FMLA
And
Medical Leave without FMLA

EMPLOYEE PACKET

To be given to each employee who will be or who has been absent more than 3 days for personal or family illness, or for delivery, adoption, or foster placement of a child.

Thirty days' notice is required for planned medical leave.

- There are **two** medical certification forms; one for an employee's own serious health condition, and one for a defined family member for whom the employee needs to provide care (both included in this packet).

- There are **two** medical certification forms for military leave entitlements (available at your request from Human Resources).

- HR staff can now contact an employee's health care provider for clarification and/or verification of information on the certification form. Direct supervisors may not make contact.

SCPS

Surry County Public Schools

When applying for Family and Medical Leave (FMLA), please make certain that you do the following:

FMLA CHECKLIST

- ❑ You must apply for Family and Medical Leave if you are taking an extended medical leave for yourself or a family member ***and*** if you wish to be covered under its protections.

- ❑ Read the 2-page explanation of FMLA *BEFORE* completing the ***Request for Medical Leave of Absence*** form. This explanation should answer most of your questions.

- ❑ Read the following also (included in the packet):
  - "Your Rights Under the Family and Medical Leave Act of 1993"
  - SCPS Leave Policies

- ❑ Complete the ***Request for Medical Leave of Absence*** form.
  - Be certain to sign and date it.
  - You must provide the first date you will be out (even if it is tentative) and also a tentative return date.
  - Provide your email address in the appropriate space.

- ❑ Make certain to forward the ***Certification of Health Care Provider*** for the birth of a child or a serious illness – yours or a family member's. These are now two separate forms. Both are included in this packet. This is required for all FMLA requests. The employee is **not** to complete the form. **The doctor must complete the form and sign it.** (Be certain to complete the employee portion of the form by writing and signing your name on the form before submitting to your Doctor.)

- ❑ Notify Payroll **in writing** if you do **not** wish to use short-term disability insurance.

- ❑ Ask your school/department secretary to notify Human Resources and Payroll by email the first day you go out and the day you return to work. Ask for a copy of the email for your records.

- ❑ If you run out of sick leave, please call the Payroll Office (757-294-5229) so you can arrange to continue paying for your health insurance and any other voluntary deduction from your paycheck.

- ❑ Notify Human Resources and Payroll (757-294-5229) of the delivery date of your baby (if applicable.)

- ❑ If you are out **30** or more days, please provide a written medical update from your doctor to Human Resources every 30 days.

- ❑ Return on workday **66** (school calendar is available upon request)

- ❑ **It is your responsibility to always keep your principal or supervisor informed of your progress and when you plan to return to work.**

SURRY COUNTY SCHOOLS FAMILY AND MEDICAL LEAVE (FMLA)

FMLA

Surry County Public Schools provides **Family and Medical Leave (FMLA)** to eligible employees for medical and family reasons in accordance with applicable state and federal requirements. It provides time off, for up to 13 weeks (26 work weeks for care of a family member in the armed forces who is injured in the line of duty, 13 weeks to deal with issues that arise because of that duty). This policy applies to all eligible Surry County Public Schools employees.

Eligibility

To be **eligible for FMLA**, you must have worked for Surry County Public Schools for **at least 1250** hours over the **past 12 months.**

Amount of leave

An eligible employee is generally entitled up to 13 weeks of protected leave for appropriate reasons. The leave year will be determined on a **Rolling 12 Month Period basis. The twelve-month period for calculating family and medical leave eligibility shall be determined by your first leave date of absence. (Example: Leave approved with first date of absence as October 1, 2013, your 12 month period would be October 1, 2013 through September 30, 2014.)** Any FMLA leave taken by an employee during the twelve-month period will be used to determine the amount of available leave pursuant to the Family and Medical Leave Act. Other conditions of use follow:

Reasons for leave

Leave will be granted for any one or combination of the following reasons:

- Birth of a son or daughter
- Placement of a son or daughter in adoption or foster care
- To care for a parent, spouse, son, or daughter with a serious health condition, to include care of military family member injured in the line of duty/and or to deal with issues that arise because of that duty (qualifying exigency)
- Because of a serious health condition that renders the employee unable to perform the essential functions of his or her job.

Paid Leave

The employer requires all applicable paid leave, including sick, annual and personal leave, be exhausted before unpaid leave is granted during the 13-week FMLA period, unless the employee has short-term disability insurance and elects to receive this during his/her medical leave. In this case, the employee must use any available leave, including sick, annual and personal leave during the prescribed waiting period of his/her policy prior to the commencement of insurance payments. In addition, worker's compensation leave counts as part of the FMLA leave. Employees on approved family and medical leave up to 13 weeks are entitled to their same or an equivalent position upon their return to work.

