POLICY 3.76

4-C I recommend that the Board adopt the proposed revised Policy 3.76, entitled "Family and Medical Leave Act Policy."

[Contact: Mark Mitchell PX 48911, Elizabeth McBride, PX 48751.]

Development **CONSENT ITEM**

- The revised policy addresses recent congressional amendments to the Family and Medical Leave Act, which was amended by the National Defense Authorization Act for Fiscal Years 2008 and 2010 (FMLA) to provide:
  - Two new FMLA military family leave (*See* Sec. 3e and 4b) provisions which offer employees:
    - Up to 26 weeks to care for a family member injured on active military duty (Military Caregiver Leave). *See* Sec. 3f and 4(b) (i).
    - Up to 12 weeks for "qualifying exigencies" caused by a family member being recalled to active duty (Military Qualifying-Exigent Leave). *See* Sec. 3g, 4(a) (v), and 4(b) (ii).
  - For employees to provide notice to the District of the need for unforeseeable leave within as soon as practicable and follow the work unit's usual and customary call-in procedures for reporting of absence, eliminating the previous requirement permitting the employee to wait up to 2 days. *See* Sec. 7(a). This notice may be given by another person if the employee is unable to do so.

- The proposed provisions provide new definitions for covered service members to include veterans, and expand the definition of serious injury or illness with respect to veterans to include an injury or illness which may manifest itself before or after the servicemember becomes a veteran.

- Proposed provisions permit domestic partners, registered in accordance with District policy, to be eligible for family medical leave to care for a domestic partner. See Sec. 4(a)(iii), 4(a)(v), and 4(b)(i).

- An employee is prohibited from working another job, if the medical leave relates to a health condition or injury of the employee. *See* Sec. 9.

- Health benefits are maintained for employees on family medical leave if: the employee was eligible and received such benefits from the District prior to leave; and the employee makes the required employee contribution, if the leave is unpaid. If an employee fails to return to work after the leave, the District may seek reimbursement for health care premiums paid. *See* Sec. 6.

- Upon return from FMLA, an employee is entitled to same position held prior to leave or an equivalent position with equivalent benefits, etc. See Sec. 7e.

- The policy provides for notices to employees and incorporates forms to obtain information as required by federal laws and regulations. See Sec. 11.

- The Board approved development of this revised Policy at the development reading on November 22, 2011.

POLICY 3.76

FAMILY AND MEDICAL LEAVE ACT POLICY

1. **Purpose.** The purpose of this policy is to provide family and medical leave for District employees in a manner that meets the requirements of the federal laws and regulations governing the Family and Medical Leave Act of 1993, as amended in 2008, including amendments to the FMLA pursuant to the National Defense Authorization Act for Fiscal Years 2008 and 2010(FMLA) and preserves the ability of the school system to fulfill its mission. FMLA leave is intended to allow employees to balance their work and family life by taking reasonable paid and/or unpaid leave for a serious health condition, for the birth or adoption of a child, and for the care of a child, spouse, or parent who has a serious health condition, or who is called to certain active duty status in the armed forces. The School Board of Palm Beach County has long recognized the importance of providing assistance to employees in meeting family obligations and has provided for paid and unpaid time away from work for the reasons recognized by the FMLA.

2. **Scope.** This policy applies to eligible District employees, excluding such employees whose collective bargaining agreements have controlling provisions governing FMLA.

3. **Definitions.** For the purposes of this policy, the following words shall have the definitions as provided below.

   a. *Eligible Employee* means an employee who: (a) has been employed for at least twelve (12) months by the District; *and* (b) has at least one thousand two hundred fifty (1,250) hours of service with the District during the twelve (12) months prior to the start of the requested leave.

   b. *Eligible Domestic Partner* shall be an individual who has become a registered domestic partner of an employee as provided in Policy 3.78.

   c. *Covered Servicemember* means a 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 a veteran with a serious injury or illness.

   d. *Intermittent Leave* means leave taken in separate blocks of time, rather than in one continuous period, related to a single illness or injury. Such leave may be taken in blocks of hours, days, or weeks.

e. *Military Family Leave* comprises the two categories of leave entitled: Military Caregiver Leave and Military-Qualifying Exigency Leave, the provisions of which are outlined in this policy.

f. *Military Caregiver Leave* means leave with or without pay granted to an eligible employee who is the spouse, son, daughter, parent, domestic partner or the next of kin of a covered servicemember of the armed forces, including a member of the National Guard or Reserves, or a veteran, who has a serious illness or injury that was incurred in the line of duty while on active duty, or that existed before the member's active duty and was aggravated by service in the line of duty.

g. *Military- Qualifying Exigency Leave* means leave with or without pay granted to an eligible employee, including an eligible domestic partner, who has a covered family member serving in either the regular armed forces, or the National Guard or the Reserves for any qualifying exigency that arises while the covered family member is on active duty or called to active duty status in support of a contingency operation. Examples of "qualifying exigency" include, but is not limited to: attending military events and related activities; arranging alternative childcare and school activities; managing financial and legal arrangements; rest and recuperation; attending counseling sessions; attending post-deployment activities; or, short notice (e.g. less than 7 days) deployment to a foreign country; or additional activities agreed upon by the employee and employer.

