Cami Anderson
State District Superintendent

Joseph Blundo
Interim Executive Director

THE NEWARK PUBLIC SCHOOLS
Human Resource Services
Administrative Operation Services

2 Cedar Street, Rm 811
Newark, New Jersey 07102-3091
Phone: 973-733-8155
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www.nps.k12.nj.us

Christopher D. Cerf
Acting Commissioner of Education

FML/NJFL

ELIGIBILITY FORM

ELIGIBILITY NOTICE

Please be advised that you should give your immediate supervisor proper notice of your plan to take a leave in an effort to assist the District with securing proper staffing during your absence.

In short, FMLA (the "Family Medical Leave Act") allows for employees to care for themselves and/or immediate family members; NJFLA (the "New Jersey Family Leave Act") only allows for employees to care for immediate family members.

Notice of **APPROVAL** to take a leave of absence can only be provided by the Office of Administrative Operation Services ("AOS"). The terms and conditions to take a leave of absence are found in your respective Collective Bargaining Agreement. AOS is charged with the responsibility of determining "eligibility" of the employee's request to take a leave of absence. The process to take a medical leave of absence, with the exception of an emergent leave, includes AOS's determination as to whether the employee:

1. Worked for Newark Public Schools for **at least 12 months**;
2. Worked **at least 1,250 hours** during the 12 months prior to the start of the FMLA;
3. Worked for Newark Public Schools for **at least 1,000 hours** during the last 12 months (NJFLA); and
4. Submitted a medical certificate approved by the Newark Public Schools Health Services Office/District physician.

With regard to requests to take a medical leave of absence, employees are responsible to provide the Newark Public Schools with:

1. At least 30 days' notice to take a leave;
2. Completed application forms; and
3. Complete medical certificate(s).[1]

No employee should take a leave of absence without receipt of a **WRITTEN APPROVAL** by AOS. **Upon approval of "eligibility," we ask that you complete and return a copy of the HIPAA form together with FMLA/NJFLA form.**

	FOR HRS/AOS USE ONLY
Date: ____________________ Anticipated "start date" of leave: ______________	
ID#:__________ Employee Name: ______________________________	Eligible ☐
Address:____	Not Eligible ☐
____ (P.O. Box addresses are not acceptable)	Pending ☐
Home/Cell: ________________________	Comment:
Loc/School:____	________________________
Region: ______________________________ (North/ South /East-Central/West/Central Office)	________________________
Position: ______________________________Union: ____________	________________________
Last "start date" of previous medical leave of absence: ____________________	________________________
Requesting leave for: Self ☐ Qualified Family Member ☐ Placement/Adoption ☐ Qualified Service Member ☐	________________________
Type of Leave: Continuous ☐ Intermittent ☐ (Check one or both)	________________________ Authorized Signature
Start Date: __/__/__ End Date: __/__/__	Date:__/__/__

[1] In the case where an employee is requesting an intermittent leave of absence, the Newark Public Schools (the "District") reserves the right to secure a schedule of absences in order to ensure that the District has the appropriate staffing to conduct business.

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FMLA/NJFLA FORM

(FAMILY AND MEDICAL LEAVE ACT OF 1993)
(NEW JERSEY FAMILY LEAVE ACT)

Public Burden Statement

Please be advised that you should give your immediate supervisor proper notice of your plan to leave in an effort to assist the District with securing proper staffing during your absence.

We estimate that it will take an average of twenty (20) minutes to complete this collection of information, including the time for reviewing instruction, 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 of information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, Department of Labor, Room S-3502, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

We ask that you complete and return a copy of the HIPAA form together with this Family Medical Leave Act ("FMLA")/New Jersey Family Leave Act ("NJFLA") form.

