APPLYING FOR A LEAVE-OF-ABSENCE

- In the case of a *foreseeable* leave, contact Human Resources at least 30 days prior to the start of your leave.
- If your leave is *unforeseeable*, contact Human Resources as soon as is practicable.
- Upon notification, you must complete a leave-of-absence application packet, which can be obtained from Joyce Marquez in the Human Resources department.

Frequently Asked Questions for Leaves-of-Absence

These are the frequently asked questions for leave-of-absence. This document is for your reference and requires no action.

Your Rights Under Family Medical Leave Act of 1993 (FMLA)

This is a summary of the Family Medical Leave Act of 1993 (FMLA). This document is for your reference and requires no action.

Leave-of-Absence Application

Complete the Leave-of-Absence Application. The application must have your hiring manager / supervisor's signature of approval. By completing and signing this application, you acknowledge that you understand the terms and requirements of requesting an FMLA leave, spread docking your pay, and the impact your leave will have on your benefits through the District.

Sick Leave Bank (SLB) Request Form (*if FMLA leave and enrolled in the Sick Leave Bank*)

Only employees who are applying for a medical leave and enrolled in the Sick Leave Bank are eligible to apply for the use of the Sick Leave Bank.

HIPAA Release: Request to Distribute Personnel / Payroll Information

The Health Insurance Portability and Accountability Act (HIPAA) was designed to promote the confidentiality and portability of patient records. This form must be completed if you are applying for a medical leave.

Employer Response Letter (if FMLA leave)

This form covers the FMLA in detail and helps you to determine if you qualify for an FMLA leave. **Please read through this form carefully as it contains important information.** Be sure to sign and date the end of this form.

Certification from Your Health Care Provider (if FMLA leave)

This form is **required** by the FMLA and must be completed by your health care provider if you are applying for a medical leave. This signed notice must be received in Human Resources within 15 days from the original notification of the leave. Your health care provider may fax it to 303.657.3938 with your authorization.

Once the required documents are completed and received in Human Resources, the LOA Request will be submitted to the Executive Director of Human Resources for final approval. Upon approval, a letter will be sent to your home with important information regarding dates, continuation and payment of health care premiums, etc.

While on your leave-of-absence, you are required to call Human Resources five days prior to your anticipated return to work date to confirm or amend such date.

*****If you are on a medical leave-of-absence, you are required to submit a doctor's note to Human Resources prior to returning to work. Do not return to work until this notice has been submitted Human Resources. If you are released to return to work with limitations or restrictions on your ability to perform your normal duties, you must submit the medical statement listing these limitations/restrictions at least five working days prior to the scheduled return-to-work date. The restrictions/limitations will be reviewed to determine whether you can return to work under these conditions.*****

Human Resources Department
✓ 6933 Raleigh Street ✓ Westminster, CO 80030
✓ Phone: 303.428.3511 ✓ Fax: 303.657.3938

Template Updated: 11/15/2010 (JTM)

Frequently Asked Questions for Leaves of Absence

Adams County School District 50 complies with all requirements of the Family and Medical Leave Act of 1993 along with the WEA Negotiated Agreement.

1. What is the Family Medical Leave Act (FMLA) of 1993?

The FMLA provides up to 12 weeks of job-protected unpaid leave for eligible employees to care for the employee's child after birth or placement for adoption or foster care; to care 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.

2. Am I eligible for FMLA?

Employees who have at least 12 months of service and have worked at least 1,250 hours in the last consecutive months are eligible for FMLA.

3. Is maternity leave considered FMLA?

Maternity Leave is considered medical leave under FMLA. The duration of a normal maternity leave is usually 6 weeks, or as designated by the health care provider.

The medical portion of the leave that is certified by the health care provider will be covered by cumulative days and sick leave bank. The sick leave bank may be utilized ***only*** by members enrolled in the sick leave bank (SLB, pg. 8). Additional leave time may be requested under FMLA provisions.

4. Will I continue to receive benefits while I'm on an FMLA leave?

For the duration of the FMLA leave, Adams County School District 50 will maintain the employee's health care coverage, however, the employee is still responsible for his/her portion of health care and dental premiums.

5. Will I continue to accrue Cumulative Leave while I'm on leave?

Per Article 24-1-2 of the Negotiated Agreement, Cumulative Leave will not accrue during the period of a leave; however, accrued Cumulative Leave will be maintained.

