FMLA LEAVE OF ABSENCE PACKET

Employee Serious Health Condition

The following will provide you with the process for requesting a leave of absence. Please review carefully	
1. Your Rights Under the Family and Medical Leave Act of 1993 Keep for your records	
2. FMLA Request form Complete and return as soon as possible along with the signature page for items 3, 4 and 5 below:	**X** **Complete and return**
3. Notice of Expectations and Obligations of Employee Employee is required to read and sign the last page.	**X** **Sign and return last page**
4. Employee Benefits While on a Leave of Absence Employee is required to read and sign the last page.	**X** **Sign and return last page**
5. Leave of Absence Procedure and Guidelines Employee is required to read and sign the last page.	**X** **Sign and return last page**
6. Certification of Health Care Provider form Section I – Completed by Employee Section II – Completed by your health care provider and returned as soon as possible. The form can be mailed, faxed, or scanned/emailed to the contact information on the form.	**X**
7. Physician Release to Return To Work Your Physician is to complete this form (or their own form on their letterhead) and the form should be submitted to Human Resources prior to or on your return date. If the Physician lists any restrictions, that information will need to be reviewed by Human Resources prior to your Return.	**X – At time of your return to work**
8. Return to Work Form Submit this form on your first day back, confirming return date	**X – At time of your return to work**

West Chester Area School District
Benefits Office/Debbie Baker
782 Springdale Drive
Exton, PA 19341
484-266-1011 (direct dial)
484-266-1180 (fax)
Benefits@wcasd.net

*** ALL ABOVE FORMS WITH AN "X" SHOULD BE SUBMITTED TO THE BENEFITS OFFICE***

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.

For additional information:
1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627
WWW.WAGEHOUR.DOL.GOV

U.S. Wage and Hour Division

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

WHD Publication 1420 Revised January 2009

WEST CHESTER AREA SCHOOL DISTRICT

EMPLOYEE REQUEST FOR FAMILY OR MEDICAL LEAVE

Today's Date: _____

Employee Name: _____

Position and Grade Level/Subject (if applicable): _____

School: _____

Employee Home Address: _____

City: _____ State: _____ Zip Code: _____

Reason for Leave (Check all applicable): Attach completed Certification of Health Care Provider, Notice of Expectations and Obligations of Employees, and signed last page of Benefits While on Leave of Absence with this form.

- ☐ The birth and care of my newborn child or placement of a child with me for adoption or foster care
- ☐ To care for my spouse, child, or parent who has a serious health condition
- ☐ My own serious health condition that makes me unable to perform at least one of the essential functions of my job
- ☐ To care for my spouse, child, parent or next of kin who is a covered service member for a serious injury or illness
- ☐ A qualifying exigency because my spouse, child or parent is on covered active duty or call to covered active duty status in the Armed Forces

Please complete the following section if leave will be taken continually for the entire period:

Date when leave will start:	**Date when I will return to work:**

***Please complete the following section if leave will be taken intermittently.**

Schedule of needed time off:

***Note:** You must seek approval from the Human Resources Department for intermittent or reduced schedule*

Employee Signature:	**Date:**

SUBMIT COMPLETED FORM(S) TO THE BENEFITS OFFICE

WEST CHESTER AREA SCHOOL DISTRICT

No. 335AG3

ADMINISTRATIVE GUIDELINE

APPROVED: August 1, 2015

REVISED:

335AG3 NOTICE OF EXPECTATIONS AND OBLIGATIONS OF EMPLOYEES ON LEAVE UNDER THE FAMILY AND MEDICAL LEAVE ACT OF 1993

This notice is being provided to you in accordance with 29 C.F.R. § 825 301(c), requiring employers to provide employees with "notice detailing the specific expectations and obligations of the employee and explaining any consequences for failure to meet these obligations". In that regard, please be advised of the following:

1. Designation of Leave Under the Act. Your leave will be counted against your annual Family and Medical Leave Act leave entitlement.

2. Medical Certification. If your leave request is due to a serious health condition, you must furnish medical certification of the serious health condition:

    a. As soon as possible, but in no event more than fifteen (15) calendar days after the employee's request for such leave; unless the facts illustrate that it was not practicable under the particular circumstances to do so despite the employee's diligent, good faith efforts;

    b. Whenever intermittent leave or leave on a reduced schedule is requested;

    c. Whenever the District finds a certification incomplete, the employee shall be notified and be given reasonable opportunity to cure any such deficiency.

