________

READ EACH STATEMENT BELOW AND INITIAL:

____ All Extended leave will be subject to rules of the DCPS, Civil Service Board and/or employee bargaining agreements in effect the date leave is approved.
____ Employee will need to contact Employee Benefits at (904) 390-2887 to continue existing insurance plans.
____ Any employee on the optional pay plan (12 mth) will automatically be placed on regular pay plan (10 mth) for the remainder of the school year upon returning from leave. You MUST reapply for the optional pay plan for the next school year.
____ **Employee must report to the Extended Leave Office to complete necessary paperwork PRIOR to returning to work location.**
____ Employee will need to contact Employee Benefits with return to work date and to discuss any adjustments to benefits.
____ Failure to return from leave will be considered a resignation.

DATES ABSENT:

Start Date: ____________ End Date: ____________ **(IF DATES ARE UNKNOWN, LEAVE BLANK)**

REASON FOR REQUEST: ____

Employee Signature ____________ Date ____________ Principal/Supervisor Signature ____________ Date ____________

OFFICE USE ONLY:
Staffing Supervisor: _______ Certification: _________ Date Received: _________ Position Code: ___________

DCPS – Extended Leave Office – 1st Floor – 1701 Prudential Drive – Jacksonville, FL 32207
Phone: (904) 390-2065 Fax: (904) 390-2395

Certification of Health Care Provider for
Employee's Serious Health Condition
(Family and Medical Leave Act) **WH-380-E**

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division

OMB Control Number: 1215-0181

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

Employer and Contact: **DUVAL COUNTY PUBLIC SCHOOLS, Extended Leave Office**

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 20 C.F.R. § 825.313. Your employer must give you at least **15 calendar days to return this form**. 29 C.F.R. § 825.305(b).

Your Name: ____
First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to 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 on the last page.

Provider's name: ____

Business address: ____

Type of practice / Medical specialty: ____________________________________

Telephone: (________)_______________________ Fax:(_________)______________________________

PART A: MEDICAL FACTS

1. Approximate date condition commenced: ____

   Probably duration of condition: ____

   Mark below as applicable:

   Was the patient admitted for an overnight stay in a hospital, hospice or residential medical care facility?
   _____ No _____ Yes. If so, dates of admission:

   ____

   Date(s) you treated the patient for condition:

   ____

   Will the patient need to have treatment visits at least twice per year due to the condition?
   ____ No ____ Yes.

   Was medication, other than over-the-counter medication, prescribed? ____ No ____ Yes.

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? ____ No ____ Yes.

   If so, state the nature of such treatments and expected duration of treatment:

   ____

2. Is the medical condition pregnancy? ____ No ____ Yes

   If so, expected delivery date: ______________________

3. Answer these questions based upon the employee's own description of his/her job functions.

   Is the employee **unable** to perform any of his/her job functions due to the condition:
   ____ No ____ Yes.

   If so, identify the job functions the employee is unable to perform:

   ____

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment): ____

   ____

   ____

   ____

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ____ No ____ Yes.

   If so, estimate the beginning and ending dates for the period of incapacity:

   ____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ____ No ____ Yes.

   If so, are the treatments or the reduced number of hours of work medically necessary?
   ____ No ____ Yes.

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   ____

   Estimate the part-time or reduced work schedule the employee needs, if any:

   ____ hour(s) per day; ____ days per week from ____ through ____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ____ No ____ Yes.

   Is it medically necessary for the employee to be absent from work during the flare-ups?
   ____ No ____ Yes. If so, explain:

   ____

   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 last 1-2 days):

   Frequency: _____ times per _____ week(s) month(s) _____

   Duration: _____ hours or ___ day(s) per episode

ADDITIONAL INFORMATION:
IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

____
____
____

____ ________________________
Signature of Health Care Provider **Date**

FITNESS FOR DUTY CERTIFICATION

(Physician's medical release form)

PLEASE PRINT

Employee Name: ____

______________________ ______________ ______________________

Personnel # Work Location # School Name or Department

You have my permission to contact the health care provider indicated on this form for purposes of certification and authentication.

Employee Signature ______________________________ Date ______________

BELOW FOR PHYSICIAN'S USE ONLY

- The above patient is certified as fit to resume full time work duties on _____________.
(mm/dd/yy)
- The above patient is certified as fit to resume work duties on _______________ with the
(mm/dd/yy)

  following restrictions *(Be as specific as possible)*: ______________________________

  ____

  ____

  and is certified as fit with all restrictions lifted on ________________.
  (mm/dd/yy)

- Additional comments: ____

Health Care Provider: ____

Practice/Specialty: ____

Address: ______________________________ Telephone: ________________

Signature: ______________________________ Date: ________________

SUBMIT COMPLETED FORM PRIOR TO RETURNING TO WORK LOCATION TO:

Duval County Public Schools, Extended Leave Office

1701 Prudential Drive, Jacksonville, Florida 32207