h. *Serious health condition means* an illness, injury, impairment or physical or mental condition that requires inpatient care in a hospital, hospice, or residential medical care facility, or continuing health treatment by a health care provider.

i. *Serious injury or illness* means an injury or illness incurred by a member of the armed forces, including a member of the National Guard or Reserves, in the line of duty while on active duty in the armed forces, or existed before the beginning of the member's active duty and was aggravated by service in the line of duty on active duty, and that may render the member medically unfit to perform the duties of the member's office, grade, rank or rating.

4. **Policy Statement**. ~~1. GENERAL~~. In accord with federal law and regulations, the ~~The~~ District will provide, to eligible ~~qualified~~ employees, family and medical leave pursuant to the provisions of the ~~1993~~ Family and Medical Leave Act of 1993, as amended in 2008, including amendments to the FMLA pursuant to the National Defense Authorization Act for Fiscal Years 2008 and 2010 (FMLA). ~~FMLA leave is intended to allow employees to balance their work and family life by taking reasonable paid and/or unpaid leave for personal serious health conditions, for the birth or adoption of a child, and for the care of a child, spouse, or parent who has a~~

~~serious health condition. During the period of FMLA leave entitlement, the District will continue to provide paid health insurance for the employee.~~

~~FMLA leave shall be granted to eligible employees pursuant to the following criteria (except as otherwise provided in applicable collective bargaining agreements):~~

~~a. "Eligible Employees" are those employees who:~~

~~i. have been employed for at least twelve (12) months by the District, and~~

~~ii. have at least one thousand two hundred fifty (1,250) hours of service with the Board during the twelve (12) months prior to the requested leave.~~

~~b. Employees meeting the requirements of paragraph 2(a) shall be entitled to a total of twelve (12) weeks of FMLA leave per year (calculated on a rolling twelve (12) month basis) for the following:~~

a. *Family Medical Leave*. Eligible employees are able to use up to a total of twelve (12) weeks leave per year, as calculated on a rolling twelve (12) month basis for:

i. The birth and care of the employee's child, within one year of birth ~~of a child of the employee and/or in order to for such child~~;

ii. The placement of a child with the employee for adoption or foster care, within one year of the placement;

iii. Care of ~~To care for~~ a spouse, child, ~~or~~ parent, or eligible domestic partner ~~of the employee if said individual~~ who has a serious health condition; *or*

iv. The employee's own ~~A~~ serious health condition that makes the employee unable to perform the essential functions of his/her position with the District.

v. Any Military Qualifying Exigency Leave arising out of the fact that the employee's spouse, son, daughter, parent or domestic partner is on active duty or has been notified of an impending call or order to active duty in the armed forces, National Guard or Reserves in support of a contingency operation.

~~"Serious health condition" is defined as a condition which requires inpatient~~

~~care in a hospital, hospice, or residential medical care facility; or continuing health treatment by a health care provider.~~

b. *Military Family Leave*. Eligible employees or the next of kin may receive the military family leave relative to an immediate family member who is a covered service member, or who is on active duty or being recalled to active duty as a member of the armed forces, National Guard or Reserves who is on the temporary disability retire list, under the following circumstances.

i. *Military Caregiver Leave*. An eligible employee who is the spouse, son, daughter, parent, domestic partner or next of kin of a covered service member, including an eligible veteran, shall be granted up to twenty-six (26) weeks of paid or unpaid leave during a single 12-month period to care for the covered service member with a serious illness or injury.

ii. *Military-Qualifying Exigent Leave* shall be granted as provided in section 4(A) (v) herein.

c. The total, combined available Family Medical Leave, including the military related leave, for an eligible employee per leave year shall not exceed twenty-six (26) weeks.

5. **When Husband and Wife or Domestic Partners Are Both Employees.**

a. ~~d~~. Where both husband and wife, or eligible domestic partners, are employed by the District, they are permitted to take only a combined total of twelve (12) work weeks of leave if time off is requested for the birth and care of a newborn child; the placement of a child for adoption or foster care; or to care for a sick child, spouse, parent, or domestic partner. For FMLA leave based on other qualifying reasons, the husband and wife will each be entitled to their unused balance of twelve (12) weeks. If terms of a collective bargaining agreement differ from Board Policy, the language of the employee's agreement will take precedence.

b. If the husband and wife, or eligible domestic partners, are both employees of the District, the two employees are entitled to a combined total of 26 weeks of military caregiver leave due to the care of a seriously ill or injured covered service member of whom the eligible employee is the spouse, child, parent, domestic partner or next of kin.

