Family and Medical Leave Act (FMLA)

Please read carefully

The Family and Medical Leave Act of 1993 requires the Butts County Schools to provide up to sixty (60) days of unpaid, job-protected leave during a 12-month period for certain family and medical reasons. All employees of Butts County Schools that are full time employees and have been working for the system longer than 12 months (1,250 hours) within Butts County Schools are eligible for FMLA leave. FMLA provides that if the employee returns to work prior to or on the first scheduled day following the 60th approved FMLA day, the employee will be reinstated to the same job or an equivalent job with the same pay, benefits, and terms and conditions of employment. FMLA also provides attendance protection for approved FMLA leave. The FMLA attendance, job, and benefit protection is also exhausted with the 60 FMLA day maximum.

There are two types of FMLA:

- Block FMLA – Consecutive days of leave.
- Intermittent FMLA – Leave taken on a sporadic basis (partial days, one day at a time, etc.).

The following reasons qualify for Family and Medical Leave:

- For the employee's own qualifying serious health condition* that makes the employee unable to perform the functions of the employee's job, including incapacity due to pregnancy and for prenatal medical care.
- To care for the employee's qualified family member** with a serious health condition* including incapacity due to pregnancy and for prenatal medical care.
    - Note: FMLA approval ends when the family member's condition no longer requires the employee to provide care. It is the employee's responsibility to notify the HR Department and the employee's supervisor when such change occurs.
- The birth of a child or placement of a child for adoption or foster care to the employee:
    - The first year care of an employee's child and/or within one year of placement of child with employee.
    - To bond with a child (Block FMLA leave must be taken within 1 year of the child's birth or placement).
- Any period of incapacity or treatment for a chronic serious health condition* of an employee (or qualified family member that requires the employee's care) which continues over an extended period of time, requires periodic visits (at least twice a year) to a health care provider and may involve occasional episodes of incapacity (Intermittent FMLA).
- Military Family Leave Entitlements – Eligible employees whose spouse, son, daughter or parent is a member of the Armed Forces (including the National Guard and Reserves) and on covered active duty or called to covered active duty status may use their 12-week (60 days) 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 can also be provided to spend up to 15 calendar days with a military member who is on rest and recuperation leave.
- FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness*; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran. An eligible employee is limited to

a combined total of 26 workweeks of leave for any FMLA–qualifying reasons during the single 12-month period.

*The FMLA definitions of "serious injury or illness" for current service members and veterans are distinct from the FMLA definition of "serious health condition". (Contact the HR Department for details.)

*SERIOUS HEALTH CONDITION:

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either:

- Any period of incapacity or treatment connected with inpatient care (an overnight stay) in a hospital, hospice, or residential medical care facility; or
- A period of incapacity lasting more than three consecutive, full calendar days, and requiring ongoing medical treatment (either multiple appointments with a health care provider, or a single appointment and follow-up care such as prescription medication); or
- Any period of incapacity related to a pregnancy or prenatal care; or
- Any period of incapacity that 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 (Alzheimer's Syndrome, stroke, terminal diseases); or
- Any period of incapacity or treatment for a chronic serious health condition; or
- Any absences to receive multiple treatments for, by, or on referral from a health care provider for a condition that would likely result in incapacity for three or more days if left untreated (chemotherapy, physical therapy, dialysis).
    - NOTE: FMLA does not apply to routine medical examinations, such as a physical, or common medical conditions, such as an upset stomach, unless complications develop.

A Chronic Serious Health Condition is defined as one that (1) requires "periodic visits" (at least twice a year) for treatment by a health care provider or nurse under the supervision of a health care provider, (2) recurs over an extended period of time, and (3) may cause episodic rather than continuing periods of incapacity.

NOTE: If your leave is due to something other than the previously listed condition/reasons, your request must also be processed through our Human Resource Services-HR Department.

** QUALIFYING FAMILY MEMBER:

The form "Employee Statement of Family Relationship for FMLA Leave" must be completed by the employee and included in the FMLA application submitted to the HR Department.