6. What if my leave is longer than 12 weeks?

Leaves that are longer than 12 weeks are not protected by FMLA. Once the FMLA period expires, the employee is responsible for paying both the employer and employee contributions for Health and Dental coverage.

*****This payment must be received in the payroll department by the 10th of each month to pay for the following month's coverage. Failure to make this payment will result in cancellation of coverage.*****

7. What if I do not qualify for FMLA?

You may still apply for a personal, educational, or Military leave. All leaves are subject to approval by the Executive Director of Human Resources.

8. How do I apply for a leave-of-absence?

Contact Joyce Marquez in Human Resources at 303-428-3511 x5068 and she will explain the required paperwork to you.

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The District of Choice.
Adams County School District 50

9. Do I get paid during my leave?

All leaves-of-absence are unpaid. Any unused cumulative leave you have will be used to cover your absences before you go without pay. Spread docking may be available to lessen the financial impact of unpaid days.

10. What is spread-docking?

You may have the option of having unpaid days deducted evenly throughout your paychecks for a maximum of six months during your contact year. This alleviates the possibility of having to go without a paycheck and enables your benefits to continue through normal payroll deductions rather than requiring you to bring in premium payments. 260-day employees are not eligible to spread dock.

11. If I elect to spread dock, how will I know what my pay will be?

A worksheet to calculate your spread dock can be found on the District website. A hard copy can also be requested from the Payroll department.

Can my spread dock begin before my leave begins?

No. Your spread dock will not begin until your leave begins.

12. Can I use Sick Leave Bank for my leave?

Approval for the Sick Leave Bank is determined on a case-by-case basis and must be applied for at the time you apply for your leave. Please contact Joyce Marquez in Human Resources to request this application. You must be a member of the Sick Leave Bank to apply.

13. What if my anticipated leave dates change?

It is your responsibility to notify the Human Resources department as soon as possible with any changes to your leave of absence. You will also need to contact your supervisor/principal and the substitute office with this information.

14. What do I need to do prior to returning from my leave?

You must visit Joyce Marquez in the Human Resources department before returning to work and obtain a "Release Back to Work Authorization" form. If your leave was for medical reasons, including maternity, you must provide a letter from your physician stating the date you may return to work with no restrictions. If there are any restrictions, the physician needs to list the restrictions in this letter.

15. Once I return from leave and have no available cumulative days, what if I need to take a sick day?

Unless you have frozen or accumulated days, you will be docked your daily per diem if you miss additional days.

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✓ 6933 Raleigh Street✓ Westminster, CO 80030
✓ Phone: 303.428.3511 ✓ Fax: 303.657.3938

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.

NOTICE

Military Family Leave

On January 28, President Bush signed into law the National Defense Authorization Act for FY 2008 (NDAA), Public Law 110-181. Section 585(a) of the NDAA amended the FMLA to provide eligible employees working for covered employers two important new leave rights related to military service:

(1) **New Qualifying Reason for Leave.** Eligible employees are entitled to up to 12 weeks of leave because of "any qualifying exigency" arising out of the fact that the spouse, son, daughter, or parent of the employee is on active duty, or has been notified of an impending call to active duty status, in support of a contingency operation. By the terms of the statute, this provision requires the Secretary of Labor to issue regulations defining "any qualifying exigency." In the interim, employers are encouraged to provide this type of leave to qualifying employees.

(2) **New Leave Entitlement**. An eligible employee who is the spouse, son, daughter, parent, or next of kin of a covered servicemember who is recovering from a serious illness or injury sustained in the line of duty on active duty is entitled to up to 26 weeks of leave in a single 12-month period to care for the servicemember. This provision became effective immediately upon enactment. This military caregiver leave is available during "a single 12-month period" during which an eligible employee is entitled to a combined total of 26 weeks of all types of FMLA leave.

Additional information on the amendments and a version of Title I of the FMLA with the new statutory language incorporated are available on the FMLA amendments Web site at http://www.dol.gov/esa/whd/fmla/NDAA_fmla.htm.