6. **Maintenance of Health Benefits**. During a period of FMLA leave, an eligible employee's health coverage will continue under the same conditions that applied before the leave commenced.

a. ~~e~~. The District shall maintain, in full effect for the duration of the leave, health insurance coverage for an employee who is on leave, provided the employee:

i. was eligible for and received District provided group health insurance prior to the leave ~~when actually working for the District~~; and/or

ii. if ~~is~~ on unpaid leave ~~and~~, ~~if~~ he/she pays for dependent insurance, pays partial premiums for his/her own coverage, ~~or~~ pays for other types of District offered insurance coverage, and continues to make direct premium payments to the District ~~while on leave~~.

b. Employee payments will be due on the same schedule that payroll deductions are made (whether the employee is in paid or unpaid status).

c. If an employee voluntarily fails to return to work upon the expiration of the leave or if the employee informs of the intent to not return to work at the end of the leave period, the employee must reimburse the District for health care premiums paid by the District during the period of any unpaid leave.

7. **Notification, Application and Medical Certifications**

a. ~~f.~~ An eligible employee wishing to take FMLA leave, as provided for herein ~~outlined in paragraphs b(i) and b(ii) above~~, must provide the District with not less than thirty (30) calendar days written notice, before the date the FMLA leave is to begin, if the leave is foreseeable. Examples of foreseeable leave are such as an expected birth, placement for adoption or foster care, or planned medical treatment for a serious health condition of the employee, an eligible family member or eligible domestic partner. ~~except if the birth or placement requires FMLA leave to begin in less than thirty (30) calendar days,~~ When the need for leave is not foreseeable, the employee shall provide notice ~~as~~ in keeping with any work unit rules for calling in sick or reporting an absence, or as soon as it is practical, preferably within one to two business days of when the employee learns of the need for the leave. This notice may be given by another responsible person if the employee is unable to do so. ~~Where FMLA leave is requested, as outlined in paragraphs b(iii) and b(iv) above, the employee, in writing, shall provide thirty (30) days notice, except that if the date of treatment requires the employee's leave to begin in less than thirty (30) days, the employee shall provide such written notice as is practical. The employee shall make a reasonable effort to schedule the treatment so as not to unduly disrupt the operations of the District.~~

b. Requests for FMLA leave must be made through the Office of Compensation and Human Resources Planning. The Office of Compensation and Human Resources Planning will provide appropriate forms and will process leave requests. Employees must also notify their director or supervisor that FMLA leave is being requested.

c. The District shall require medical certification, signed by the employee's health care provider, when FMLA leave is requested for the serious health condition

of the employee, or for a serious health condition of the employee's spouse, child, parent, domestic partner or next of kin. Employees seeking leave based upon the serious health condition of the employee, the employee's spouse, child, parent, next of kin or domestic partner, must complete one of the forms as provided in section 11 herein. ~~Such certification shall include, but not be limited to:~~

i. ~~The date on which the serious health condition commenced;~~

ii. ~~The probable duration of the condition;~~

iii. ~~The appropriate medical facts within the knowledge of the health care provider regarding the condition.~~

d. A second and third opinion may be required at District expense for any case in which the District has reason to doubt the validity of the certification. In addition, when an employee has a continuing medical condition for which FMLA coverage is requested, the District may request recertification of the medical condition every thirty (30) days.

e. Upon return from FMLA leave, the employee is entitled to be restored to the same position held prior to the leave or to an equivalent position with equivalent benefits, pay and other terms and conditions of employment. An employee whose FMLA leave was due to his/her own serious health condition must provide medical certification that he/she is fit for duty before returning to work.

8. **Intermittent Leave or Reduced Leave Schedule**

~~A second and third opinion may be required at District expense for any case in which the District has reason to doubt the validity of the certification. In addition, when an employee has a continuing medical condition for which FMLA coverage is requested, the District may request recertification of the medical condition every thirty (30) days.~~

a. Medical leave as provided for in this policy ~~outlined in paragraphs b(iii) and b(iv) above~~ may be taken intermittently, or on a reduced leave schedule, when medically necessary~~. Intermittent leave is defined as leave taken in separate blocks of time due to a single illness or injury, rather than one continuous period of time. Intermittent leave may include leave of periods from an hour or more to several weeks. Such leave is available for~~ or due to the employee's own serious health condition, or for the employee to provide care for, ~~and/or transport~~ a seriously ill spouse, son, daughter, ~~or~~ parent, or domestic partner. ~~to receive recurring necessary medical treatment (i.e. chemotherapy, prenatal visits, physical therapy, chiropractic care). Under such circumstances, the employee must try to schedule the leave so as not to~~

~~unduly disrupt the operation of the District. Furthermore, the District may place the employee in an alternative position, with equal pay and benefits, which better accommodates intermittent leave~~. Intermittent leave is not available to care for a newborn or ~~recently~~ newly placed adopted or foster child.

b. Employees needing intermittent or reduced schedule leave for foreseeable medical treatment must work with their director or supervisor to schedule the leave so as not to unduly disrupt the District's operations, subject to the approval of the employee's health care provider. Furthermore, the District may place the employee temporarily in an alternative position, with equal pay and benefits, which better accommodates the employee's intermittent or recurring periods of leave.