- Child (biological, adoptive, step or foster children, legal ward, or a child of a person standing in loco parentis).
    - Note: Child must be either under age 18; or,
    - Age 18 or older and have a disability as defined by the Americans with Disability Act (ADA) at the time FMLA leave is to commence and, be incapable of self-care because of a mental or physical disability and, have serious health condition, and need care because of the serious health condition.

  NOTE: If child is over age 18, the form "Adult Child Disability Medical Inquiry for FMLA" (page 9) must be completed by the child's health care provider and included in FMLA application submitted to the HR Department.
- Parent (biological, adoptive, step or foster father or mother, or any other individual who stood in loco parentis to the employee when the employee was a child). This term does not include parents "in law".
- Spouse
- For purposes of military caregiver leave under FMLA, next of kin of a covered service member means the nearest blood relative other than the covered service member's spouse, parent, son or daughter in the following order of priority: Blood relatives who have been granted legal custody of the covered service member by court decree or statutory provisions, brothers and sisters, grandparents, aunts and uncles, and first cousins

unless the covered service member has specifically designated in writing another blood relative as his or her nearest blood relative for purposes of military caregiver leave under the FMLA.

- Note: In-laws, grandparents, siblings and other extended family members are NOT covered by FMLA.

WHEN DO I NEED TO REQUEST FMLA?

If you meet one of the aforementioned qualifications, you may apply for FMLA. If you expect to be out of work for 10 days or longer, you **must** apply for FMLA. If you incur 10 days of leave (cumulative and/or consecutive) you **must** apply for FMLA. A 30-day notice of pending leave is required when the leave is foreseeable. In any event, written notice in the form of this application should be submitted by you as soon as possible. Failure to submit a completed FMLA application (including supporting documentation such as medical certification) within 15 days of absence could result in automatic denial of FMLA and possible employment action.

NOTE: Excessive absences (consecutive and/or cumulative) not covered by FMLA can result in an attendance/performance issue and possible employment action.

WHAT ARE THE STEPS TO BE TAKEN?

1) Consult with your health care provider about the number of days you must be absent. A signed statement from the health care provider is required for illness or birth of a child.
2) Discuss the leave with your principal or local supervisor. The department/school protocol concerning and including reporting out must always be followed.
3) Complete the FMLA application –The form (completed by employee) must include anticipated beginning and ending date (or anticipated duration) of FMLA Leave.
4) Include medical certification and/or other required documents supporting your reason for FMLA.
5) All completed forms must be submitted to the Human Resources Department.
6) Provide (upon request from the HR Department) certification updates and intent to return to work.
7) It is the employee's responsibility to ensure the supervisor/principal and leave-entry-person are aware of leave dates and details and return to work date.
8) Prior to returning to active employment, you must provide written certification from your physician regarding your release to return to work. Your return to work is dependent upon receipt of this documentation. The HR Department will provide to you a copy of your job description for your treating physician to review and complete the bottom portion concerning release to return to work. You should provide notification of at least two workdays prior to the date you intend to report for work.

It is the employee's responsibility to ensure the FMLA application guidelines are followed.

HOW MUCH LEAVE CAN BE TAKEN?

Under FMLA, the maximum is 60 days in a 12-month period. The 60 days in a 12-month period will be measured from the first date FMLA leave is used. An employee can apply and be approved for FMLA due to multiple reasons; however, the combination for all reasons cannot exceed 60 FMLA days per FMLA year.

- If the FMLA leave is for a serious health condition, the dates provided by the health care provider will be used to approve FMLA leave (up to 60 FMLA days per FMLA Year). You cannot request additional time unless ordered by your health care provider. However, for the birth of a child, you may request additional time for the care of your child during his/her first year (or bonding time). Recovery plus Bonding Time cannot exceed 60 FMLA days per FMLA Year.
- Time off due to a Workers' Compensation injury will be counted as FMLA time (not to exceed 60 FMLA days per FMLA Year).
- **Please remember that 60 days per FMLA Year is the maximum allowed.**

Note: (The special FMLA Leave entitlement to care for a covered military service member is an exception.)