WHD
U.S. Wage and Hour Division

The District of Choice.
Adams County School District 50

LEAVE-OF-ABSENCE APPLICATION

I am requesting a leave of absence and have discussed this request with my supervisor. I submit the following information in support of this request:

Section I: Employee Information

_____ , _____ ____
(*Last Name*) (*First Name*) (*M.I.*)

_____
(*Employee I.D. #*)

_____ _____
(*Home Street Address*) (*Apartment #*)

_____ , _____ _____
(*City*) (*State*) (*Zip Code*)

(_____) _____ - _____
(*Home #*)

(_____) _____ - _____
(*Cell #*)

_____
(*School / Location*)

_____
(*Position / Assignment*)

_____
(*# of Contract Work Days*)

____/____/_____
(Date of *Hire*)

☐ Probationary ☐ Non-Probationary

Employment Classification: ☐ ESP ☐Teacher/Licensed ☐Middle Manager ☐Administrator

Section II: Leave Of Absence Information

This section is a tool to determine the type of leave you are applying for, whether or not you can spread dock, if you need to pay for your insurance premiums while you are out, and whether or not you qualify for use of the Sick Leave Bank.

If your request is a Family Medical Leave (FMLA), a completed Certification of Healthcare Provider must be submitted for leave of absence approval.

Type of Leave: *(Check all that apply)* ☐ Family Leave ☐ Medical Leave *(Includes maternity)* ☐ Personal ☐ Military ☐ Educational ☐ Sick Leave Bank *(Must be enrolled)*

My absence is the result of a medical condition of my own, my child, spouse or parent; or to care for my newborn child or place for adoption or foster care.	☐ Yes	☐ No	If you answered YES to both of these questions, you are eligible for FMLA protection. Answering NO does not mean that you do not qualify for a leave of absence. Please continue.
I have worked for the District for at least one year, and for 1,250 hours over the previous 12 months.	☐ Yes	☐ No	

I anticipate that my leave will begin: ____/____/_____ **My anticipated date of return is:** ____/____/_____

Is the duration of your requested leave longer than 12 weeks? ☐ Yes ☐ No **If YES, indicate the duration:** ☐ One Semester ☐ One Year ☐ Other

Do you want to access your available days during this leave of absence? ☐ Yes ☐ No

Section III: Sick Leave Bank

Those electing Sick Leave Bank may not be eligible for spread docking during the waiting period prior to Sick Leave Bank becoming effective. Your Sick Leave Days must be used consecutively.

ESP *employees must utilize 15 consecutive days of their own cumulative leave or days without pay prior to becoming eligible to draw up to 36 days from the Sick Leave Bank.*

Licensed *employees must utilize 25 consecutive days of their own cumulative leave or days without pay prior to becoming eligible to draw up to 60 days from the Sick Leave Bank.*

I am a member of Sick Leave Bank.	☐ Yes	☐ No	**If you answered NO to either of these two questions, you are **NOT** eligible to apply for use of the Sick Leave Bank.** *****Use of the Sick Leave Bank may be subject to approval of the Sick Leave Bank Committee.*****
My absence is due to serious illness or injury. (*Pregnancy can be considered if not released by a doctor after the first six weeks.)*	☐ Yes	☐ No	

Section IV: Spread Dock

I would like to request that if I need to be docked any pay, that it be spread dock through my paychecks. ☐ Yes ☐ No

My leave is starting the first day of the school year.	☐ Yes	☐ No	**If you answered YES to any of these three questions, you are **NOT** eligible to spread dock your salary for your missed days.** *****If I elected to have my pay spread docked, I understand that the reduced amount will carry no longer then a six month period. (Only nine, ten, and eleven month employees are eligible).*****
I am a 260-day employee. *(260 Contract Work Day Employees are not eligible).*	☐ Yes	☐ No	
I am applying to use Sick Leave Bank.	☐ Yes	☐ No	

Section V: Health and/or Dental/ or Vision Benefits Information

If you have health and/or dental insurance coverage through the District, and your leave results in a period where you do not receive a paycheck, you are responsible for your portion of your health and dental care premiums. Payments must be set up with Payroll and are due by the 10th of each month for the following months of coverage.

Do you have health benefits through the District?	☐ Yes	☐ No	☐ Kaiser HMO MultiChoice ☐ Kaiser HMO High ☐Kaiser HMO Low ☐ Kaiser DHMO ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family
Do you have dental benefits through the District?	☐ Yes	☐ No	☐ Delta Dental PPO ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family
Do you have vision benefits through the District?	☐ Yes	☐ No	☐ VSP ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family

It is your responsibility to contact the benefits department and substitute office of any change and to arrange coverage during your leave. Upon your return from leave, you must submit a medical release form from your physician to Human Resources to be released back to work.