3. Certification Form. The required medical certification shall be on the form attached hereto. The information required by the form must be provided. You and your health provider are not required to provide additional information for purposes of the Act. Failure of your health care provider to provide the required information can extinguish your right to relief under the Act.

4. Second and Third Opinions. If the District doubts the validity of a medical certification, it may require you to obtain a second opinion at the District's expense by a health care provider designated by the District. This health care provider will not be employed on a regular basis by the District. If the opinions of your health care provider and the District's provider differ, the District may require you to obtain certification from a third health care provider at the District's expense. This third care provider shall be designated or approved jointly by you and the District and you must act in good faith to attempt to reach an agreement on whom to select. If you do not attempt in good faith to reach agreement, you will be bound by the second certification. Where a third opinion is obtained, it shall be final and binding on you and the District.

5. Updated Certification. The District may request updated certification at reasonable intervals: if you request an extension of any leave; if the circumstances change significantly; if the District receives information casting doubt on the validity of the certification; or if you are unable to return to work because of the continuation, recurrence or onset of a serious health condition.

6. Failure to Provide Certification. Your failure to provide adequate certification can have the following consequences:

   a. You will be ineligible for:

      (1) A leave of absence under the Act; or
      (2) Sick leave under District policy and practice in the case of the employee's own serious health condition

   b. Loss of health care coverage in the event you stop working without qualifying for any leave during which such coverage would continue; and/or

   c. Loss of seniority or employment should you take an unapproved leave for which you are ineligible.

7. Utilization of Paid Leaves. You are required, during your leave under the Act, to utilize any paid leaves to which you may be otherwise eligible by virtue of law, District policy, collective bargaining agreement, compensation agreement or contract. The District requires you to utilize and exhaust such leaves to the fullest extent possible during any leave under the Act Leave under the Act during which you are utilizing available paid leaves to which you are eligible shall be referred to herein as paid leave under the Act. When no such paid leaves are available for use by you, the leaves shall be referred to herein as unpaid leave under the Act.

8. Continuation of Health Care Benefits. During your paid or unpaid leave under the Act, health insurance coverage will be provided if it had been provided before the leave was taken and will be provided on the same terms as if you had continued to work. Therefore, if you pay premiums to the District, in whole or in part, before the leave, you will have to continue to make such payments during the leave under the Act. If premiums are raised or lowered during the leave under the Act, you will be required to pay the new premium rates. In addition, any co-pays you would be required to pay while working, you will still be required to pay.

9. Delinquent Premium Payments. If you are delinquent in the payment of any premium in whole or in part, by thirty (30) days or more from the due date for the payment, the District has the option to terminate your coverage or to pay your share of the premiums. In the event the District pays your share of the premiums, the District will recover said premiums from you in accordance with 29 C F R §825 212(b).

10. Duty to Return to Work. You have a duty to return to work after your entitlement to leave under the Act has been exhausted or expires, unless the reason you do not return to work is due to:

    a. The continuation, recurrence or onset of a serious health condition which would entitle you to leave under the Act; or
    b. Circumstances beyond your control in accordance with 29 C F R. §825 213 (a) (2)

    In the event you fail to return and you assert one of the excuses recognized in this paragraph, you must provide appropriate documentation of the excuse. In the event of the continuance, recurrence or onset of a serious health condition, a medical certification is required and must be provided within thirty (30) days from the date of the exhaustion

or expiration of your leave under the Act. In the event you fail to return for reasons beyond your control, you must submit within thirty (30) days of the date of the exhaustion or expiration of your leave under the Act, a written document signed by you detailing the circumstances. The District may rely on the statements contained in the written document or upon any other information of which it is aware. If you fail to provide a certification or written document in accordance with this provision in a timely manner, or the circumstances surrounding your failure to return to work are not sufficient, health care premiums paid by the District will be considered to be a debt owed by you to the District and the District will recover from you any health care premiums it paid during the period of unpaid leave under the Act (the District will not recover its share of health insurance premiums for any period of leave under the Act during which any paid leave was utilized in accordance with paragraph 4 hereof). This debt may be recovered through lawful deductions from sums owed to you or through legal action against you, all in accordance with 29 C F R. § 825 213(a). Absent adequate excuse as stated herein, you will have fulfilled your duty to return to work only if you return to work for at least thirty (30) calendar days in accordance with 29 C F R §825 213(b).