Upon completion by the physician/health care provider, this FMLA/ NJFLA form will be delivered to the patient/employee and forwarded to the employer within fifteen (15) days of the employee's receipt of the form. Mail to: Newark Public Schools, Office of Health Services, Rm 901, 2 Cedar Street, Newark, NJ 07102

	FOR HRS/AOS USE ONLY
DATE: ____________________	Approved ☐
ID#:__________ Employee Name: ______________________________	Denied ☐
Address: ____	Pending ☐
____ (P.O. Box addresses are not acceptable)	Comment:
Home/Cell: ________________________	______________________
Loc/School: ____	______________________
Region: ________________________________ (North South East/Central/West/Central Office)	______________________
Position: ________________________________Union: _____________	______________________
Care of a healthy "new born"? Yes ☐ No ☐	______________________
Does your spouse work for the district? Yes ☐ No ☐ (Optional)	
Continuous ☐ Intermittent ☐ (Check on or both)	Authorized Signature Date:___/___/___

Changing Hearts and Minds to Value Education

NEWARK PUBLIC SCHOOLS

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I, ____(name) hereby authorize the use or disclosure of my health information as set forth below:

1. Person(s)/Entity(ies) authorized to provide information:

____

2. Person/Entity(ies) authorized to receive information:

Physician at the Newark Public Schools ____________________.

3. Description of Information to be released:

____

I understand that I have the right to revoke this authorization at any time by notifying Newark Public Schools in writing at Human Resource Services, Benefit Services, 2 Cedar Street, Room 811, Newark, NJ 07102. I understand that revocation is only effective after it is received and recorded by Newark Public Schools.

I understand that any use or disclosure made prior to revocation under this authorization will not be affected by a revocation.

I understand that after this information is disclosed, it may no longer be protected by federal or state privacy laws and the recipient may disclose it.

I understand that my initial and continued employment and position are subject to any agreement to this authorization if it is requested by Newark Public Schools.

I understand that I am entitled to receive a copy of this authorization.

I understand that this authorization expires when my employment is terminated, unless otherwise noted here _________ (alternate termination date).

Signature:_____________________________________ Date:_______________

If this form is signed by a personal representative, the signature represents that he or she has authority to sign because:____(reason for authority).

THE FOLLOWING INFORMATION IS TO BE COMPLETED BY
YOUR HEALTH CARE PROVIDER

Print Name of Health Care Provider ______________________ Signature of Health Care Provider ______________________

Type of Practice ______________________ (____)______________________ Telephone Number

Address ______________________ ____/____/____ Date

1. Employee's Name	2. Patient's Name (If different from employee) and age

3. Relationship to the family member/patient?

4. Does the patient's condition[1] qualify under any of the categories described? "Yes" or "No"

If "Yes," please check the applicable category. (See "Definitions" below for description of "**serious health condition**" under the Family and Medical Leave Act ("FMLA")).

- ☐ Hospital Care
- ☐ Absence plus treatment
- ☐ Pregnancy (EDC date: __/__/__ (See page 6))
- ☐ Chronic conditions requiring treatments
- ☐ Permanent/Long term conditions requiring supervision
- ☐ Multiple treatment for non-chronic conditions
- ☐ **Other (please describe below)**

5. Describe the **medical facts** which support the employee's certification. (Medical fact(s) include but is/are not limited to a Statement of Incapacity, diagnosis, prognosis, symptoms, abnormal laboratory results and physical findings, *etc.*) Attachments are acceptable.

[1] Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking family medical leave.

6. a. State the time period of the absence for this period of **incapacity**[2] (e.g., start and end date of incapacity) and the probable duration of the condition. (Please circle one.)

- o Start date __/__/__ to 3 months
- o 6 months
- o 9 months
- o other

b. What are the dates of the most recent visit(s) associated with the present episode of incapacity?

c. Will it be necessary for the employee to work only **intermittently or to work on a less than a full schedule** as a result of the employee's condition (including for treatment described in item six (6) below)? "Yes" ☐ or "No" ☐

If "Yes," please give the probable duration of time needed for recovery.

d. If the condition is a **chronic condition** (condition #4) or **pregnancy**, state whether the patient is presently incapacitated and the likely duration and frequency of **episodes of incapacity.**

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7. a. If additional **visits** will be required for the condition, provide an estimate of the probable number of such visits (**include date(s)**).