_____ _____/_____/_____
(*Employee Signature*) (*Date*)

Section VI: Supervisor / Principal Section

This leave will require a substitute. ☐ Yes ☐ No A substitute is required from _____ to _____

This leave will require a job posting. ☐ Yes ☐ No *(If yes, please submit a job requisition through Open Hire.)*

_____ _____/_____/_____
(*Supervisor / Principal Signature*) (*Date*)

Human Resources Department
✓ 6933 Raleigh Street ✓ Westminster, CO 80030
✓ Phone: 303.428.3511 ✓ Fax: 303.657.3938

Template Updated: 10/21/2010 (JTM)

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Adams County School District 50

SICK LEAVE BANK REQUEST

The Sick Leave Bank Request applies only to those who are enrolled in the Sick Leave Bank, which will be verified.

I submit the following information below in support of my request to use the Sick Leave Bank:

_____ (*Last Name*) , _____ (*First Name*) ____ (*M.I.*)	_____ (*Employee I.D. #*)
_____ (*Home Street Address*) _____ (*Apartment #*) _____ (*City*) , _____ (*State*) _____ (*Zip Code*)	(_____) _____ - _____ (*Home #*) (_____) _____ - _____ (*Cell #*)
_____ (*School / Location*)	_____ (*Position / Assignment*)

All available and accrued cumulative leave days will be applied toward the required 15 consecutive days for employees.	All available and accrued cumulative leave days will be applied toward the required 25 consecutive days for **Certified** employees.

(Please refer to your Compensation & Benefits booklet for additional information)

Are you enrolled in the Sick Leave Bank? ☐ Yes ☐ No ☐ I don't know

Reason for the use of Sick Leave Bank: _____

I anticipate that my leave will begin:	_____/_____/_____ (*Date*)	**I anticipate my date of return will be:**	_____/_____/_____ (*Date*)

Attached is the *required* doctor's note verifying my days that I will be out: ☐ Yes ☐ No

If no, I will have my doctor's note verifying my days that I will be out by: _____/_____/_____

***** I understand if I do not have the required cumulative days my wages will be docked the proper amount of days.***

***** I understand that it is my responsibility to contact the benefits department and substitute office of any change and to arrange coverage during my leave.***

***** I understand that is it my responsibility that I must submit a medical release form from my physician to Human Resources to be released back to work.***

_____ (*Employee Signature*)	_____/_____/_____ (*Date*)

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✓ 6933 Raleigh Street ✓ Westminster, CO 80030
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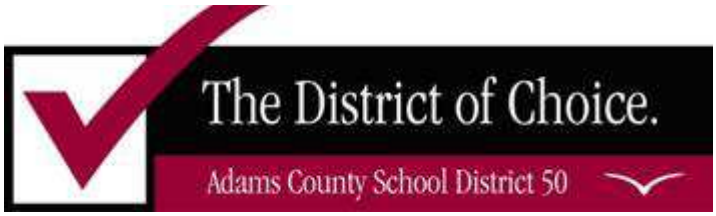

HIPAA Release
Request to Distribute Personnel / Payroll Information

HIPPA (Health Insurance Portability and Accountability Act) was created to increase the privacy of individuals' personal health information. It affects all those who are in contact with medical or personal health information. Under the law, ATC's will no longer be able to speak to anyone in regards to an injury or condition unless a release is signed and specifics are given as to what can be disclosed and to whom it can be divulged to. This must be signed for each new injury that occurs.

I, _____ authorize
(*Print employee full name*)

Adams County School District 50 Human Resources

to receive personal information regarding my payroll and Leave of Absence.

_____ _____
(*Employee Signature*) (*Date*)

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✓ 6933 Raleigh Street ✓ Westminster, CO 80030
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Template Updated: 11/02/2011

Employer Response to Employee
Request for Family or Medical Leave
(Form Expires: 02-28-2015)

(Family and Medical Leave Act of 1993)

TO: _____ _____
(Employee's Full Name) *(Employee I.D. #)*

_____ _____
(Location/Building) *(Job Title)*

FROM: JOYCE MARQUEZ
(Name of Appropriate Employer Representative)

SUBJECT: **REQUEST FOR FAMILY/MEDICAL LEAVE**

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

☐ *MEDICAL LEAVES*
- ☐ A serious health condition that makes you unable to perform the essential functions for your job[1],
- ☐ Birth of a child/pregnancy-related disability[1]: or

☐ *FAMILY LEAVES*
- ☐ A serious health condition affecting your ☐**spouse,** ☐**child,** ☐**parent**, for which you are needed to provide care[2]
- ☐ Father's attendance at birth of child
- ☐ Parent's care of child following birth
- ☐ Placement of child with employee for adoption or foster care[3]

☐ *WORK-RELATED INJURY*
Will be coordinated with your workers' compensation lost-time claim.