11. Fitness for Duty Certification. If you are or have been suffering from a serious health condition, you must obtain and present certification to the District from the health care provider that you are able to resume work; except where such a requirement would be in violation of a collective bargaining agreement or where the employee has taken a paid leave concurrent with the leave under the Act and the District policy and practice does not require a fitness for duty certificate to be filed. The certification is required only with regard to the particular health condition that caused your need for leave under the Act and the certification need only be a statement of your ability to return to work. You will not be required to obtain or provide a second such fitness for duty certification. You will not be permitted to return to work until you submit a required fitness for duty certificate.

12. Rights on Return to Work. On return from leave under the Act, you are entitled to be returned to same position you held before your leave commenced, or to an equivalent position with equivalent benefits, pay and other terms and conditions of employment, provided, however, that you have no greater right to reinstatement or to other benefits and conditions of employment then if you had been continuously employed during leave under the Act. For example, if you would have been laid off during the leave period, you will have no right to reinstatement. If your shift was eliminated or overtime increased, you would not be entitled to return to work that shift or for the original overtime hours upon reinstatement.

13. Notice of Intent to Return to Work. With respect to any unpaid leave under the Act, you are required to give the District written notice of your intent to return to work at least ten (10) days prior to the anticipated end of your leave as set forth on your leave request form. If you give an unequivocal notice of intent not to return to work, the District's obligations to maintain health benefits (subject to COBRA requirements) and to restore you to employment may cease.

Date	**Employee Signature** (this signature signifies employee's receipt of this Notice)

(Also attached find U.S. Department of Labor Employment Standards Administration Publication WHD 1420, revised January 2009; Employee Rights and Responsibilities Under the Family and Medical Leave Act.

Employee Benefits While On A Leave of Absence

If an employee needs to be away from work for a period of time, he or she may be eligible for a paid or unpaid leave of absence, or a combination of both. These will be approved by Human Resources on a case by case basis based on the employment contracts and FMLA laws. The information presented here is to assist the employee in understanding the effect of his or her leave on various employee benefits.

Benefits While On A Paid Leave of Absence

If an employee uses paid leave, their benefits are not affected. If the employee's District paycheck is not sufficient to pay the employee contribution rates for all elected benefits, the employee will be billed directly for the difference between those rates and the amount deducted from their pay.

Important note for Teaching Staff: 1) Teaching Staff are Salaried employees and are paid AHEAD of actual work days throughout the school year. When an employee goes out on leave, Payroll will calculate the amount paid versus the actual number of work days and paid time off days, and will determine a final payout amount. The date range on the district paychecks does NOT apply to Salaried staff. 2) Accrued Flex Time CANNOT be used during a leave of absence.

Benefits While on An Unpaid Leave of Absence

Health Benefits (Medical/Prescription/Dental/Vision)
The employee's share of premium costs for Medical, Prescription, Dental and Vision while on an unpaid leave varies depending on the type of unpaid leave. These are detailed below:

Leave Qualified Under FMLA

FMLA eligibility runs for up to 60 work days and is dependent upon medical documentation. To qualify for FMLA, an employee must have been employed with the district for at least one (1) year and worked at least 1,250 hours during the 12 months prior to the start of the FMLA leave.

If the employee elects to retain health coverage during an unpaid FMLA leave, then he or she must continue to pay the employee portion of applicable premiums via direct bill.

Unpaid Leave- Not FMLA Eligible or beyond FMLA eligibility

If the employee is approved for an unpaid leave outside of FMLA (child rearing, workers compensation, medical, personal, etc.) and elects to retain health coverage during this period, then he or she must pay the full cost of applicable premiums via direct bill.

The maximum duration an employee can purchase benefits at full cost is for 18 months.

** Please note, premium rates increase on July 1 of each year. As such, your premium bills will be adjusted to reflect the rates in effect at the month of billing.

Adding Newborn Dependents While On A Leave Of Absence

When going on a leave of absence, employees should be aware that coverage for newborn children is not automatic and the following applies:

- To enroll a newborn child who is an Eligible Dependent, employees must add the dependent child to the BenefitSolver System within 30 days of the date of birth.

- Employees are required to provide proof of birth (i.e. copy of birth record or letter requesting the baby's social security number) at that time.