Taking Leave for the Birth of a Child: Employees taking medical leave for the birth of a child will be paid 6 calendar weeks immediately following delivery (8 weeks for a Cesarean Section) if sick leave is available. The medical certification form for employee's own illness may now be used for this purpose (Section III, Part A, Question 3). (If applicable, short-term disability insurance may be substituted after the appropriate waiting period.) **Once the 6 week or 8 week period under the care of a doctor is completed, then additional leave will be without pay.** For example, if a baby is born July 30, a 12-month employee's salary would end 6 weeks later in early September. However, the employee may elect to remain out of work on unpaid leave for an additional 5 or 7 weeks if eligible for FMLA. A teacher, who does not work during the summer, may take up to 13 weeks of FMLA beginning the first day of the contractual year, but available sick leave or short-term disability will end 6 or 8 weeks immediately following the baby's birth.

Requesting leave

If leave is foreseeable, the employee must make the request **at least 30 days before leave begins** when practicable.

Submit leave information as soon as possible to the **Department of Human Resources**. Employees must provide sufficient information regarding reasons for the leave. Failure to provide sufficient information may result in delay or denial of the FMLA request. Requests for medical leave will be reviewed and notification of approval/denial will be sent by email if the employee has an SCPS email account. Otherwise, the approval or denial will be sent to the employee by Pony or U.S. Mail. (PLEASE PROVIDE YOUR EMAIL ADDRESS ON THE FMLA REQUEST FORM.)

Scheduling leave

If leave is taken on an intermittent or reduced schedule basis, it must be scheduled so it does not unduly disrupt the school division's operations. Special provisions exist for instructional personnel. If the requested intermittent leave is for a classroom teacher or special education instructional assistant and constitutes 20% or more of the time to be out, the administration reserves the right to deny the intermittent leave. In additions, an instructional employee requesting leave near the end of an academic term may be required to continue the leave until the end of the term. **PLEASE NOTE: INTERMITTENT LEAVE IS NOT AVAILABLE FOLLOWING THE BIRTH OF A CHILD.**

Medical certifications

Where leave involves a serious health condition. **Surry County Public Schools will require you to provide a medical certification from your health care provider. Please note the following:** Some health care providers now charge fee to complete medical certification. Surry County Public Schools does **not** reimburse any employee for the cost of obtaining medical certification.

Surry County Public Schools reserves the right to require a second opinion. A third opinion may be sought if the first and second disagree.

Surry County Public Schools requires medical recertification of a serious health condition every 30 days.

Benefit continuation

Employees may elect to continue group health insurance while on leave. This coverage will continue at the same levels prior to leave. Employees are required to pay their share of the premiums each month.

Reinstatement

An employee returning to work following an FMLA leave will be able to return to the same job or an equivalent position. Salary, benefits, and status in place immediately before the leave will be reinstated following the 13 weeks of FMLA leave.

A fitness-for-duty Report/return-to-work letter from the employee's doctor will be required BEFORE reinstatement for leave involving the employee's own serious health conditions. The report must state the employee's current health status and the effective date of return to work. This doctor's certification must be sent to Human Resources. Medical reports are NOT to be retained at the school or department level.

SURRY COUNTY SCHOOLS FAMILY AND MEDICAL LEAVE (FMLA)

The Family Medical Leave Act **of 1993 entitles qualified employees up to 13 weeks of leave per year for the birth, placement for adoption, or foster care of a child; to care for spouse, parent or child with a serious health condition; or when an employee is unable to work due to a serious health condition. In addition, family medical leave may be used to care for a spouse, son, daughter, parent, or next of kin injured in the line of duty (26 weeks), or to take care of any qualifying exigency resulting from a call to active duty (13 weeks). If you are approved, your position or an equivalent position will be held for you. You will be required to use appropriate leave as outlined in our personnel policy handbook. If both spouses work for the school system, the total leave in any 12-month period is limited to 13 weeks (65 days) if the leave is taken:**
(a) for the birth or adoption of a child, or
(b) to care for a sick parent.

Please note that Intermittent Leave is not available after the birth of a child.

*NOTE: FAMILY MEDICAL LEAVE IS TIME ONLY. To be compensated for this time, an employee must have available sick leave or short-term disability insurance and must have medical certification.