☐ *SICK LEAVE BANK*
In accordance to the Sick Leave Bank requirements
As designated by your Health Care Provider

☐ *MILITARY FAMILY LEAVE*
- ☐ ***Qualifying Exigency Leave:***
  Arising out of active duty or call to active duty of ☐spouse, ☐son, ☐daughter or ☐parent
- ☐ ***Military Caregiver Leave:***
  For ☐spouse, ☐son, ☐daughter, ☐parent or ☐next-of-kin to care for service member with serious injury/illness

(Where indicated by "1," or "2," above, the employee may be required to provide medical certification on form DOL WH-380-E for "1"; or form DOL WH-380-F for "2"; and submit all required documents for "3", in accordance with the employer's policy. The leave may or may not be designated as a FMLA leave, depending on the information in the certification. Failure to provide certification within 15 calendar days of request, when practicable, may result in denial of leave until certification if provided. Continued absence after denial of leave may result in disciplinary action in accordance with the employer's attendance policy.)

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

Except as explained below, you have a right under the FMLA for 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 conditions 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.

Covered Servicemember Leave: Under the FMLA, an eligible employee who is a spouse, son, daughter, parent, or next of kin of a current member of the Armed Forces, including a member of the National Guard or Reserves, with a serious injury or illness may be granted up to a total of **26 workweeks** of **unpaid** leave during a "single 12-month period" to care for the service member.

Spouses employed by the same employer are limited in the **amount of** family leave they may take for the birth and care of a newborn child, placement of a child for adoption or foster care, or to care for a parent who has a serious health condition to a combined total of 12 weeks (or 26 weeks if leave to care for a covered service member with a serious injury or illness is also used). Leave for birth and care, or placement for adoption or foster care, must conclude within 12 months of the birth or placement.

"**Serious health condition**" means an illness, injury, impairment, or physical or mental condition that involves either:

► Inpatient care (*i.e.*, an overnight stay) in a hospital, hospice, or residential medical-care facility, including any period of incapacity (*i.e.*, inability to work, attend school, or perform other regular daily activities) or subsequent treatment in connection with such inpatient care; **or**

► Continuing treatment by a health care provider, which includes:

(1) A period of incapacity lasting more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that **also** includes:
- treatment two or more times by or under the supervision of a health care provider (*i.e.*, in-person visits, the first within 7 days and both within 30 days of the first day of incapacity); **or**
- one treatment by a health care provider (*i.e.*, an in-person visit within 7 days of the first day of incapacity) with a continuing regimen of treatment (*e.g.,* prescription medication, physical therapy); **or**

(2) Any period of incapacity related to pregnancy or for prenatal care. A visit to the health care provider is not necessary for each absence; **or**
(3) Any period of incapacity or treatment for a chronic serious health condition which continues over an extended period of time, requires periodic visits (at least twice a year) to a health care provider, and may involve occasional episodes of incapacity. A visit to a health care provider is not necessary for each absence; **or**
(4) A period of incapacity that is permanent or long-term due to a condition for which treatment may not be effective. Only supervision by a health care provider is required, rather than active treatment; **or**
(5) Any absences to receive multiple treatments for restorative surgery or for a condition that would likely result in a period of incapacity of more than three days if not treated.

Employees seeking to use FMLA leave are required to provide 30-day advance notice of the need to take FMLA leave when the need is foreseeable and such notice is practicable. If leave is foreseeable less than 30 days in advance, the employee must provide notice as soon as practicable – generally, either the same or next business day. When the need for leave is not foreseeable, the employee must provide notice to the employer as soon as practicable under the facts and circumstances of the particular case. Absent unusual circumstances, employees must comply with the employer's usual and customary notice and procedural requirements for requesting leave.