- If the required paperwork is completed and received within 30 days of the date birth, coverage will be effective as of the date of birth and the employee will be responsible for the applicable premiums.

Spending Accounts

1. Dependent Care Account
   A Dependent Care Flexible Spending Account is intended to help an employee pay for eligible dependent care expenses to allow them to work. The IRS doesn't allow an employee to be reimbursed for such expenses incurred while on a leave of absence.

   While on an unpaid leave, the employee's contributions to a Dependent Care Account will cease. The account will be deactivated on the last day of the month during which the leave commenced. Note- the employee can still access their account for services incurred prior to the leave of absence. If the employee returns to work during the Plan Year, he or she can adjust the per pay contribution over the remaining pays in order to meet the goal originally elected for the Plan Year. If no communication is received by the employee, the remaining pays will resume at the original per pay calculation taken before the leave commenced.

2. Health Flexible Spending Account
   The employee may choose from the following options at the onset of their unpaid leave:

   Pay As You Go:
   If the employee chooses to continue making contributions into their health flexible spending account, the contribution will be included on the monthly direct billed invoice and be paid on a post- tax basis. If the employee continues to make contributions, the account will remain open and the employee will be entitled to submit a request for reimbursement of any eligible charges incurred during the months the employees is on an unpaid leave.

   De-Activate Account
   If the employee chooses not to make the monthly contributions, the account will be deactivated. The employee will be unable to be reimbursed for services incurred during the leave. Note- the employee can still access their account for services incurred prior to the leave of absence. When the employee returns to work, his or her bi-weekly will resume and he or she will be entitled to submit a request for reimbursement of any eligible charged incurred prior to and after the unpaid leave.

3. Health Savings Account
   If an employee's leave is unpaid and they wish to make post tax contributions to their HSA, the individual will need to submit those contributions directly to the HSA vendor. HSAs are employee-owned accounts therefore the individual is responsible for ensuring the contributions do not exceed the IRS limits including all HSA contributions through payroll deductions, district contributions, and post-tax contributions the employee or anyone else has made to the account combined. If an individual chooses to cancel their High Deductible Health Plan during unpaid

leave, they will no longer be eligible to make contributions to their Health Savings Account until they re-enroll in a qualifying High Deductible Health Plan.

Voluntary Supplemental Disability

If the employee has elected to retain a Long Term Disability Supplemental plan, then he or she must continue to pay the cost of that plan via direct bill. The employee will be covered for any disability that occurred prior to the commencement of the leave or during the 12 week FMLA period. As such, if the employee elects to retain the Disability Supplemental Plan during an unpaid leave, the District will bill for this cost during the FMLA period, only. If an employee's unpaid leave continues past the 12 week FMLA period, the supplemental policy will terminate and they can re-enroll within 30 days upon returning to work.

Benefits Not Direct Billed

- Humana & Aflac

  Humana and Aflac are voluntary benefits. They will not be direct billed by the District while an employee is on an unpaid leave.

  Humana Policy - If an employee has not had payroll deductions for more than 90 days, Humana will transfer the policies to a direct billed arrangement, and the individual will receive a bill at their home address. The 90 day clock starts with the first missed deduction. If the individual doesn't pay the premium bill, they will eventually be notified that the policy has lapsed.

  Aflac Policy – Once an employee goes out on an unpaid leave, they are responsible for contacting Aflac customer service at 1-800-433-3036 to request a port package. The individual has 30 days from the date of the unpaid leave to contact Aflac. If they do not contact Aflac within 30 days, the policy will be terminated.

For more information on contacting Humana and Aflac directly, please contact the Benefits Specialist.

District Paid Benefits While On An Unpaid Leave

Group Term Life/AD&D

Employees on an approved unpaid leave will continue to be eligible for the level of Group Term Life and AD&D insurance held at the time the leave began for the period of up to two (2) years. For leaves extending past 2 years, these benefits will cease after 2 years following the beginning of the unpaid leave.

Long Term Disability

An employee will continue to be covered by the District's Long Term Disability plan if the date of the disability is prior to their leave date or occurs within the 12 week FMLA period.

Direct Billing

Once an employee begins an unpaid leave, they will begin receiving monthly invoices for either the employee portion or the full cost rates (see above) for all elected benefits until they return to active employment.