If the patient will be absent from work or other daily activities because of visits/**treatment** on an **intermittent** or **part-time** basis, also provide an estimate of the probable number of intervals between such visits/treatments, actual or estimated dates of treatment (if known), and period required for recovery, if any.

b. If any of these treatments will be provided by **another provider of health services** (e.g., physical therapist), please state the nature of the treatments.

[2] "Incapacity," for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment thereof, or recovery there from.

c. **If the employee is required to undergo a regimen of continuing treatment** under your supervision, please provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment, *etc.*).

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8. a. If leave is required to **care for a family member** of the employee with a serious health condition, in what capacity will the employee be providing care to the family member?

   - Transportation ☐
   - Psychological ☐
   - Activities of daily living ☐
   - **Other (please describe below)** ☐

   b. If the employee will need care only **intermittently** or on a part-time basis, please indicate the probable **duration** of this need **and appointment dates**.

TO BE COMPLETED BY THE EMPLOYEE NEEDING FAMILY LEAVE TO CARE FOR A FAMILY MEMBER

If the condition is pregnancy, please state the estimated dates of care and the care you will provide during the period of care, including a schedule if leave is to be taken **intermittently** or if it will be necessary for you to work less than a full schedule.

I understand that per my request type, I am required to provide official documentation to the Newark Public Schools Health Services department at the time of application <u>and</u> upon my return when necessary. Without the required official documentation, the Human Resource Services department (HR) has the right to deny my request for leave or return at any time.

I understand that I must provide HR advanced written notice thirty (30) days prior to the start of my leave of absence. I further understand that my failure to timely return to work following the expiration of my authorized leave of absence may be construed as my **voluntary resignation** and/or subject me to **disciplinary action**.

Employee's Signature

Date

DEFINITIONS:

A "**Serious Health Condition**" means an illness, injury impairment or physical/ mental condition that involves one of the following:

1. Hospital Care

Inpatient care (*i.e.*, an overnight stay) in hospital, hospice or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

   a) A period of incapacity of **more than three consecutive calendar days** (including any subsequent treatment or period of incapacity relating to the same condition) that also involves:

      1) **Treatment two or more times** by a health care provider, nurse or physician's assistant under direct supervision of a health care provider or by a provider of health care services (*e.g.*, physical therapist under orders of or on referral by a health care provider; or

      2) **Treatment** by a health care provider on **at least one occasion** which results in a **regimen of continuing treatment**[3] under the supervision of the health care provider.

3. Pregnancy

Any period of incapacity due to **pregnancy** or **prenatal care**.

4. Chronic Conditions Requiring Treatments

A **chronic condition** which:

   a) Requires **periodic visits** for treatment by a health care provider, nurse or physician's assistant under direct supervision of a health care provider;

   b) Continues over an **extended period of time** (including recurring episodes of s single underlying condition); and

   c) May cause **episodic** rather than a continuing period of incapacity (*e.g.*, asthma, diabetes, epilepsy, etc.).

5. Permanent/Long-term Conditions Requiring Supervision

A period of **incapacity** which is **permanent or long-term** due to a condition for which treatment may not be effective. The employee or family member must be **under the continued supervision of, but need not be receiving active treatment by, a health care provider**. Examples include Alzheimer's, a severe stroke or the terminal stages of a disease.

6. Multiple Treatments (Non-Chronic Conditions)

Any period of absence to receive **multiple treatments** (including any period of recovery therefore) by a health care provider or by a provider of health care services under orders of or on referral by a health care provider, either for **restorative surgery** after an accident or other injury or for a condition that **would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment**, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), and kidney disease (dialysis).

This optional form may be used by employees to satisfy a mandatory requirement to furnish a medical certification (when requested) from a health care provider, including second or third opinions and recertification (29 CFR 825.306).

Note: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

[3] A regimen of continuing treatment includes, for example, a course of prescription medication (*e.g.*, an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or slaves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.