- *Employee sick leave* **– All full time employees earn up to 120 days accumulation of sick leave. You may use your sick leave for your own illness, or up to 65 days* for immediate family: a spouse, parent, or child. Medical certification will be required.**

- *Bereavement leave* **–An employee may be granted up to three consecutive days for death of a mother, father, husband, wife, or child for a period not to exceed three (3) days per occurrence. Additional days and all other funerals shall be charged to sick leave.**

- *Annual leave* **–All full-time 12-month employees earn annual leave.**

SCPS Employee Name: _____

CERTIFICATION OF HEALTH CARE PROVIDER FOR EMPLOYEE'S OWN SERIOUS HEALTH CONDITION (FAMILY AND MEDICAL LEAVE ACT)

Surry County Public Schools, 45 School Street, Surry, VA 23883

SECTION I (FOR COMPLETION BY EMPLOYER – PLEASE PRINT):

Employee's job title: _____

Employee's essential job functions: _____

_____

Job description attached: ☐ Yes ☐ No

SECTION II (FOR COMPLETION BY EMPLOYEE – PLEASE PRINT):

INSTRUCTIONS to the EMPLOYEE: Please complete your name below and sign 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 days to return this form (29 C.F.R. § 825.305(b)).

Your name: _____
First Middle Last

Employee Signature: _____ Date: _____

SECTION III (FOR COMPLETION BY HEALTH CARE PROVIDER – PLEASE PRINT):

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 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 "undetermined" 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: (_____) _____

SCPS Employee Name: _____

PART A: MEDICAL FACTS – PLEASE PRINT

1. Does the condition qualify under the definition of a "SERIOUS HEALTH CONDITION" (SEE PAGE 9)?
   ☐ Yes (Complete this section of the form in its entirety) ☐ No **(Sign and date on page 6)**

2. 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 yes, 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 yes, state the nature of such treatments and expected duration of treatment:

   _____

   _____

3. Is the medical condition pregnancy? ☐ No ☐ Yes If yes, expected delivery date: _____

4. 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:

   _____

5. 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):

   _____

   _____

   _____

SCPS Employee Name: _____

PART B: AMOUNT OF LEAVE NEEDED – PLEASE PRINT

6. 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: _____

7. 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

   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 _____

8. 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 yes, 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 THE QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER (PLEASE PRINT)

_____

_____

_____

_____

_____ _____

Signature of Health Care Provider **Date**

Note: Definition of Serious Health Condition is attached.

SCPS Employee Name: _____

DEFINITION OF SERIOUS HEALTH CONDITION

"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 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 or more than three days if not treated.

SCPS employees needing information regarding use of paid leave, benefits or short term disability, please contact Vonda Thomas in payroll at **vonda_thomas@surryschools.net** or by phone at 757-294-5229. For information regarding FMLA, please contact Renita Bailey in Human Resources at **renita_bailey@surryschools.net** or by phone at 757-294-5229.

SCPS Employee Name: _____

CERTIFICATION OF HEALTH CARE PROVIDER – FAMILY MEMBER'S SERIOUS HEALTH CONDITION (FAMILY AND MEDICAL LEAVE ACT)

Surry County Public Schools, 45 School Street, Surry, VA 23883

SECTION I (FOR COMPLETION BY EMPLOYEE – PLEASE PRINT):

INSTRUCTIONS to the EMPLOYEE: Please complete your name below and sign 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 (20 C.F.R. § 825.313). Your employer must give you at least 15 days to return this form (29 C.F.R. § 825.305(b).

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: _____

SECTION II (FOR COMPLETION BY HEALTH CARE PROVIDER – PLEASE PRINT):

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under FMLA to care for your patient. **Answer, fully and completely**, all applicable parts. **Several questions seek a response as to 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 "undetermined" may not be sufficient to determine FMLA coverage**. Limit your responses to the condition for which the patient requires care. **Please** be sure to **sign the form on the last page**.

Provider's name and business address: _____

Type of Practice/medical specialty: _____

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

SCPS Employee Name: _____

PART A: MEDICAL FACTS – PLEASE PRINT

1. Does the condition qualify under the definition of a "SERIOUS HEALTH CONDITION" (SEE PAGE 13)

   ☐ Yes (Complete this section of the form in its entirety) ☐ No **(Sign and date on page 10)**

2. 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 yes, 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 yes, state the nature of such treatments and expected duration of treatment:

   _____

3. Is the medical condition pregnancy? ☐ No ☐ Yes If yes, expected delivery date: _____

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 CARE NEEDED – PLEASE PRINT

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:

5. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ☐No ☐ Yes

   If so, 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:

   _____

   _____

SCPS Employee Name: _____

6. 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:

   _____

   _____

7. 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:

   _____

   _____

8. Will 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 day _____ 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: _____

   _____

   _____

_____ _____

Signature of Health Care Provider **Date**

Note: Definition of Serious Health Condition is attached.