Payment of applicable contributions is due on the 15th day of each month. **If the payment is more than 15 calendar days late, then elected benefits will be terminated for lack of payment and will not be reinstated.** Termination of benefits will be effective on the first day of the month following the due date.

Return to Work

If the employee's coverage is canceled, either because they voluntarily canceled coverage or they failed to pay the required premium, the employee will have 30 days upon returning to work to re-enroll. Re-enrollment is effective the first of the month following the return date. At that time, the employee may be required to complete an Evidence of Insurability when re-enrolling in the Humana, Aflac and the Buy Up LTD plans upon returning to work. In addition, the carrier may deny the benefit based on the Evidence of Insurability.

Employee Acknowledgement:

I have received the attached description of **Employee Benefits While on a Leave of Absence** and will retain a copy for my records:

_____ _____

Employee Name Date

_____

Employee Signature

WEST CHESTER AREA SCHOOL DISTRICT
Leave of Absences Procedures and Guidelines

This document serves to advise all employees who are approved for any leave of absence of the internal procedures and processes surrounding same. Please review carefully.

Technology While on Leave
On the last physical day in their home building/office the employee must return to their building Technology Specialist all district issued technology devices (laptop, IPad, etc.) Employees may not take or retain any district issued devices while on their leave of absence. In the event that an individual has to start their leave early and was not able to return the devices prior to their last physical day, the employee must make arrangements with the building technology team or administrator to return the devices to their home building as soon as they are physically able.

This policy applies to all leaves of absences, paid or unpaid, including **medical, childbirth/childrearing, personal and sabbatical** so employees must plan accordingly prior to their leave. District issued technology will be returned to the employee on their first day back from leave. **Please note**, this may not be your original device so please save any documents or materials you may need upon your return prior to turning in your device at the start of your leave. Your original device will be re-imaged for security purposes.

Tuition Reimbursement
Employees are not eligible for tuition reimbursement while out on a medical or childrearing leave of absence. If an employee is currently enrolled in a program and have to suspend classes while on leave they do not have to re-apply for program approval upon their return. They can commence classes upon their official return from leave and be eligible for reimbursement as long as they follow the collective bargaining agreement language surrounding the tuition reimbursement process.

If an employee's medical leave starts after a session has started they can finish the course and receive reimbursement. However, they would not be able to start a new class/session and be eligible for tuition reimbursement. Any questions or concerns regarding the tuition reimbursement process should be directed to Amelia Pumala (APumala@wcasd.net) in the Human Resources Office.

Step Movement for Year Following Return from Leave
Employees must work for at least fifty-percent of each scheduled work year in order to advance on the salary schedule. Please refer to your individual employee group contract/agreement to determine your yearly work day requirement. Movement is also dependent on whether the collective bargaining agreement allows for step/salary movement in the school year following the leave of absence and annual performance evaluation scores. "Work" days include any **paid** time off during the approved leave. Any days that are unpaid during the leave do not qualify as "work" days and do not count in calculating eligibility.

PPL/Accrued Flex Time
Accrued Flex time cannot be used during a leave of absence. If an employee is unable to return to work during the school year for any reason, the PPL/Flex Hours are forfeit.

Professional Development
Employees on a leave of absence are not able to attend Professional Development virtually or in-person.

Amending the Return Date (for leave other than leave due to health condition)
Employees on a leave of absence must provide at least 30-day's notice should they wish to amend their return date (all leaves other than medical leave). The notice requirements are as follows: a) to amend to an earlier return date, the request must be submitted to the Benefits Office at least 30 days ahead of the newly requested return date; or b) to amend to a later return date, the request must be submitted to the Benefits Office at least 30 days ahead of the original stated return date.

Pay Information Specific to Teaching Staff:
Teaching Staff are salaried employees and are paid **AHEAD** of actual work days throughout the school year. When an employee begins leave, Payroll will calculate the amount paid versus the actual number of work days and paid time off days, and will determine a final payout amount. The date range on the district paychecks does not apply to Salaried staff.

* By my signature, I acknowledge that I have read, understand, and consider myself bound by the above statements, and further acknowledge receipt of a copy of this statement.

_____

Employee Name (Printed)

_____ _____

Employee Signature Date

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

U.S. Department of Labor
Wage and Hour Division

WHD
WAGE AND HOUR DIVISION

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR. RETURN TO THE PATIENT.