c. ~~The District shall require medical certification, signed by the employee's health care provider, when FMLA leave is requested for the serious health condition of the employee, or for a serious health condition of the employee's spouse, child or parent or domestic partner. Such certification shall state:~~

i. ~~The date on which the serious health condition commenced;~~

ii. ~~The probable duration of the condition;~~

iii. ~~The appropriate medical facts within the knowledge of the health care provider regarding the condition.~~

d. ~~Upon return from FMLA leave, the employee is entitled to be restored to the same position held prior to the leave or to an equivalent position with equivalent benefits, pay and other terms and conditions of employment. An employee whose FMLA leave was due to his/her own serious health condition must provide medical certification that he/she is fit for duty before returning to work.~~

9. Prohibition of Work on Leave. While on FMLA leave, an employee is prohibited from ~~engaging~~ working another job for money, barter or trade or on a voluntary basis, if the FMLA leave relates to the employee's serious health condition ~~in outside employment~~.

10. **Fraudulent Obtaining FMLA Leave.** An employee who fraudulently obtains FMLA leave is not protected by the FMLA's job restoration or maintenance of health benefits provisions and will be subject to termination.

11. **Requesting Family and Medical Leave** ~~PROCEDURE~~. An employee wishing to request leave under the FMLA shall submit ~~PBSD Form #1650(revised 3/5/98)~~ to the Office of Compensation and Human Resources Planning ~~Department of Employee Records and Information Services~~ one or more of the following:

a. **PBSD Form 2316** (FMLA Designation/Eligibility Notice), attached and incorporated hereto, is to be completed by the Office of Compensation and Human Resources. .

b. **PBSD Form 2312** (FMLA Health Care Provider for Employee's Serious Health Condition Certification), attached and incorporated hereto, must be completed for an eligible employee's request for FMLA related to the employee's serious health condition.

c. **PBSD Form 2313** (FMLA Health Care Provider for Family Member's Serious Health Condition Certification),attached and incorporated hereto, must be completed for an eligible employee's request for FMLA related to the employee's spouse, son, daughter, parent, or domestic partner's serious health condition.

d. **PBSD Form 2314** (FMLA Health Care Provider for a Covered Service member Certification). attached and incorporated hereto, must be completed for an eligible employee's request for a Military Caregiver Leave related to the serious illness or injury of the employee's spouse, son, daughter, parent, domestic partner, or next kin who is a covered service member.

e. **PBSD Form 2315** (FMLA Military Family Leave Qualifying Exigency Certification), attached and incorporated hereto, must be completed for an eligible employee's request Military Qualifying Exigency Leave due to the employee's spouse, son, daughter, parent or domestic partner is on active duty or has been notified of an impending call or order to active duty in the armed forces, National Guard or Reserves in support of a contingency operation.

12. **Posting of Notices.** The District shall conspicuously post the U.S. Department of Labor's FMLA poster explaining the provisions of the Family and Medical Leave Act in all areas where employees work, and place an electronic notice on the School District's website. The notice must be posted in areas visible to both employees and applicants for employment.

13. **Responsibilities.**

a. The superintendent or designee is responsible for:

i. Developing and disseminating administrative procedures related to this policy.

ii. Ensuring that the provisions of this policy are followed.

b. Employees are responsible for:

i. Notifying the principal, supervisor or responsible administrator of a need for a foreseeable FMLA leave with at least 30 days notice whenever possible, so as not to unduly disrupt the work unit's operations.

ii. Notifying the principal, supervisor or responsible administrator of an unforeseeable FMLA leave as provided herein.

iii. Providing the medical certification or other certifications required by law and/or this policy, including any additional requested information needed due to an incomplete or insufficient certification, to the Office of Compensation and Human Resources Planning within 15 calendar days to seek any FMLA leave.

iv. Providing any requested recertification or certification of fitness for duty in a timely manner.

v. Communicating with the Office of Compensation and Human Resources Planning and the employee's supervisor regarding the return to work or the medical necessity of additional leave beyond the granted 12 weeks, before the anticipated end date of a leave.

c. The Division of Human Resources, Office of Compensation and Human Resources Planning, is responsible for:

i. Administering this policy, including informing employees of FMLA leave provisions and requirements, and consulting with the employee's supervisor and Human Resources if the employee does not return requested certification forms or information in a timely manner.

ii. Providing notice to employees regarding the FMLA, including providing notice to the employee that the leave is or is not designated FMLA, as required by federal laws and regulations.

iii. Advising principals, supervisors and responsible administrators on FMLA leave management.

iv. Maintaining appropriate documentation in accord with the terms of this policy.

d. The Office of Risk and Benefits Management is responsible for:

i. Establishing a payment schedule for payment premiums, collecting the premiums and for sending notification of delinquent payments.

