Family Medical Leave Procedures

1. Notify principal or immediate supervisor thirty (30) days in advance when leave is foreseeable.
2. Complete Request for Extended Leave Form.
3. Complete request for Family Medical Leave Form stating the specific reason for needing the Family Medical Leave.
5. Secure signature of the principal or supervisor.
6. Submit Request for Extended Leave Form, Family Medical Leave Form and the completed Healthcare Provider Form to the Human Resources Department.
7. Human Resources Department will fax or scan a copy of the approved or denied Request for Family Medical Leave to the Principal.

Statement of Employee Rights under the Family and Medical Leave Act of 1993

The Family and Medical Leave Act (FMLA) requires covered employers to provide up to 12 weeks of unpaid, job protected leave to “eligible” employees for certain family and medical reasons. Employees are eligible if they have worked for a covered employer for at least 1 year and for 1250 hours over the previous 12 months, and if there are at least 50 staff members within 75 miles.

REASONS FOR TAKING LEAVE:

Unpaid leave must be granted for any of the following reasons:
- To care for any employee’s child after birth, or placement for adoption or foster care.
- To care for an employee’s spouse, son or daughter, or parent who has a serious health condition.
- For a serious health condition that makes the employee unable to perform his or her duties.

Any family and medical leave granted an employee under extended sick leave, medical sabbatical leave or maternity leave shall run concurrently with any leave available to the employee under this policy. If paid leave is used by an employee, the Bossier Parish School Board shall provide only enough unpaid family and medical leave time to total the allowed twelve (12) week period.

ADVANCE NOTICE AND MEDICAL CERTIFICATION:

The employee may be required to provide advance leave notice and medical certification. Taking leave may be denied if requirements are not met. Employees ordinarily must provide thirty (30) days advance notice when the leave is foreseeable. An employer may require medical certification to support a request for leave because of a serious health condition and may require second or third opinions (at the employer’s expense) and a fitness for duty certification to return to work.

JOB BENEFITS AND PROTECTION:

For the duration of FMLA leave, the employer must maintain the employer’s health coverage under any group health plan. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms. The use of FMLA leave cannot result in the loss of any employment benefits that accrued prior to the start of an employee’s leave.
Bossier Parish School Board

REQUEST FOR FAMILY MEDICAL LEAVE

EMPLOYEE’S NAME__________________________________________DATE________________

SCHOOL/DEPARTMENT________________________________POSITION_______________________

EMPLOYEE ID NUMBER_________________ TELEPHONE NUMBER________________________

*Dates Requested for Leave____________________________________________________________

*Reason for Leave Request_____________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

*The attached Forms should be completed by your physician and submitted with your request.

Submit Family Medical Leave Request Forms to the Human Resources Department at least thirty (30) days before the leave is to commence, when practicable.

A Family Medical Leave is without pay; however, the Bossier Parish School Board will continue to pay their portion of your insurance premium(s). The employee is responsible for paying his/her part and is also responsible for contacting the insurance department for notice of payment. Please be reminded that after twelve (12) weeks, the employee will be responsible for paying both the employee and employer part of the insurance premium(s). Extended Sick Leave, Medical Sabbatical or Maternity Leave shall run concurrently with any Family Medical Leave. If paid leave is used by an employee, the Board shall provide only enough unpaid family medical leave time to total the allowed 12-week period.

I hereby authorize the release of medical information as requested in this medical certification pursuant in my request for leave of absence from: Bossier Parish School Board

Employee Signature:__________________________________________ Date:____________________

Principal/Supervisor Signature: ________________________________ Date: ________________

(For Office Use Only)

( ) Approved for Processing

( ) Denied for Processing

Human Resource Director’s Signature __________________________ Date:____________________

After approval, a copy of this page must be sent to the insurance department.
INSTRUCTIONS to the HEALTHCARE 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. 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; ___________ dates 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 six (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.

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

SIGNATURE OF HEALTH CARE PROVIDER________________________________________ DATE__________

PRINTED NAME OF HEALTH CARE PROVIDER_____________________________________________