OMB Control Number: 1235-0003
Expires: 6/30/2023

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. 29 U.S.C. §§ 2613, 2614(c)(3); 29 C.F.R. § 825.305. The employer must give the employee **at least 15 calendar days** to provide the certification. If the employee fails to provide complete and sufficient medical certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

SECTION I – EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, this form asks the health care provider for the information necessary for a complete and sufficient medical certification, which is set out at 29 C.F.R. § 825.306. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308.** Additionally, you **may not** request a certification for FMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care.

Employers must generally maintain records and documents relating to medical information, 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, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

(1) Employee name: _____
First *Middle* *Last*

(2) Employer name: West Chester Area School District Fax 484-266-1180 Date: _____ *(mm/dd/yyyy)*
(List date certification requested)

(3) The medical certification must be returned by _____ *(mm/dd/yyyy)*
(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee's diligent, good faith efforts.)

(4) Employee's job title: _____ Job description (☐ is / ☐ is not) attached.
Employee's regular work schedule: _____
Statement of the employee's essential job functions: _____

(The essential functions of the employee's position are determined with reference to the position the employee held at the time the employee notified the employer of the need for leave or the leave started, whichever is earlier.)

SECTION II - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form. Your patient has requested leave under the FMLA. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of the employee. For FMLA purposes, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves *inpatient care* or *continuing treatment by a health care provider*. For more information about the definitions of a serious health condition under the FMLA, see the chart on page 4.

You may, but are **not required** to, provide other appropriate medical facts including symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment. Please note that some state or local laws may not allow disclosure of private medical information about the patient's serious health condition, such as providing the diagnosis and/or course of treatment.

Employee Name: _____

Health Care Provider's name: *(Print)* _____

Health Care Provider's business address: _____

Type of practice / Medical specialty: _____

Telephone: (___) _____ Fax: (___) _____ E-mail: _____

PART A: Medical Information

Limit your response to the medical condition(s) for which the employee is seeking FMLA leave. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. **After completing Part A, complete Part B to provide information about the amount of leave needed.** Note: For FMLA purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

(1) State the approximate date the condition started or will start: _____ *(mm/dd/yyyy)*

(2) Provide your **best estimate** of how long the condition lasted or will last: _____

(3) Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

☐ **Inpatient Care**: The patient (☐ has been / ☐ is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): _____

☐ **Incapacity plus Treatment**: *(e.g. outpatient surgery, strep throat)*
Due to the condition, the patient (☐ has been / ☐ is expected to be) incapacitated for *more than* three consecutive, full calendar days from _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*.

The patient (☐ was / ☐ will be) seen on the following date(s): _____
_____

The condition (☐ has / ☐ has not) also resulted in a course of continuing treatment under the supervision of a health care provider *(e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment)*

☐ **Pregnancy**: The condition is pregnancy. List the expected delivery date: _____ *(mm/dd/yyyy)*.

☐ **Chronic Conditions**: *(e.g. asthma, migraine headaches)* Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

☐ **Permanent or Long Term Conditions**: *(e.g. Alzheimer's, terminal stages of cancer)* Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

☐ **Conditions requiring Multiple Treatments**: *(e.g. chemotherapy treatments, restorative surgery)* Due to the condition, it is medically necessary for the patient to receive multiple treatments.

☐ **None of the above**: If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed. Go to page 4 to sign and date the form.

Employee Name: _____

(4) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. *(e.g., use of nebulizer, dialysis)* _____

_____

PART B: Amount of Leave Needed

For the medical condition(s) checked in Part A, complete all that apply. 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.

(5) Due to the condition, the patient (☐ had / ☐ will have) **planned medical treatment(s)** (scheduled medical visits) *(e.g. psychotherapy, prenatal appointments)* on the following date(s): _____

_____

(6) Due to the condition, the patient (☐ was / ☐ will be) **referred to other health care provider(s)** for evaluation or treatment(s).

State the nature of such treatments: *(e.g. cardiologist, physical therapy)* _____

Provide your **best estimate** of the beginning date _____ *(mm/dd/yyyy)* and end date _____ *(mm/dd/yyyy)* for the treatment(s).

Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery *(e.g. 3 days/week)*

_____

(7) Due to the condition, it is medically necessary for the employee to work a **reduced schedule**.