STATUTORY AUTHORITY: Fla. Stat. §§ 1001.41, 1001.42, 1001.43(6) ~~230.23(17); 230.23005~~
LAWS IMPLEMENTED: Fla. Stat. §§ Family Medical Leave Act of 1993, as amended in 2008, 29

U.S.C. § 2601 et seq., 29 Code of Federal Regulations Part 825; Public Law 110-181, Sec. 585(a), the National Defense Authorization Act for FY 2008, FY 2010

HISTORY: 2/17/99; __/___2011

Legal Signoff:

The Legal Department has reviewed proposed Policy 3.76 and finds it legally sufficient for development by the Board.

_____ _____

Attorney Date

THE SCHOOL DISTRICT OF PALM BEACH COUNTY

Family Medical Leave Act (FMLA) Designation Notice

You have requested a leave of absence and you may be eligible for the benefits under the Family Medical Leave Act (FMLA). This form is to advise you of your FMLA status. Read the information below. If additional information is needed please respond within the 15 days allotted. Failure on your part to respond may cause undue delay or ineligibility for the leave/FMLA.

SECTION I: FMLA Request

Employee Name _____ Employee ID # _____

School/Department _____ Date _____

This Family and Medical Leave of Absence is for the following qualifying reason:

☐ The birth of a child or placement of a child with you for adoption or foster care.

☐ Your own serious health condition.

☐ Because you are needed to care for your ☐ spouse ☐ child ☐ parent due to a serious health condition.

☐ Because of a qualifying exigency arising out of the fact that your ☐ spouse ☐ son or daughter ☐ parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves.

☐ Because you are the ☐ spouse ☐ son or daughter ☐ parent ☐ next of kin of a covered servicemember with a serious injury or illness (up to 26 weeks).

Anticipated date FMLA leave is to begin _____ end _____

SECTION II: Designation Notice

☐ **PENDING** - FMLA **pending** receipt of medical certification. **Certification due by** _____
If certification is not provided within the time allowed it may be denied.

☐ **GRANTED** - Certification was received and has been reviewed. Final approval is **granted**.

☐ **DENIED** - Leave of absence **denied** because:

- ☐ Employee has not been employed for 12 months .
- ☐ Employee has not worked 1250 actual work hours in past 12 months prior to this leave.
- ☐ Employee did not provide supporting certification.
- ☐ Employee's allotment of FMLA has been exhausted.

Be advised you will be required to present a full release certification from your physician to be restored to employment. If such certification is not timely received, your return to work may be delayed until certification is provided. Attached is the Employee Rights and Responsibilities handout from the U.S. Department of Labor.

Department Contact _____ Phone/PX Ext _____

_____ _____
Signature of Department Representative *Date*

THE SCHOOL DISTRICT OF PALM BEACH COUNTY

Family Medical Leave Act (FMLA)
Military Family Leave Qualifying Exigency Certification

PRINT OR TYPE

INSTRUCTIONS FOR EMPLOYEE: Complete the following fully and completely. The FMLA permits an employer to require that you submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a qualifying exigency. Several questions in this section seek a response as to the frequency or duration of the qualifying exigency. Be as specific as you can; terms such as **"unknown" or "indeterminate**" may not be sufficient to determine FMLA coverage. Your response is required to obtain a benefit, pursuant to 29 C.F.R. § 825.310. While you are not required to provide this information, failure to do so may result in a denial of your request for FMLA leave. Your employer must give you at least fifteen (15) calendar days to return this form to your employer.

Provide the name and employee ID number of the employee requesting leave to care for covered servicemember.

Employee Name _____ Employee ID # _____

Provide the information below of the servicemember for whom the employee is requesting leave to care for.

Service Member Name _____ ☐ Spouse ☐ Parent ☐ Son

Period of covered military member's active duty _____ ☐ Daughter ☐ Next of Kin

A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes written documentation confirming a covered military member's active duty or call to active duty status in support of a contingency operation. Check one of the following:

☐ A copy of the covered military member's active duty orders is attached.

☐ Other documentation from the military certifying that the covered military member is on active duty (or has been notified of an impending call to active duty) in support of a contingency operation is attached.

☐ I have previously provided my employer with sufficient written documentation confirming the covered military member's active duty or call to active duty status in support of contingency operation.

PART A: Employee Requesting Leave

1. Describe the reason you are requesting FMLA leave due to a qualifying exigency (include the specific reason for your leave request). _____

2. A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes any available written documentation which supports the need for leave. Such documentation may include a copy of a meeting announcement for informational briefings sponsored by the military, a document confirming an appointment with a counselor or school official, or a copy of a bill for services for the handling of legal or financial affairs. Is written documentation supporting this request for leave attached?

☐ Yes ☐ No ☐ None Available

PART B: Amount of Leave Needed

1. Approximate date exigency commenced _____

   Probable duration of exigency _____

2. Will you need to be absent from work for a single continuous period of time due to the qualifying exigency?

   ☐ Yes ☐ No If yes, estimate the beginning and ending dates for the period of absence:

   Beginning _____ Ending _____

3. Will you need to be absent from work periodically to address this qualifying exigency? ☐ Yes ☐ No

   Estimate schedule of leave, including the dates of any scheduled meetings or appointments.