If the employee and the employee's spouse work for the school system, each is entitled to 60 days for their own illness or the illness of a child. However, the 60 days must be split between them if it is to care for a parent, or for the first year care or bonding time with a newborn child or the newly placed child with the employees (adoption or foster care)**.**

INTERMITTENT FMLA IS APPROVED…WHAT MUST I DO NEXT?

Upon approval of Intermittent FMLA:

- You must always follow your school/department's protocol concerning reporting your absence from work.
- When possible, you should provide to your principal/supervisor advance notice of any absences (partial days, etc.); and, coordinate your return to work date (in advance) with your principal/supervisor.
- In order for your intermittent leave to be covered by FMLA, you must notify the Human Resources Department of leave dates that are related to the FMLA approved reason. Notification can be done via email to brentius.watts@bcssk12.org or williamsm@bcssk12.org or via note faxed to the HR Department (770.504.2305) or via note sent through interoffice school mail addressed to Human Resource Department, Central Office. Please provide your name and employee number and the date leave is taken due to the FMLA approved reason. Notification should be made within 15 days of the leave/absence. Failure to provide notification within the designated time will result in automatic denial of FMLA coverage for that specific leave/absence.

DO I TAKE PAID LEAVE OR UNPAID LEAVE?

The employee is required (during FMLA) to use all paid leave, (sick/personal and/or vacation) available to him/her. At the time paid leave is exhausted, Leave-Without-Pay (LWOP) will be entered. Please keep in mind the cut off dates for payroll. As an example, it is possible that an employee will begin LWOP on February 10th but will not see the effects of it until the March paycheck. For each day that you do not have paid leave, your pay will be reduced by your daily rate of pay. To find the daily rate for a 10 month employee use the following formula: annual salary ÷ 190 = daily rate.

DO MY BENEFITS CONTINUE UNDER FMLA LEAVE?

When you are receiving a paycheck with sufficient funds, benefit deductions continue. When paid leave is exhausted and the funds are not sufficient, you are required to pay for your benefits to avoid loss of coverage. Please contact Janet Dahlin, Payroll Specialist (dahlinj@bcssk12.org) for guidance.
Note: Failure to remit timely premiums will result in immediate loss of coverage. It is the employee's responsibility to ensure payments are received timely.

WHAT IF I HAVE A SECONDARY JOB WITH BUTTS COUNTY SCHOOLS?

Employees that have a full time job with Butts County Schools and work a secondary job with Butts County Schools (such as "After School Enrichment Program") and must take FMLA from their full time job are required to:

- Notify their secondary job supervisor of their FMLA status and
- Notify the HR Department of their secondary job with Butts County Schools

WHAT IF I NEED TO EXTEND MY FMLA?

If the period of leave needs to be extended beyond the original approved period (within the 60 FMLA day maximum), the employee should notify their principal/supervisor as soon as possible and request said extension in writing prior to the last day of approved leave. Employees should direct the request to the Human Resources Department for approval. A medical update from the attending physician/provider must be provided if leave is for a serious health condition. Medical documentation must be kept current during leave of absence.

WHAT IF MY DISABILITY LASTS BEYOND THE 60 FMLA DAY MAXIMUM?

The FMLA provided attendance, job and benefit protection is also exhausted with the 60 FMLA day maximum. If you are not able to return to work prior to or on the first scheduled day immediately following the 60th approved FMLA day and the reason is due to your (the employee's) serious health condition, you may qualify for Approved Extended Leave (AEL). With the appropriate medical documentation, AEL will enable you to continue your benefits. Medical documentation must be kept current during leave of absence. Contact the Human Resources Department for more details. **Note: Failure to remit timely premiums will result in immediate loss of coverage and possible termination of leave.**

If your leave extends beyond the end of your 60-day FMLA entitlement, you do not have return-to-work rights under FMLA.

Certified employees who are unable to return to work prior to or on the first scheduled work day following the 60th FMLA day may or may not be recommended for a contract for the next school year.

WHAT DO I NEED TO DO TO RETURN FROM FMLA?