Employees must provide sufficient information for an employer reasonably to determine whether the FMLA may apply to the leave request. Depending on the situation, such information may include that the employee is incapacitated due to pregnancy, has been hospitalized overnight, is unable to perform the functions of the job, and/or that the employee or employee's qualifying family member is under the continuing care of a health care provider.

This is to inform you that: *(check appropriate boxes, explain where indicated)*

1. You are _____ for leave under FMLA.
   ☒ eligible
   ☐ not eligible

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

3. You _____ will be required to furnish medical certification of a serious health condition.
   ☒ will
   ☐ will not

   If required, you must furnish certification by _____ / _____ / _____ *(insert date)* ***(this 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. Is the employee required to use any cumulative leave days if accrued days or frozen days pay under a pay continuation plan?
   ☒ Yes
   ☐ No

   If not, does the employee elect to use any cumulative leave days?
   ☐ Yes
   ☐ No

   If applicable, does the employee elect to use any vacation days?
   ☐ Yes
   ☐ No

   If yes, specify the pay continuation required or elected: _____

5. All leaves-of-absence are unpaid. Any unused cumulative leave you have will be used to cover your absences before you go without pay. Spread docking may be available to lessen the financial impact of unpaid days.

   You may have the option of having unpaid days deducted evenly throughout the remainder of your paychecks for the contract year. This alleviates the possibility of having to go without a paycheck and enables your benefits to continue through normal payroll deductions rather than requiring you to bring in premium payments. Your spread dock will not begin until your leave begins. 260-day employees are not eligible to spread dock.

6. If you need to take a sick day once you return from leave and you have no available cumulative days, unless you have frozen or accumulated days, you will be docked your daily per diem if you miss additional days.

7. Sick Leave Bank (SLB) may only be applied to your own personal medical condition portion of your FMLA, a*s designated by your Health Care Provider.* Usage of the SLB follows the SLB language. Approval for the Sick Leave Bank is determined on a case-by-case basis and must be applied for at the time you apply for your leave. You must be a member of the Sick Leave Bank to apply.

8. **a.** If you normally pay a portion of the premiums for your health and dental insurance, and supplemental benefits, 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 forth date, e.g., the tenth of each month, or pay periods, etc., that specifically cover the agreement with the employee.) Payment must be received in Human Resources by the 10th of each month for the following month's benefits. If you are not receiving a paycheck, you are responsible to pay all deductions. All other payroll deductions will continue unless you initiate changes.

   If you are on an approved FMLA leave and extend your leave past 12 weeks or do not return to work following your leave, you are responsible for the full health, dental insurance, and/or supplemental premiums. You may be required to reimburse Adams County School District 50 for the amount of any District paid benefits (i.e. health, dental) paid on your behalf during your leave, as well as any cumulative leave you accessed prior to accruing.

   b. You have a minimum 30-day (or indicate period, if applicable) grace period in which to make premium payments. If payment is not made timely, your group health insurance may be canceled, *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 the premiums during FMLA leave, and recover these payments from you upon your return to work. We **will not** pay your share of health insurance premiums while you are on leave.

   c. We will do the same with other benefits (*e.g.*, life insurance, disability insurance, while you are on FMLA leave. If we do pay an employer portion for your premiums for other benefits, when you return from leave you will be expected to reimburse us for the payments made on your behalf.

9. During the FMLA leave, group health plan benefits will continue the same as an active employee if premium payments are continued.

   While the employee is on paid leave and the employee pays a portion of the health insurance premium, these payments will continue through normal payroll deductions.

   While the employee is on unpaid leave, the premium must be by the 10th or each month for the following months' coverage.

   (***If an employee fails to return from leave, the employer may recover premiums paid for maintaining group health and dental plan benefits, except for some circumstances beyond the employee's control.***)

10. Will the employee be required to report periodically on his/her status and intent to return to work?
    ☒ Yes
    ☐ No

    If yes, specify: _____

    Please contact the Benefits Office in the Human Resources Department at least 5 days prior to your anticipated return date to confirm.

11. Will the employee be required to furnish recertification?
    ☐ Yes
    ☒ No

12. The employee is expected to return from leave of absence on this date: _____ / _____ / _____

    If employee is able to return to work earlier than the date indicated, he/she is required to notify us at least two work days prior to the date employee intends to report to work.

    Failure to return to work on the day after expiration of leave will result in termination of employment (unless other arrangements are made with employer).