   _____

   Estimate the frequency and duration of each appointment, meeting, or leave event, including any travel time (i.e., 1 deployment-related meeting every month lasting four (4) hours):

   Frequency _____ Times per: week(s) _____ month(s) _____

   Duration _____ hours(s) _____ day(s) per event _____

PART C: Leave to Meet with Third Party ☐ Not applicable

If leave is requested to meet with a third party (such as to arrange for childcare; to attend counseling; to attend meetings with school or childcare providers; to make financial or legal arrangements; to act as the covered military member's representative before a federal, state, or local agency for purposes of obtaining, arranging or appealing military service benefits; or to attend any event sponsored by the military or military service organizations), a complete and sufficient certification includes the name, address, and appropriate contact information of the individual or entity with whom you are meeting (i.e., either the telephone or fax number or E-mail address of the individual or entity). This information may be used by your employer to verify that the information contained on this form is accurate.

Name of Individual _____ Title _____

Organization _____

Address _____

Telephone _____ Fax _____

E-mail Address _____

Describe nature of meeting _____

_____

_____

_____

PART D: Signature

I certify that the information I provided above is true and correct.

_____ _____

Signature of Employee *Date*

THE SCHOOL DISTRICT OF PALM BEACH COUNTY

Family Medical Leave Act (FMLA)
Health Care Provider for a
Covered Servicemember Certification

SECTION I: For completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the employee is requesting leave: (This section must be completed before any of the below sections can be completed by a health care provider.)

PART A: EMPLOYEE INFORMATION

Name and address of employer (this is the employer of the individual requesting leave to care for a covered servicemember): **The School District of Palm Beach County**
Compensation and HR Planning
3300 Forest Hill Blvd., A-115
West Palm Beach, FL 33406

Provide name and ID number of employee requesting leave to care for a covered servicemember.

Employee Name _____ Employee ID # _____

Provide name of covered servicemember for whom the employee is requesting leave to care for.

Covered Servicemember Name _____

Relationship of Employee to Covered Servicemember:

☐ Spouse ☐ Parent ☐ Son ☐ Daughter ☐ Next of Kin

PART B: COVERED SERVICEMEMEBER INFORMATION

1. Is the covered servicemember a current member of the regular Armed Forces, the National Guard or Reserves?

☐ Yes ☐ No If yes, provide the covered servicemember's military branch, rank, and unit currently assigned.

_____

Is the covered servicemember assigned to a military medical treatment facility as an outpatient or to a unit established for the purpose of providing command and control of members of the Armed Forces who are receiving medical care as outpatients (such as a medical hold or warrior transition unit)? ☐ Yes ☐ No If yes, provide the name of the medical treatment facility or unit. _____

2. Is the covered servicemember on the Temporary Disability Retired List (TDRL)? ☐ Yes ☐ No

PART C: CARE TO BE PROVIDED TO THE COVERED SERVICEMEMBER

Describe the care to be provided to the covered servicemember and an estimate of the leave duration needed to provide care.

_____

_____

SECTION II: For completion by a United States Department of Defense ("DOD") Health Care Provider or a Health Care Provider who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider. If you are unable to make certain of the military-related determinations contained below in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator). (Section I above **must be** completed before completing this section.) **Be sure to sign the form on the last page.**

PART A: HEALTH CARE PROVIDER INFORMATION

Type of Practice/Medical Specialty _____

Health Care Provider _____ Fax # _____

Telephone # _____ E-mail Address _____

Health Care Provider Business Address _____

PART B: MEDICAL STATUS

1. Covered servicemember's medical condition is classified as (check **one** of the appropriate boxes):

☐ **(VSI) Very Seriously Ill/Injured -** Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately. (Note this is an internal DOD casualty assistance designation used by DOD health care providers.)

☐ **(SI) Seriously Ill/Injured** - Illness/Injury is of such severity that there is cause for immediate concern, but there is no imminent danger to life. Family members are requested at bedside. (Note this is an internal DOD casualty assistance designation used by DOD health care providers.)

☐ **OTHER Ill/Injured** - A serious injury or illness that may render the servicemember medically unfit to perform the duties of the member's office, grade, rank, or rating.

☐ **NONE OF THE ABOVE** (Note to Employee: If this box is checked, you may still be eligible to take leave to care for a covered family member with a "serious health condition" under § 825.113 of the FMLA. If such leave is requested, you may be required to complete a FMLA Health Care Provider for Family Member's Serious Health Condition Certification (PBSD 2313) form.