If the leave was due to a serious health condition of the employee, written certification from the treating health care provider addressing release to return to work (listing any specific restrictions and/or request for accommodations described in detail) must be submitted to the Human Resource Services-HR Department. The employee's return to work is dependent upon receipt of this documentation. This must be done at least two work days prior to or on the first day of return to work.

Any restrictions and/or requests for accommodations must be reviewed to determine if work is available to reasonably accommodate. If no work is available to reasonably accommodate, approved FMLA will continue (up to 60 FMLA days per FMLA Year) and possibly Approved Extended Leave (AEL) as a means of accommodation.

The employee must always coordinate/confirm return to work (in advance) with their principal/supervisor.

RESTRICTIONS AND/OR REQUEST FOR ACCOMMODATIONS:

Employees are expected to perform the full duties of their job until medical documentation signed by a health care provider is submitted to the employee's principal/supervisor or HR Department.

The medical documentation listing the specific restrictions/request for accommodations described in detail must be submitted to Human Resources Department for review to determine if work is available to reasonably accommodate.

- If there is no work available to reasonably accommodate, the employee may be placed on FMLA (not to exceed the 60 FMLA day maximum per FMLA Year) as a means of reasonably accommodation.
- If the leave extends beyond the 60 FMLA day maximum, Approved Extended Leave (AEL) will be considered.

Application for FMLA (and certification updates) should be provided to the following address:

Butts County Schools
Att: Human Resources
181 North Mulberry Street
Jackson, GA 30233
Fax 770.504.2305
Scanned copy sent via email to
brentius.watts@bcssk12.org or williamsm@bcssk12.org

Upon receipt of the FMLA request, a notification letter will be forwarded to the employee.

NOTE: To avoid pay discrepancies, please ensure the appropriate leave forms are completed and submitted at your work location as soon as possible. Upon return to work, the employee should notify the HR Department of their return to work date. This can be done by telephone (770.504.2300) or email brentius.watts@bcssk12.org or williamsm@bcssk12.org or a note sent via school mail to the HR Department.

Additional FMLA Application packages can be obtained from the Butts County Schools Web site (www.butts.k12.ga.us select Departments>Human Resource Services>Employee Information>FMLA) or upon request from your school or the Human Resources Department.

If you have any questions regarding FMLA, please contact the Human Resources Department.

REQEST FOR FAMILY and MEDICAL LEAVE ACT (FMLA) LEAVE

(This form should be completed by employee requesting FMLA)

Employee's Name: _____ **Employee Number**: _____

Position: _____ **School/Location:**_____

Home Address: _____ **Phone Number**: _____

City/State/Zip: _____

If you are married, is your spouse employed by BCSS? __No __Yes

If yes, Spouse's Name and Employee #: _____

TYPE OF FMLA REQUESTED: ☐**Block** *(consecutive days)* ☐**Intermittent** (*sporadic leave i.e. partial days, etc.)*

I am requesting Family and Medical Leave for the following dates (maximum of 60 days per FMLA Year)

_____ _____ _____

Beginning Date **Ending Date** **Anticipated Return to Work Date**

Prior to processing request, employee must provide anticipated (estimated) leave dates as requested above.

LEAVE IS REQUIRED FOR:

A. Serious Health Condition of: *Medical documentation certifying need for leave must be provided within 15 days .*

Check one:

___ **Employee** (Submit page 10-14)

OR

___ **Spouse (***name)*_____OR

___ **Parent** (name) _____OR

___ **Child** *(name)*_____

Child's age _____ *If child is 18 or older, submit page 9

**For family member submit pages 8 and 14-17*

B. ____ Birth of child (Medical documentation certifying need for leave must be provided within 15 days.

OR

(***Must *provide supporting documentation)*

___ ***Adoption of a Child**

___ ***Placement of a Child**

Date (or expected date) of birth, adoption, or placement of a foster child: _____

(Date)

C. Military: *Contact HR Department (address and number below) for appropriate request forms.*

___ Qualifying Exigency – *Provide supporting documentation (i.e., copy of official orders, etc.)*

___ To care for a covered service member with qualified serious injury or illness (up to 26 weeks in a single 12-month period) (*Appropriate medical certification required*).