13. Medical certification to return to work may be required in accordance with the employer's policy. For this leave, is certification that the employee is able to return to work required?
    ☒ Yes
    ☐ No

    If certification is required but not received, your return to work may be delayed until the certification is provided.

    You must obtain and submit a medical release provided by your physician to the Benefits Office prior to returning to work. This medical release must indicate the following:

    - Date you are medically released back to work
    - If there are any or no restrictions (restrictions must be listed)
    - Signed and dated by your physician

14. Upon return form Family of Medical Leave, the employee is restored to the same or equivalent position equivalent pay, benefits, and other conditions of employment, subject to the rules of FMLA.

    Is this a key employee?* If yes, this employee may be denied job restoration.
    ☐ Yes
    ☒ No (Not at this time; to be determined during leave.)

    **An employee among the highest paid ten percent (a key employee) may be denied job restoration if restoration will cause "substantial and grievous economic injury" to the operations of the employer.*

15. Your FMLA leave reflects an estimation, is based on the District calendar, and could be subject to change.

I acknowledge that I have reviewed and understand the above information.

_____	_____	_____/_____/_____
(Print Name)	*(Employee Signature)*	*(Date)*

OMB Control Number: 1235-0003
Expires: 02/28/2015

Certification of Health Care Provider for Employee's Serious Health Condition (Family and Medical Leave Act)

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

Please Note: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. `Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

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. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertification's, 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 name and contact: _____

Employee's job title: _____ Regular work schedule: _____

_____

Employee's essential job functions: _____

Check if job description is attached: _____

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. § 825.3 13. 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 and business address: _____

Type of practice / Medical specialty: _____

Telephone: ( ) _____ Fax: ( ) _____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

Probable 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. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, 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 lasting 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.

_____

_____

_____

_____

CONTINUED ON NEXT PAGE

Signature of Health Care Provider **Date**

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**

Certification of Health Care Provider for Family Member's Serious Health Condition (Family and Medical Leave Act)

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

OMB Control Number: 1235-0003
Expires: 02/28/2015

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 to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees' family members, 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 name and contact: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your family member or his/her 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 to care for a covered family member with a 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. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Your name: _____
First Middle Last

Name of family member for whom you will provide care: _____
First Middle Last

Relationship of family member to you: _____

If family member is your son or daughter, date of birth: _____

Describe care you will provide to your family member and estimate leave needed to provide care:

_____

_____

_____

_____ _____
Employee Signature Date

CONTINUED ON NEXT PAGE

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. 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 patient needs leave. Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address:_____

Type of practice / Medical specialty: _____

Telephone: (_____)_____ Fax:(_____)_____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

   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: _____

   Was medication, other than over-the-counter medication, prescribed? ___No ___Yes.

   Will the patient need to have treatment visits at least twice per year due to the condition? ___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. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

_____

_____

_____

_____

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ___No ___Yes.

   Estimate the beginning and ending dates for the period of incapacity: _____

   During this time, will the patient need care? __ No __ Yes.

   Explain the care needed by the patient and why such care is medically necessary:

   _____

   _____

   _____

   _____

   _____

5. Will the patient require follow-up treatments, including any time for recovery? ___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:

   _____

   Explain the care needed by the patient, and why such care is medically necessary: _____

   _____

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? __ No __ Yes.

   Estimate the hours the patient needs care on an intermittent basis, if any:

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

   Explain the care needed by the patient, and why such care is medically necessary:

   _____

   _____

   _____

   _____

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ____No ____Yes.

   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

   Does the patient need care during these flare-ups? ____ No ____ Yes.

   Explain the care needed by the patient, and why such care is medically necessary: _____

_____

_____

_____

_____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Health Care Provider **Date**

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210.
DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.

Certification of Health Care Provider Understanding

I, _____, understand that my application
(Print full name)

for a Leave-of-Absence will not be processed and approved until the Human Resources Department receives all required documents, including, Certification of Health Care Provider.

I will submit the Certification of Health Care Provider by and not later than

_____/_____/_____ .

_____ _____
(*Employee Signature)* *(Human Resources Signature)*

_____/_____/_____ _____/_____/_____
(Date) *(Date)*

SECTION FOR HUMAN RESOURCES USE ONLY	
Date Received CHCP: _____/_____/_____	Human Resources Representative: _____

Human Resources Department
✓ 6933 Raleigh Street ✓ Westminster, CO 80030
✓ Phone: 303.428.3511 ✓ Fax: 303.657.3938