Provide your **best estimate** of the reduced schedule the employee is able to work. From _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)* the employee is able to work: *(e.g., 5 hours/day, up to 25 hours a week)*

_____

(8) Due to the condition, the patient (☐ was / ☐ will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.

Provide your **best estimate** of the beginning date _____ *(mm/dd/yyyy)* and end date _____ *(mm/dd/yyyy)* for the period of incapacity.

(9) Due to the condition, it (☐ was / ☐ is / ☐ will be) medically necessary for the employee to be absent from work on an **intermittent basis** (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, episodes of incapacity are estimated to occur _____ times per (☐ day / ☐ week / ☐ month) and are likely to last approximately _____ (☐ hours / ☐ days) per episode.

Employee Name: _____

PART C: Essential Job Functions

If provided, the information in Section I question #4 may be used to answer this question. If the employer fails to provide a statement of the employee's essential functions or a job description, answer these questions based upon the employee's own description of the essential job functions. An employee who must be absent from work to receive medical treatment(s), such as scheduled medical visits, for a serious health condition is considered to be *not able* to perform the essential job functions of the position during the absence for treatment(s).

(10) Due to the condition, the employee (☐ was not able / ☐ is not able / ☐ will not be able) to perform *one or more* of the essential job function(s). Identify at least one essential job function the employee is not able to perform:

_____

_____

Signature of Health Care Provider _____ **Date** _____ *(mm/dd/yyyy)*

Definitions of a Serious Health Condition *(See 29 C.F.R. §§ 825.113-.115)*
Inpatient Care
• An overnight stay in a hospital, hospice, or residential medical care facility. • Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.
Continuing Treatment by a Health Care Provider (any one or more of the following)
Incapacity Plus Treatment: A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either: o Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or, o At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.
Pregnancy: Any period of incapacity due to pregnancy or for prenatal care.
Chronic Conditions: Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.
Permanent or Long-term Conditions: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.
Conditions Requiring Multiple Treatments: Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR. RETURN TO THE PATIENT.

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AREA
SCHOOL
DISTRICT

Employee Benefits

782 Springdale Drive • Exton, Pennsylvania 19341 • (484) 266-1011 • FAX (484) 266-1180

ATTENDING PHYSICIAN'S STATEMENT

Employee: _____

Please have your doctor complete the following questions and return fax to the Benefits Office at 484-266-1180 prior to your return to work date

When was patient last seen? _____

Date of next office visit? _____

Progress of Patient (check one) ___Recovered ___ Improved ___Unchanged ___Retrogressed

If physical or psychiatric limitations exist, how long do you feel limitations will last? _____

_____

Do you feel patient can work with current limitations? _____

If yes, what restrictions does this patient have? _____

_____

_____

When can he/she return to work if these restrictions can be accommodated? _____

If there are no limitations/restrictions, on what date can this employee return to work? _____

Attending Physician's Name (please print) _____

Street Address: _____

City, State Zip _____

Telephone # _____ Fax # _____

Signature: _____ Date: _____

Return completed form to:

West Chester Area School District
Spellman Administration, Benefits Office
782 Springdale Drive
Exton, PA 19341
Attn: Deborah Baker, Benefits Specialist
Fax: 484-266-1180; email: dbaker1@wcasd.net

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Do you feel patient can work with current limitations? _____

If yes, what restrictions does this patient have? _____

_____

_____

When can he/she return to work if these restrictions can be accommodated? _____

If there are no limitations/restrictions, on what date can this employee return to work? _____

Attending Physician's Name (please print) _____

Street Address: _____

City, State Zip _____

Telephone # _____ Fax # _____

Signature: _____ Date: _____

Return completed form to:

West Chester Area School District
Spellman Administration, Benefits Office
782 Springdale Drive
Exton, PA 19341
Attn: Deborah Baker, Benefits Specialist
Fax: 484-266-1180; email: dbaker1@wcasd.net

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Return to Work

_____ has returned to work on
Employee Name

_____ .
Date

_____ _____
Employee Signature Date

_____ _____
Principal/Supervisor's Signature Date

Employee: this form should be handed to your principal/supervisor the day you return to work.

Principal/Supervisor: Sign this form the day your staff member has physically returned to work.

Scan/email or Interoffice mail to:

Debbie Baker
dbaker1@wcasd.net
Benefits Specialist
Spellman Administration Building
Fax: 484-266-1180