Attach verification/certification from a certified health care provider (addressing the Serious Health Condition of the employee or employee's qualified family member). Medical certification must include the following:

1. Medical certification substantiating a serious health condition that requires FMLA due to the employee's inability to work or required to care for a qualified family member
2. The beginning and estimated ending date of employee's need for leave (or estimated duration of FMLA leave)
3. Confirm there is a regimen of treatment
4. Health care provider's signature

Signature of Employee: _____ Date: _____

Return complete FMLA application to:
Butts County Schools
Human Resources Department
181 North Mulberry Street
Jackson, GA 30233
Fax: 770-504-2305
Email: brentius.watts@bcssk12.org or williamsm@bcssk12.org

Employee Statement of Family Relationship for FMLA Leave

This form required ONLY if FMLA request is to care for a family member.
To be completed by employee.

In order to approve your request for leave to be covered under FMLA, Butts County Schools is requesting information of your relationship to the individual for whom you will be caring. Please complete this form and attach relevant documentation as necessary. Return the completed form as a part of the FMLA application package.

Employee Name: _____ Employee Number: _____

Reason for FMLA Leave is to care for the family member as follows:

Family Member's Name: _____

Relationship to Employee: _____

If the family member is the Employee's Child:

Child's birthdate: _____ Age: _____

Family members covered under FMLA include:

- Child (biological, adoptive, step or foster children, legal ward, or a child of a person standing in loco parentis).
    - Note: Child must be either under age 18; or, age 18 or older and 'incapable of self-care because of a mental or physical disability" at the time that FMLA leave is to commence.
        - If child is 18 years or older, the form "Adult Child Disability Medical Inquiry for FMLA" must be completed and submitted to the FMLA office.
- Parent (biological, adoptive, step or foster father or mother, or any other individual who stood in loco parentis to the employee when the employee was a child).
- Spouse
- For purposes of military caregiver leave under FMLA, next of kin of a covered service member means the nearest blood relative other than the covered service member's spouse, parent, son or daughter in the following order of priority: Blood relatives who have been granted legal custody of the covered service member by court decree or statutory provisions, brothers and sisters, grandparents, aunts and uncles, and first cousins unless the covered service member has specifically designated in writing another blood relative as his or her nearest blood relative for purposes of military caregiver leave under the FMLA.

Note: In-laws, grandparents, siblings and other extended family members are NOT covered by FMLA.

I certify that the family member for whom I need to provide care (for a serious health condition under the FMLA) is a covered family member as defined above.

Employee Name:_____

Employee Signature:_____

Date: _____

Adult Child Disability Medical Inquiry for FMLA

This form required ONLY if employee is requesting FMLA to care for child 18 years of age or older.

To approve your request for FMLA leave to care for an adult child, Butts County Schools is requesting medical information and documentation to determine if the adult child has a disability as defined by the Americans with Disabilities Act (ADA) and amendments. Please have the adult child's medical care provider complete this form. Return the completed form to the Butts County Schools with the medical certification of your qualified family member's serious health condition.

This section to be completed by Employee:

Employee Name (print):_____Employee Number: _____

Name of Adult Child (Patient): _____Date of Birth:_____

Employee Signature: _____ Date: _____

To be completed by Adult Child's Health Care Provider:

A parent will be entitled to take FMLA leave to care for a son or daughter 18 years of age or older, if the adult son or daughter:

- *has a disability as defined by the ADA;*
- *is incapable of self-care due to that disability;*
- *has a serious health condition; and*
- *is in need of care due to the serious health condition.*

It is only when all four requirements are met that an eligible employee is entitled to FMLA–protected leave to care for his or her adult son or daughter.

1. Does the adult child have a disability as defined by the ADA? Defined as a physical or mental impairment that substantially limits one or more of the major life activities of an individual? Yes ____ No ____

2. Can you confirm that the daughter's or son's disability causes them to be "incapable of self-care" in at least three "daily living activities" (please identify) listed below? Yes _____ No _____

Please check applicable activities:

___ Grooming and hygiene.
___ Bathing and dressing.
___ Feeding and eating.
___ Cooking and preparing meals.
___ Cleaning of dishes and of clothing.
___ Shopping for normal basic living.
___ Taking public transportation.
___ Paying bills, using a bank and post office.
___ Helping to maintain a residence.
___ Other (please specify) _____

3. What is the probable duration of the disability? _____
4. What is the probable duration of the serious health condition requiring FMLA?

