Carroll County School System

Request for Family Medical Leave
(Family Medical Leave Act 1993)

Name:_____School/Facility_____

Current Address:_____

_____
City State Zip Code

Beginning Date of Leave:_____ Ending Date of Leave_____

Reason for Leave (Explain):_____

_____

NOTE: **A leave request based on an employee's health condition or the serious health condition of an employee's spouse, child, or parent must be accompanied by a verifying medical certification from a physician/health care provider.**

I hereby authorize the Carroll County School System to contact my physician/health care provider to verify the reason for my requested leave or for any other information concerning my requested leave.

I understand that a failure to return to work at the end of my leave period will be treated as a resignation unless an extension has been agreed upon and approved in writing by the Carroll County School System.

Signature:_____ Date:_____

APPROVED BY:

_____ Date:_____
Principal/Supervisor

_____ Date:_____
Assistant Superintendent of Human Resources

Carroll County School System

Medical Certification Statement
Illness of Employee's Family Member
(Family Medical Leave Act 1993)

Name of Employee:_____

Name of Ill Family Member:_____

Date Condition Began:_____

Medical facts regarding the condition:_____

_____

_____

_____

Explanation of extent to which employee is needed to care for the ill spouse, child or parent:

_____

_____

_____

_____

Health Care Provider Signature:_____

Date:_____ Office Phone:_____

_____

Medical Release:

I authorize the release of any medical information necessary to process the above request.

Patient's Signature:_____ Date:_____

Carroll County School System

Certification of Health Care Provider
(Family and Medical Leave Act 1993)

1. Employee's Name:_____

2. Patient's Name (if different from employee) _____

3. The attached sheet describes what is meant by a **"serious health condition"** under the Family Leave Act. Does the patient's condition qualify under any of the categories described? If so, please check the applicable category.
   (1)_____ (2)_____ (3)_____ (4)_____ (5)_____, or None of these_____.

4. a. State the approximate **date** the condition began, and the probable **duration** of the condition (and also give the probable duration of the patient's present **incapacity** if different).

   b. Will it be necessary for the employee to take work only **intermittently or to work on a less than full schedule** as a result of the condition (including for treatment in Item 5 below)? _____ If yes, give the duration.

   c. If the condition is a **chronic condition** (condition #4) or **pregnancy**, state whether the patient is presently **incapacitated** and the likely duration and frequency of **episodes of incapacity**:

5. a. If additional treatments will be required for the condition, provide an estimate of the probable number of treatments.

   If the patient will be absent from work or other daily activities because of treatment on an intermittent or part-time basis, also provide an estimate of the probable number and interval between such treatments, actual or estimated dates of treatment if known, and period required for if any:

   b. If any of these treatments will be provided by another provider of health services (e.g., physical therapists), please state the nature of the treatments:

Here and elsewhere on this form the information sought relates only to the condition for which the condition for which the employee is taking FMLA leave.

Incapacity for the purpose of FMLA is defined to mean inability to work, attend school, or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom.

5. c. If a **regimen of continuing treatment** by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment):

6. a. If medical leave is required for the employee's **absence from work** because of the **employee's own condition** (including absences due to pregnancy or a chronic condition), is the employee **unable to perform** work of any kind? _____

b. If able to perform some work, is the employee **unable to perform any one or more of the essential functions of the employee's job** (the employer will provide you with information about the essential job functions)? _____ If yes, please list the essential functions the employee is unable to perform:

c. If neither a. nor b. applies, is it necessary for the employee to be **absent from work for treatment**? _____

7. a. If leave is required **to care for a family member** of the employee with a serious health condition, **does the patient require assistance** for basic medical or personal needs or safety, or for transportation? _____

b. If the patient will need care only **intermittently** or on a part-time basis, please indicate the probable duration of this need:

_____ _____

Signature of Health Care Provider Date

_____ _____

Street Address Telephone Number

_____

City State Zip Code

_____

Type of Practice

Carroll County School System

Descriptor Categories

(Family Medical Leave Act 1993)

A **"Serious Health Condition"** means an illness, injury, impairment, or physical or medical condition that involves one of the following:

1. **Hospital Care**

   Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity of subsequent treatment in connection with or consequent to such inpatient care.

2. **Absence Plus Treatment**

   (a) A period of **incapacity** of **more than three consecutive calendar days** (including any subsequent treatment or period of **incapacity** relating to the same condition), that also involves:

   (1) **Treatment two or more times** by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g. physical therapist) under orders of, or on referral by, a health care provider or

   (2) **Treatment** by a health care provider on **at least one occasion** which results in a **regimen of continuing treatment** under the supervision of a health care provider.

3. **Pregnancy**

   Any period of **incapacity** due to **pregnancy**, or for **prenatal care**.

4. **Chronic Conditions Requiring Treatments**

   A **chronic condition** which:

   (1) Requires **periodic visits** for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider.

   (2) Continues over an **extended period of time** (including recurring episodes of a single underlying condition), and

   (3) May cause **episodic** rather than a continuing period of **incapacity** (e.g. asthma, diabetes, epilepsy, etc.

5. **Permanent/Long-term Conditions Requiring Supervision**

   A period of **incapacity** which is **permanent** or **long-term** due to a condition for which treatments may not be effective. The employee or family member must be under the **continuing supervision or, but not need be receiving active treatment by, a health care provider**. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

6. **Multiple Treatments (Non-Chronic Conditions)**

   Any period of absence to receive **multiple treatments** (including any period of recovery therefrom) by a health care provider or a provider of health care services under orders of, or on referral by, a health care provider, either for **restorative surgery** after an accident or other injury, **or** for a condition that **would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment**, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis)

Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical exams, eye examinations, or dental examinations.

A regimen of continuing treatment includes, for example a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

Carroll County School System

Notice of Intention to Return from Leave
(Family Medical Leave Act 1993)

Name: _____

Supervisor/Principal: _____

Date Leave Began: _____

Date of Planned Return: _____

I understand that my restoration to employment is subject to the following conditions:

1. **As a condition of restoration, each employee must provide a written certification from his or her health care provider that the employee is able to perform the essential functions of their respective job.**

2. **Every attempt will be made to restore an employee returning from leave to her or his original position. If the employee's original position is unavailable, the employee will be placed in an equivalent position with equivalent pay and benefits.**

_____ _____

Employee's Signature **Date**

I have examined (employee) and can verify that he/she is fully able to perform the essential functions of his/her job and is fully able to resume working.

_____ _____

Health Care Provider's Signature **Date**