2. Was the condition for which the covered servicemember is being treated incurred in the line of duty on active duty in the Armed Forces? ☐ Yes ☐ No

3. Approximate date condition commenced _____

4. Probable duration of condition and/or need for care _____

5. Is the covered servicemember undergoing medical treatment, recuperation, or therapy? ☐ Yes ☐ No

If yes, describe medical treatment, recuperation or therapy _____

_____

PART C: COVERED SERVICEMEMBER'S NEED FOR CARE BY FAMILY MEMBER

1. Will the covered servicemember need care for a single continuous period of time, including any time for treatment and recovery? ☐ Yes ☐ No

If yes, estimate the beginning and ending dates for this period of time _____

2. Will the covered servicemember require periodic follow-up treatment appointments? ☐ Yes ☐ No

If yes, estimate the treatment schedule _____

3. Is there a medical necessity for the covered servicemember to have periodic care for these follow-up treatment appointments? ☐ Yes ☐ No

4. Is there a medical necessity for the covered servicemember to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)? ☐ Yes ☐ No

If yes, estimate the frequency and duration of the periodic care _____

_____ _____

Signature of Health Care Provider *Date*

THE SCHOOL DISTRICT OF PALM BEACH COUNTY

Family Medical Leave Act (FMLA)
Health Care Provider for Family Member's Serious Health Condition Certification

PRINT OR TYPE

INSTRUCTIONS FOR EMPLOYEE: Complete the following questions 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, pursuant to 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**, pursuant to 29 C. F. R. §825.313. Your employer must give you at least fifteen (15) calendar days to return this form to your employer, pursuant to 29 C.F.R. § 825.305.

Employee name _____ Employee ID # _____

Family Member for Whom You Will Provide Care _____

Relationship of Family Member to You _____

If the family member is your son or daughter, provide date of birth. _____

Describe care you will provide to your family member and estimate leave time needed to provide care. _____

_____

_____ _____

Signature of Employee *Date*

INSTRUCTIONS TO THE HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. 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 patient's family member is seeking leave. Page Two (2) provides space for additional information, should you need it. **Be sure to sign the form on page 2.** Provide original to employee.

Health Care Provider _____

Type of Practice/Medical Specialty _____

Health Care Provider Business Address _____

Telephone # _____ Fax # _____

PART A: MEDICAL FACTS

1. Approximate date condition commenced _____

Probable duration of condition _____ Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ☐ Yes ☐ No

If yes, dates of admissions _____

Date(s) you treated the patient's condition _____

Was medication, other than over-the-counter medication, prescribed? ☐ Yes ☐ No

Will the patient need to have treatment visits at least twice per year due to the condition? ☐ Yes ☐ No

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?

☐ Yes ☐ No If yes, state the nature of such treatment and **expected duration of treatment.** _____

_____

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

3. Describe the serious medical condition for which the employee seeks leave to care for an immediate family member. _____

_____

_____

PART B: AMOUNT OF CARE NEEDED

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.

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

   Estimate the beginning (date) _____ and ending (date) _____ dates for the period of incapacity (If leave estimated end date cannot be determined provide us the date of the next evaluation.)

5. Will the patient require follow-up treatments, including any time for recovery? ☐ Yes ☐ No

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period. _____

   _____

6. Will the patient require care on an **intermittent** or **reduced scheduled** basis, including any time for recovery?

   ☐ Yes ☐ No Estimate the hours the patient needs care on an **intermittent** basis, if any:

   hour(s) per day _____ days per week _____ from (date) _____ through (date) _____

   Explain the care needed by the patient, and why such care is medically necessary. _____

   _____

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities ? ☐ Yes ☐ No 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 incur over the next six (6) months (e.g., 1 episode every 3 months lasting 1-2 days):

   Frequency: _____ time per _____ week(s) _____ month(s)

   Duration: _____ hours _____ day(s) per episode

   Does the patient need care during these flare-ups? ☐ Yes ☐ No

   Explain the care needed by the patient, and why such care is medically necessary. _____

   _____

8. **ADDITIONAL INFORMATION**: Identify question number with your additional answer.

   _____

   _____

_____ _____

Signature of Health Care Provider *Date*

THE SCHOOL DISTRICT OF PALM BEACH COUNTY

Family Medical Leave Act (FMLA)
Health Care Provider for Employee's
Serious Health Condition Certification

PRINT OR TYPE

INSTRUCTIONS FOR EMPLOYEE: Complete the following questions 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, pursuant to 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**, pursuant to 29 C. F. R. §825.313. Your employer must give you at least fifteen (15) calendar days to return this form, pursuant to 29 C.F.R. § 825.305(b).

Employee Name _____ Employee ID # _____

Employee Work Location _____

Employee Job Title _____

_____ _____

Signature of Employee *Date*

INSTRUCTIONS TO THE HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts listed below. 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. Page two (2) provides space for additional information, should you need it. **Be sure to sign the form on page 2.**

Health Care Provider _____

Type of Practice/Medical Specialty _____

Health Care Provider Business Address _____

Telephone # _____ Fax # _____

PART A: MEDICAL FACTS

1. Approximate date condition commenced _____

Probable duration of condition _____ Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ☐ Yes ☐ No

If yes, dates of admissions _____

Date(s) you treated the patient's condition _____

Will the patient need to have treatment visits at least twice per year due to the condition? ☐ Yes ☐ No

Was medication, other than over-the-counter medication, prescribed? ☐ Yes ☐ No

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?