SCPS Employee Name: _____

DEFINITION OF SERIOUS HEALTH CONDITION

"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:

6. 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 prescription medication, physical therapy); **or**

7. 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**

8. 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**

9. 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**

10. Any absences to receive multiple treatments for restorative surgery or for a condition that would likely result in a period of incapacity or more than three days if not treated.

SCPS employees needing information regarding use of paid leave, benefits or short term disability, please contact Vonda Thomas in payroll at **vonda_thomas@surryschools.net** or by phone at 757-294-5229. For information regarding FMLA, please contact Renita Bailey in Human Resources at **renita_bailey@surryschools.net** or by phone at 757-294-5229.

SURRY COUNTY PUBLIC SCHOOLS

REQUEST FOR MEDICAL LEAVE OF ABSENCE

***To be eligible for FMLA you have to be employed for at least one year and for 1250 hours over the last 12 months.**
Are you eligible for FMLA? - ☐ yes ☐ no

NAME:_____SS# **(Last 4 Digits): XXX-XX-_____**

LOCATION:_____POSITION:_____

Beginning Date of Leave:_____ Expected Date of Return: _____

Date of Initial employment: _____

REASON FOR REQUEST (Please check one):

- ❑ Birth of a child (***Cert. of Health Care Provider for Employee's Own Illness must be used (Sec. III, Part A. Q3.)***
- ❑ Placement for adoption or foster care of a child (***Copies of court papers are required.)***
- ❑ Care for spouse, child or parent with serious health condition or care for military family member ***(Certification of Family Member's Illness or Certification for Serious Injury or Illness of Covered Servicemember)***
- ❑ Unable to perform job functions because of serious health condition ***(Cert. of Health Care Provider for Employee's Own Illness.)***

Please use the space below for any details you wish to share or for explanation of INTERMITTENT LEAVE.

- If requesting leave for the birth of a child, use the ***Certification of Health Care Provider*** form provided. ***(New regulations effective Jan. 2009 require that the form be completed, specifically Section III, Part A, Question 3.)***
- If you are adopting a child, you must submit a copy of the **adoption papers.**
- If you are requesting leave to care for a child, spouse or parent with a serious health condition, the ***Certification of Health Care Provider for Family Member*** must be used as of January 2009. (For military family member care, use the *Illness of Covered Servicemember* form available at your work location or Human Resources.*)*
- If the leave is requested because of your own serious health condition, the ***Certification of Health Care Provider for Employee's Own Serious Health Condition*** must state that you are unable to perform the functions of your job. *You **must have a doctor's written release to return to work.**
- If you are requesting intermittent leave or leave on a reduced schedule for planned medical treatment, the physician must complete the **medical certification** stating the dates on which medical treatment is expected to be given and the duration of such treatment. If you are requesting intermittent leave or leave on a reduced schedule, the physician must describe the needed leave on the medical certification form. Please note: **INTERMITTENT LEAVE MAY NOT BE USED FOLLOWING THE BIRTH OF A CHILD.**
- If you do **NOT** plan to file a short-term disability claim or wish to use paid leave beyond your insurance waiting period, **YOU MUST NOTIFY THE PAYROLL OFFICE IN WRITING.**

PLEASE NOTE: If you are eligible, you may take up to 13 weeks (65 work days) of Family Medical Leave per year for qualifying reasons. During these 13 weeks, if you are taking leave for the birth of a child, personal illness, or care of a sick family member, you may use available sick leave **only for the time you or your family member is under the care of a physician**. For example, **after the birth of a child, paid sick leave would end 6 or 8 calendar weeks immediately following the birth (depending upon the type of delivery). Additional Family Medical Leave would be without pay. IN ALL CASES, IF YOU HAVE NO AVAILABLE SICK LEAVE, YOU MUST TAKE LEAVE WITHOUT PAY.**

I certify that the information given on this form is true**. I understand that making false statements on this form is grounds for discipline up to and including termination of my employment. I authorize the Director of Human Resources to consult with my physician if necessary.**

SIGNATURE	*DATE*	*EMAIL ADDRESS*

***Not all employees are eligible for FMLA. However, all employees requesting medical leave of more than 3 days must complete this form and submit it to the Department of Human Resources, Surry County Public Schools, 45 School Street, Surry, VA 23883**

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, 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 whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status 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 service-member during a single 12-month period. A covered servicemember is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness*; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness.*

***The FMLA definitions of "serious injury or illness" for current servicemembers and veterans are distinct from the FMLA definition of "serious health condition".**

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 12 months, have 1,250 hours of service in the previous 12 months*, and if at least 50 employees are employed by the employer within 75 miles.

***Special hours of service eligibility requirements apply to airline flight crew employees.**

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; and
- 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. Regulation 29 C.F.R. § 825.300(a) may require additional disclosures.

For additional information:
1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627
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