_____

5. Describe any other relevant facts, if any, related to the child's care:

_____

Health Care Provider's Signature: _____ Date: _____

Health Care Provider's Printed Name: _____

Treating Health Care Provider's Address: _____ Phone: _____

Return application to:
Butts County Schools Human Resources
Fax: 770-504-2305
Email: brentius.watts@bcssk12.org or williamsm@bcssk12.org

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

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: _____ 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.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 15 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

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

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

U.S. Department of Labor
Wage Hour Division

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 leave to care for a family member with a serious health condition to submit a medical certification issued by the family member'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 or employees' family members 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: _____ 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.)

SECTION II - EMPLOYEE

Please complete and sign Section II before providing this form to your family member or your family member's health care provider. The FMLA allows an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of your family member. If requested by your employer, your response is required to obtain or retain the benefit of the FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). **You are responsible for making sure the medical certification is provided to your employer within the time frame requested, which must be at least 15 calendar days.** 29 C.F.R. §§ 825.305-825.306. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA leave request. 29 C.F.R. § 825.313.

(1) Name of the family member for whom you will provide care: _____

(2) Select the relationship of the family member to you. The family member is your:

☐ Spouse ☐ Parent ☐ Child, under age 18
☐ Child, age 18 or older and incapable of self-care because of a mental or physical disability

Spouse means a husband or wife as defined or recognized in the state where the individual was married, including in a common law marriage or same-sex marriage. The terms "child" and "parent" include *in loco parentis* relationships in which a person assumes the obligations of a parent to a child. An employee may take FMLA leave to care for an individual who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave to care for a child for whom the employee has assumed the obligations of a parent. No legal or biological relationship is necessary.

Employee Name: _____

(3) Briefly describe the care you will provide to your family member: (*Check all that apply)*

☐ Assistance with basic medical, hygienic, nutritional, or safety needs ☐ Transportation

☐ Physical Care ☐ Psychological Comfort ☐ Other: _____

(4) Give your **best estimate** of the amount of leave needed to provide the care described: _____

_____

(5) If a **reduced work schedule** is necessary to provide the care described, give your **best estimate** of the reduced schedule you are able to work. From _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy),* I am able to work _____ (*hours per day*) _____ (*days per week).*

Employee Signature _____ **Date** _____ *(mm/dd/yyyy)*

SECTION III - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form below. A family member of your patient has requested leave under the FMLA to care for your patient. 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 to care for a family member with a serious health condition. 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 at the end of the form.

You also 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.

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 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) Patient's Name: _____

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

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

(4) For FMLA to apply, care of the patient must be medically necessary. Briefly describe the type of care needed by the patient (*e.g., assistance with basic medical, hygienic, nutritional, safety, transportation needs, physical care, or psychological comfort).*

_____

_____

Employee Name: _____

(5) 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.

(6) 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 if the benefits and protections of the FMLA apply.

(7) 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): _____

_____

(8) 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)*

Employee Name: _____

(9) 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.

(10) Due to the condition it, (☐ was / ☐ is / ☐ will be) medically necessary for the employee to be absent from work to provide care for the patient 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.

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

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BUTTS COUNTY SCHOOLS
181 North Mulberry Street
Jackson, Georgia 30233

http://www.butts.k12.ga.us

Telephone (770) 504-2300
Fax (770) 504-2305

RELEASE TO RETURN TO WORK

_____ is released to return to work _____
[Name of Employee] [Date]

_____ With no work-related restrictions

OR

_____ With the following work-related restrictions:_____
_____
_____
_____
_____
_____

Duration of restrictions:
_____
_____

_____ _____
[Name of Attending Health Care Provider - Please Print] [Type of Practice]

_____ _____ _____
[Signature of Attending Health Care Provider] [Phone Number] [Date]