

**CARTERET COUNTY PUBLIC SCHOOL SYSTEM
OFFICE OF HUMAN RESOURCES**

REQUEST FOR USE OF FAMILY AND MEDICAL LEAVE

CERTIFICATION OF HEALTH CARE PROVIDER

An employee requesting extended leave for a serious health condition or the serious health condition of the employee's spouse, child, or parent must submit this form to the Office of Human Resources before a recommendation can be made to the Board of Education.

If you meet the eligibility requirements under the federal Family and Medical Leave Act (FMLA):

- You have a right to receive up to 12 weeks of leave each school year.
- If you qualify, you will be able to continue your basic medical insurance coverage during FMLA Leave
- You will be returned to the same or an equivalent position with the same pay, benefits, terms and conditions of employment on your return from FMLA leave unless there is a reduction in force or reorganization that affects your position. In such an event you would have the same rights as other employees affected by a reduction in force or reorganization.
- If you are a certified teacher you may use 20 days of extended sick leave. There will be a deduction from your paycheck for substitute pay for each day you use.
- Tenured employees approved for a leave of absence under this provision, retain career status upon return from authorized leave.
- Probationary teachers must begin a new probationary period if a leave of absence, paid or unpaid, prevents the probationary teacher from completing four (4) consecutive years of 120 workdays each.

We are designating your leave days as being Family and Medical Leave and are giving you notice that such days shall be subtracted from the twelve weeks you can accrue per school year under the Family Medical Leave Act of 1993.

PART 1 – To Be Completed by Employee

Employee's Name (please print) _____

School/Department _____

Family and Medical Leave is needed for (check one):

____ Personal health condition

____ Family member's health condition - Parent ____ Spouse ____ Child ____

____ Newborn or newly placed adoptive/foster child

Leave Request (check one)

____ I am requesting leave of absence: From (date) _____ to (date) _____

____ I am requesting a reduced work schedule: From _____ hours/week to _____ hours/week until date _____

____ I am requesting an intermittent work schedule (attach a written description of requested schedule).

If you are requesting a reduced or intermittent work schedule because of your own serious health condition, please provide your health care provider with a copy of your job description. If you need assistance contact the Office of Human Resources at (252) 728-4583, Ext. 136

If you are requesting leave to care for a family member, include a written description of the care you will provide.

Employee Signature _____ Date _____

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



OMB Control Number: 1215-0181
Expires: 12/31/2011

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, 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 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. 29 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 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