☐ Yes ☐ No If yes, state the nature of such treatment and **expected duration of treatment.** _____

_____

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

3. Use the information provided by the employee in Section 1 to answer this question. If the employee's essential job functions or job description is not provided, answer these questions based upon the employee's own description of his/her functions.

   Is the employee unable to perform any of his/her job functions due to the condition? ☐ Yes ☐ No

   If so, identify the job functions the employee is unable to perform. _____

   _____

4. Describe the serious medical condition for which the employee seeks leave.

   _____

   _____

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to the medical condition, including any time for treatment and recovery? ☐ Yes ☐ No

   Estimate the beginning (date) _____ and ending (date) _____ dates for the period of incapacity.

   (If leave estimated end date cannot be determined provide us the date of the next evaluation.)

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? ☐ Yes ☐ No

   If yes, are the treatments or the reduced number of hours of work medically necessary? ☐ Yes ☐ No

   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 (date) _____ through (date) _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing required job functions ? ☐ Yes ☐ No

   Is it medically necessary for the employee to be absent from work during the flare-ups? ☐ Yes ☐ No

   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 incur over the next six (6) months (e.g., episode every three (3) months lasting 1-2 days):

   Frequency: time per week(s) _____ times per month(s) _____

   Duration: hours _____ day(s) per episode _____

8. **ADDITIONAL INFORMATION**: Identify question number with your additional answer.

   _____

   _____

   _____

_____ _____

Signature of Health Care Provider *Date*

UNIVERSITY OF MINNESOTA

Family and Medical Leave Act (FMLA): Certification for Birth/Care of Newborn

Route this form to:	U Wide Form UM 1602
Supervisor/responsible administrator	Rev: Mar 2009

NOTE: Failure to fully complete this form could result in an initial denial of an FMLA leave or a delay in approval of an FMLA leave for the employee. Where the need for leave is foreseeable, such as for an expected birth, an employee provides at least 30 days advance notice of the need for leave to the supervisor/responsible administrator whenever possible. This information includes the anticipated timing and duration of the leave.

SECTION I: For Completion by the SUPERVISOR/RESPONSIBLE ADMINISTRATOR OR EMPLOYEE

INSTRUCTIONS: 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 birth to submit a medical certification issued by the health care provider. Ensure that Sections I and II are completed before giving this form to the health care provider.

Employer name including department/unit:	
Supervisor/Responsible administrator name:	
Employee's job title:	Employee's regular work schedule:

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS: Ensure that Sections I and II are complete before giving this form to the health care provider. By signing this form, you represent that the information you provided is true and correct. Unless advised otherwise in writing, you have 15 calendar days to return this form to your supervisor/responsible administrator.

Employee's name:	☐ Birth mother ☐ Birth father ☐ Registered same-sex domestic partner
Length of time requested for leave for birth and/or care of newborn:	
Signature of employee:	Date signed:

SECTION III: For Completion by the HEALTHCARE PROVIDER

INSTRUCTIONS: Please provide the following information and be sure to sign the form.

Provider's name and business address:	
Type of practice/medical specialty:	(Anticipated) date of birth:
Telephone (with area code):	Fax (with area code):
Signature of Authorized Health Care Provider:	Date signed:

UNIVERSITY OF MINNESOTA

Family and Medical Leave Act (FMLA): Certification of Adoption or Foster Care Placement

Route this form to:	U Wide Form UM 1603
Supervisor/responsible administrator	Rev: Mar 2009

NOTE: Failure ***to fully complete this form could result in an initial denial of an FMLA leave or a delay in approval of an FMLA leave for the employee.*** *Where the need for leave is foreseeable, such as for an expected adoption or foster care placement, an employee provides at least 30 days advance notice of the need for leave to the supervisor/responsible administrator whenever possible. This information includes the anticipated timing and duration of the leave.*

SECTION I: For Completion by the SUPERVISOR/RESPONSIBLE ADMINISTRATOR OR EMPLOYEE

INSTRUCTIONS: Ensure that Sections I and II are completed before giving this form to the professional/agency.

Employer name including department/unit:	
Supervisor/Responsible administrator name:	
Employee's job title:	Employee's regular work schedule:

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS: Ensure that Sections I and II are completed before giving this form to the professional/agency. By signing this form, you represent that the information you provided is true and correct. Unless advised otherwise in writing, you have 15 calendar days to return this form to your supervisor/responsible administrator.

Employee's name:	Qualifying event: ☐ Adoption ☐ Foster care placement
Length of time requested for leave:	
Signature of employee	Date signed:

SECTION III: For Completion by the PROFESSIONAL/AGENCY

INSTRUCTIONS: Please provide the following information and be sure to sign the form representing that the information provided is accurate.

Professional/agency name, including contact and business address:	
Actual or anticipated date of placement:	
Telephone (with area code):	Fax (with area code):
Signature of professional/agency official:	Date signed: