

Military

Board Policies 4022 & 4038

1. Leave of Absence Request form must be completed and signed by you. The signature of your supervisor is required.
2. Supporting documentation(s) from the appropriate military commander as evidence of such duty must indicate the following:
 - a. The beginning date on the orders must match the beginning date on the Leave of Absence request.
 - b. The ending date on the orders must match the ending date on the Leave of Absence request.
 - c. A complete and sufficient certification to support a request for FMLA leave due to a current service member's serious injury or illness; serious injury or illness of a Veteran; and qualifying exigency.
3. If your service extends beyond the date originally stated on your orders, you are required to submit additional documentation to Employee Benefits.
4. If the period of service in the uniformed services was for more than ten (10) business days, you are required to report to the Office of Employee Benefits prior to reporting back to work for a written clearance to give to your supervisor.

Health and Life Benefits

If you are on an approved leave of absence and go into unpaid status, you will receive a monthly invoice for medical, dental, vision, basic life, and long term disability until your return to active employment.

The payments should be made directly to the Office of Employee Benefits Room 108. Checks and money orders are made payable to: Shelby County Schools. Failure to receive an invoice does not relieve you from your responsibility of making timely premium payments. Failure to submit your payments will result in the termination of the insurance coverage for non-payment. You will have the option to re-elect health insurance coverage within thirty (30) days of your return from the approved leave of absence. If you miss the thirty (30) day window, you will have the opportunity to re-elect coverage during the next health insurance open enrollment period.

A Statement of Health form must be completed and submitted to MetLife for re-enrollment approval in the Basic Group Life Insurance. The Statement of Health forms are available in the Benefits Office, room 108.

A Statement of Health form must be completed and submitted to Standard Insurance Company for re-enrollment approval in the Long Term Disability plan.

Educational Leave

Board Policy 4021

1. Leave of Absence Request form must be completed and signed by you. The signature of your supervisor is required.
2. A copy of your registration is required indicating you are enrolled.
3. You are required to report to the Office of Employee Benefits five (5) business days prior to the expiration of your approved leave to receive a written clearance to give to your supervisor.

NOTE TO TEACHERS/INSTRUCTIONAL EMPLOYEES ONLY:

If leave is taken more than five (5) weeks prior to the end of the semester, and the return to employment is within three (3) weeks of the ending semester, the teacher will not be able to return until the first day of the next semester.

If leave is taken five (5) weeks prior to the end of the semester, and the return to employment is within two (2) weeks of the ending semester, the teacher will not be able to return until the first day of the next semester.

***If any portion of your Leave of Absence is unpaid, upon your return to work your salary will be recalculated according to the number of scheduled workdays and pay periods remaining in the school year (excluding 12 month salaried and hourly employees).

Please note:

The Board policies of Shelby County Schools can be found on our website at www.scsk12.org.



Shelby County Board of Education

Leave of Absence Procedures

Contacts

Marvay Mosley
Locations A - K
416-5869

Dana Jackson-Dortch
Locations L - Z
416-5514

According to Board Policy and Memorandum of Understanding, if an employee *is absent or expecting to be absent* for ten (10) consecutive workdays and/or more, he or she must file a Leave of Absence request with the Office of Employee Benefits.

Personal Illness & Accident on the Job

Board Policies 4038&4014

1. Leave of Absence Request form must be completed and signed by you. The signature of your supervisor is required.
2. The Certification of Health Care Provider is to be completed by your physician. The beginning date of the request and the date you will be able to return to work to perform full duties is required (*cannot use unknown, undetermined or pending, actual dates are required*).
 - a. To request an extension of your approved Leave of Absence, you must submit a new Certification of Health Care Provider with a new return date. Your physician must complete the Certification of Health Care Provider.
 - b. The completed Certification of Health Care Provider requesting an extension must be submitted to the Office of Employee Benefits prior to the expiration date of your Leave of Absence.
3. You are required to report to the Office of Employee Benefits five (5) business days prior to the expiration of your approved leave to receive a written clearance to give to your supervisor.

Illness in Immediate Family

Board Policy 4038

1. Leave of Absence Request form must be completed and signed by you. The signature of your supervisor is required.
2. Certification of Health Care Provider is to be completed by your family member's physician. The probable duration of the patient's need for full-time assistance is required (*cannot use unknown, undetermined or pending, actual dates are required*).
 - a. To request an extension of your approved Leave of Absence, you must submit a new Certification of Health Care Provider with a new end date. Your family member's physician must complete the Certification of Health Care Provider.
 - b. The completed Certification of Health Care Provider requesting an extension must be submitted to the Office of Employee Benefits prior to the expiration date of your Leave of Absence.
3. Please refer to Board Policy 4038 – **Definition of Immediate Family** - spouse, parents, and child.
4. You are required to report to the Office of Employee Benefits five (5) business days prior to the expiration of your approved leave to receive a written clearance to give to your supervisor.

Maternity/Paternity Leave

Board Policy 4038, 4057 and (TCA 4-21-408)

1. Leave of Absence Request form must be completed and signed by you. The signature of your supervisor is required.
2. The Certification of Health Care Provider is to be completed by your physician. The beginning date of the request and the date you will be able to return to work to perform full duties is required (*cannot use unknown, undetermined or pending, actual dates are required*).
 - a. To request an extension of your approved Leave of Absence, you must submit a new Certification of Health Care Provider with a new return date. Your physician must complete the Certification of Health Care Provider.
 - b. The completed Certification of Health Care Provider requesting an extension must be submitted to the Office of Employee Benefits prior to the expiration date of your Leave of Absence.
3. You are required to report to the Office of Employee Benefits five (5) business days prior to the expiration of your approved leave to receive a written clearance to give to your supervisor.
4. **For an Adoption Leave of Absence, please contact the appropriate Leaves of Absence Administrator.**

Special Note for Maternity Leave:

You will have thirty (30) days from birth of newborn to add the child to your health plan. If you miss the 30 day window, you can add your child during the next health insurance open enrollment.

EMPLOYEE RIGHTS UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION

LEAVE ENTITLEMENTS

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

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

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

BENEFITS & PROTECTIONS

ELIGIBILITY REQUIREMENTS

REQUESTING LEAVE

EMPLOYER RESPONSIBILITIES

ENFORCEMENT

For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division



Rights and Responsibilities for taking FMLA Leave

Eligibility for FMLA Leave

To be eligible for FMLA, an employee must have:

1. Worked at least 12 months for the Shelby County Schools District. The 12 months of employment need not be consecutive months.
Separate periods of employment in which the break in service exceeds seven years will not be used to determine FMLA eligibility.
2. Worked at least 1,250 hours during the 12 months preceding the need for leave
These are actual work hours and do not include paid time off.



Time in the military service covered under the Uniformed Services Employment and Reemployment Rights Act (USERRA) counts toward eligibility for FMLA.

Qualifying Reasons for FMLA

FMLA may be taken for any of the following reasons:

Birth of a child and to care for a newborn child of the employee or spouse

Placement with the employee of a child for adoption or foster care

To care for the employee's spouse, child, or parent with a serious health condition

Employee's own serious health condition



A qualifying exigency arising out of the employee's spouse, child, or parent's covered active duty* or call to active duty in support of a contingency operation

Caring for a covered service member with a serious injury or illness incurred in the line of active duty if the employee is the spouse, child, parent, or next of kin of the service member (military caregiver leave)

Birth, Adoption, or Care of a Newborn

Both mother and father are each entitled to up to 12 weeks of FMLA leave for the birth of their child, if meeting individual FMLA eligibility. This also applies to adoption and foster care placement. If both parents are employed by the Shelby County Schools only one 12 week FMLA period is allowed. Under Tennessee law, mothers are entitled up to 16 weeks of maternity under the Tennessee Maternity Act.

Need to care for a Family Member

FMLA leave to care for a family member with a serious health condition is limited to the employee's:

- Spouse
- Parents
- Employee's child or stepchild
- Covered service member

Caring for a family member includes:

- Psychological care, such as comfort and support
- Physical care, such as feeding, dressing and transportation to doctor appointments
- Substituting for others who normally care for the family member; the employee need not be the only individual available to care for the family member
- Making arrangements for changes in care such as transfer to a nursing home

Definitions of a Family Member

Spouse

Legal spouse as defined by Tennessee law

Parent

Biological, adoptive, step or foster father or mother

Any other individual who stood in loco parentis to the employee when the employee was under age 18

Child

Biological, adopted or foster child, legal ward, stepchild or child of a person standing in loco parentis

FMLA for a child with a serious health condition, the child must be: under the age of 18

Age 18 or older if incapable of self-care because of a mental or physical disability

FMLA for military caregiver leave or family military leave, the child may be any age

Next of Kin



Nearest blood relative of the covered service member other than the spouse, parent or child in the following order of priority unless the service member has designated in writing another blood relative: Blood relatives granted legal custody of the service member

Brothers and sisters

Grandparents

Aunts and uncles

First cousins

Medical Certification

It is the employee's responsibility to provide the completed certification within 15 calendar days of the receipt of notice for eligibility; additional time may be required in some circumstances. If sufficient information is not provided in a timely manner, the request for leave may be denied.

Health Insurance Premiums during FMLA

If paid leave is substituted for FMLA leave, the employee's share of group health plan premiums must be paid by the method normally used during paid leave (usually payroll deduction). An employee on unpaid FMLA leave must make arrangements to pay the normal employee portion of the insurance premiums in order to maintain insurance coverage. If the employee's premium payment is more than 30 days late, the employee's coverage may be dropped unless the employer has a policy of allowing a longer grace period. The employer must provide written notice to the employee that the payment has not been received and allow at least 15 days after the date of the letter before coverage stops.

Please Note:

Benefits Continuation while on a Paid Leave of Absence

While on an approved paid leave of absence, the premiums for medical, dental, vision, basic life, and voluntary long term disability (Standard) insurance will continue to be deducted from your paycheck.

Benefits Continuation while on an Unpaid Leave of Absence

While on an approved unpaid leave of absence, you will be responsible for paying medical, dental, vision, basic life, and voluntary long-term (Standard) disability insurance premiums.

Each voluntary benefit is administered by the corresponding insurance carrier. You will be required to make payments for supplemental and voluntary premiums directly to the outside carriers. The carriers include: MetLife (supplemental life), AFLAC, American Fidelity, NEA, NTA, etc.

Reinstatement to Work from FMLA Leave

An employee returning from an approved FMLA leave of absence must report to the SCS Office of Employee Benefits five (5) business days prior to the end of the approved Leave of Absence. Failure to comply may result in a delay of the processing of the leave return which may affect your pay or employment status.

Shelby County Schools LEAVE OF ABSENCE REQUEST FORM FAMILY AND MEDICAL LEAVE

All completed leave requests must be accompanied by appropriate documentation as required in the Board policies of Shelby County Schools and submitted to the Office of Employee Benefits, at least thirty (30) days in advance.

Name _____ Social Security Number _____ - _____ - _____ Date ___/___/___

Any correspondences regarding this Leave of Absence request will be mailed to the address Shelby County Schools has on file. It is your responsibility to ensure your records are current at all times.

Home Phone () _____ - _____ Alt. Phone () _____ - _____ Current Assigned Location Name _____
(Required)
Current Assigned Position _____
(Required)

Type of Leave:

- Personal Illness**
 Continuous Intermittent Reduced hours
- Accident on the Job**
- Illness in Immediate Family** *(Relationship to Employee : _____)*
 Continuous Intermittent Reduced hours
- Parenting** *(Includes Maternity, Paternity, Adoption & Foster Care Placement)*
 Continuous Intermittent Reduced hours

NOTE TO TEACHERS/INSTRUCTIONAL EMPLOYEES
NOTE TO TEACHERS/INSTRUCTIONAL EMPLOYEES ONLY:
If leave is taken more than five (5) weeks prior to the end of the semester, and the return to employment is within three (3) weeks of the ending semester, the teacher will not be able to return until the first day of the next semester.
If leave is taken five (5) weeks prior to the end of the semester, and the return to employment is within two (2) weeks of the ending semester, the teacher will not be able to return until the first day of the next semester.
If the return to work date is within three weeks of the end of the semester, the teacher will not be able to report to work until the first day of the next semester.

Requested date for Leave to begin ___/___/___
(First Day of Consecutive Absence)

Requested date to return to work ___/___/___

*** If you are on an approved leave of absence and go into unpaid status, you will receive a monthly invoice for medical, dental, vision, basic life, and long term disability until your return to active employment. Failure to receive an invoice does not relieve you from your responsibility of making timely premium payments.

NOTE to Employee: You are required to report to the Office of Employee Benefits five (5) business days prior to the expiration of your approved leave to receive a written clearance to give to your supervisor.

***If any portion of your Leave of Absence is unpaid, upon your return to work your salary will be recalculated according to the number of scheduled workdays and pay periods remaining in the school year (excluding 12 month salaried and hourly employees).

Signature of Principal/Supervisor *(Required)* Date ___/___/___

Signature of Employee *(Required)* Date ___/___/___

I, *the employee*, agree to abide by the Federal and State laws and leave policies, rules and regulations of Shelby County Schools regarding the policy under which I am requesting leave.

Teachers Only: Would you like to use any accumulated personal days at the beginning of the approved leave? Yes No
If yes, how many personal days would you like to use? _____

| HUMAN RESOURCES ONLY | | Leave Extension Dates |
|--|---------------------------|-----------------------|
| <input type="checkbox"/> Approved <input type="checkbox"/> Denied Approved Leave Dates: Beginning ___/___/___ Ending ___/___/___ | _____/_____/_____ | |
| FMLA Dates: Beginning ___/___/___ Ending ___/___/___ Number of FMLA Days used: _____ | _____/_____/_____ | |
| NON- FMLA Dates: Beginning ___/___/___ Ending ___/___/___ Number of Vacation Days used: _____ | _____/_____/_____ | |
| PAID STATUS: Beginning ___/___/___ Ending ___/___/___ UNPAID STATUS: Beginning ___/___/___ Ending ___/___/___ | _____/_____/_____ | |
| Approved by: _____ Signature of Leave Administrator | Date Approved ___/___/___ | |

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



SECTION I: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: 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. Please complete Section I before giving this form to your health care provider.

Employer name and contact number: _____

Employee's job title: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a delay or denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: _____
First Middle Last

An employee who fraudulently obtains FMLA leave will be subject to disciplinary action, up to and including termination.

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to 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. Please be sure to sign the form on the last page 3.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: () Fax:()

Continued: Name of Employee (Print): _____

First

Middle

Last

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

Probable duration of condition: _____

Mark below as applicable:

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

___ No ___ Yes If so, dates of admission:

Date(s) you treated the patient for condition:

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

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

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

___ No ___ Yes If so, state the nature of such treatments and expected duration of treatment:

2. Is the medical condition pregnancy? ___ No ___ Yes If so, expected delivery date: _____

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

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

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

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

CONTINUED ON NEXT PAGE

Continued: Name of Employee (Print): _____

First

Middle

Last

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___No ___Yes

The estimated return to work date must be an actual date. (If applicable, the estimated return to work date can be extended with a new completed medical statement). We are unable to use pending, undetermined, unknown, until further notice, or periods indicating just the number of weeks or months:

If so, estimate the beginning and ending dates for the period of incapacity:

(Required) Beginning Date ____/____/____ (Required) Return to Work Date ____/____/____
(First Date of Consecutive Absence) mm dd yyyy (Estimated Date) mm dd yyyy

6. Will the employee need to attend follow-up treatment appointments or (intermittently) work part-time or on a reduced schedule because of the employee’s medical condition? ___No ___Yes

If so, are the treatments or the reduced number of hours of work medically necessary?
___No ___Yes

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

Estimate the part-time or reduced work schedule the employee needs, if any:

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

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ___No ___Yes

Is it medically necessary for the employee to be absent from work during the flare-ups?
___ No ___Yes If so, explain:

Based upon the patient’s medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

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

Duration: _____ hours or ___ day(s) per episode

Gina Notification to Health Care Providers: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or family members. In order to comply with this law, we are asking that you do not provide any genetic information when responding to this request for medical information. Genetic information, as defined by GINA, includes an individual’s family medical history, the results of an individual’s or family member’s genetic tests, the fact than individual or an individual’s family sought or received genetic services, and genetic information of a fetus carried by an individual or individual’s family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Signature of Health Care Provider

Date

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

RETURN TO BENEFITS RM 108



SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of 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.

Employer name and contact: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your family member or his/her medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a covered family member with a serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Your name: _____
First Middle Last

Name of family member for whom you will provide care: _____
First Middle Last

Relationship of family member to you: _____

If family member is your son or daughter, date of birth: _____

Describe care you will provide to your family member and estimate leave needed to provide care:

Employee Signature

Date

Continued: Name of Employee (Print): _____

First

Middle

Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

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 needs leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e). Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

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?

___No ___Yes. If so, dates of admission: _____

Date(s) you treated the patient for condition: _____

Was medication, other than over-the-counter medication, prescribed? ___No ___Yes.

Will the patient need to have treatment visits at least twice per year due to the condition? ___No ___Yes

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

___ No ___Yes. If so, state the nature of such treatments and expected duration of treatment:

2. Is the medical condition pregnancy? ___No ___Yes. If so, expected delivery date: _____

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

Continued: Name of Employee (Print): _____

First

Middle

Last

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 and recovery? ___No ___Yes

The estimated return to work date must be an actual date. (If applicable, the estimated return to work date can be extended with a new completed medical statement). We are unable to use, pending, undetermined, unknown, until further notice, or periods indicating just the number of weeks or months.

(Required) Beginning Date ____/____/____ **(Required)** Ending Date ____/____/____
(First date of Consecutive Absence) (Estimated return date)

During this time, will the patient need care? ___ No ___ Yes

Explain the care needed by the patient and why such care is medically necessary:

5. Will the patient require follow-up treatments, including any time for recovery? ___No ___Yes

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

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

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

Estimate the hours the patient needs care on an intermittent basis, if any:

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

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

Continued: Name of Employee (Print): _____

First

Middle

Last

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ___ No ___ Yes.

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: ___ times per ___ week(s) ___ month(s)

Duration: ___ hours or ___ day(s) per episode

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

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

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

Signature of Health Care Provider

Date

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 20 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 Ave., NW, Washington, DC 20210.

Shelby County Schools
Department of Human Resources
Office of Employee Benefits

REINSTATEMENT FORM

I understand that prior to my return from leave and reporting to my assigned location, I must report to the SCS Office of Employee Benefits five (5) business days prior to the end of my approved leave of absence. This form must be signed by the Leave Administrator for written clearance.

Additionally, I understand that failure to comply may result in a delay of the processing of my leave return which could affect my paycheck or employment status.

I understand by signing this form, I have read and understand the terms of condition for returning to work from my approved leave of absence.

Please Print:

Employee's Name: _____ Social Security Number: ____ - ____ - ____

Current Location Name: _____ Current Job Title: _____

Date to Return to Work: ____ / ____ / ____

Employee's Signature

____ / ____ / ____
Today's Date

(Required) Leave Administrator's Signature (The Office of Employee Benefits)

____ / ____ / ____
Today's Date

CC: Principal/Supervisor

Shelby County Schools' does not discriminate in its programs or employment on the basis of race, color, religion, national origin, disability, sex, age, or genetics. For more information, please contact the Office of Equity Compliance at 901-416-6670.



2015-16 SCS HEALTH PLAN RATES - UNPAID LEAVE OF ABSENCE

Employee Contributions

| Medical Plan | 20-Pay Premiums | | 24-Pay Premiums | |
|-----------------------------------|-----------------|----------|-----------------|----------|
| | Non-Tobacco | Tobacco | Non-Tobacco | Tobacco |
| OAP IN-NETWORK PLUS Option | | | | |
| Employee | \$124.72 | \$154.72 | \$103.94 | \$128.94 |
| Employee + 1 | \$277.94 | \$307.94 | \$231.62 | \$256.62 |
| Family | \$387.73 | \$417.73 | \$323.11 | \$348.11 |
| OAP BASIC Option | | | | |
| Employee | \$89.99 | \$119.99 | \$74.99 | \$99.99 |
| Employee + 1 | \$219.97 | \$249.97 | \$183.31 | \$208.31 |
| Family | \$306.86 | \$336.86 | \$255.72 | \$280.72 |
| CHOICE FUND HRA Option | | | | |
| Employee | \$55.20 | \$85.20 | \$46.00 | \$71.00 |
| Employee + 1 | \$151.40 | \$181.40 | \$126.17 | \$151.17 |
| Family | \$211.21 | \$241.21 | \$176.01 | \$201.2 |

| Dental Plan | 20-Pay Premiums | | 24-Pay Premiums | |
|------------------------------------|-----------------|---------|-----------------|---------|
| | Non-Tobacco | Tobacco | Non-Tobacco | Tobacco |
| DPPO (\$2,000) Option | | | | |
| Employee | \$25.62 | | \$21.35 | |
| Employee + 1 | \$53.80 | | \$44.84 | |
| Family | \$76.86 | | \$64.05 | |
| DPPO (\$1,500) Option | | | | |
| Employee | \$15.48 | | \$12.90 | |
| Employee + 1 | \$32.50 | | \$27.09 | |
| Family | \$46.43 | | \$38.69 | |
| DEPO IN-NETWORK ONLY Option | | | | |
| Employee | \$11.41 | | \$9.51 | |
| Employee + 1 | \$23.95 | | \$19.96 | |
| Family | \$34.22 | | \$28.52 | |

| Vision Plan | 20-Pay Premiums | | 24-Pay Premiums | |
|--------------|-----------------|---------|-----------------|---------|
| | Non-Tobacco | Tobacco | Non-Tobacco | Tobacco |
| Employee | \$3.70 | | \$3.08 | |
| Employee + 1 | \$7.07 | | \$5.90 | |
| Family | \$11.48 | | \$9.57 | |

LIFE INSURANCE: Please check the employee portal for your life insurance premium amount

Please submit payment and invoice for your health and life insurance to the SCS Benefits Office: SCS
Office of Benefits/Compensation
160 S. Hollywood Rm. 108
Memphis, TN 38112

PLEASE NOTE: Failure to pay insurance premiums while on leave of absence may result in termination of insurance coverage. Rates effective: 09/01/2015 - 07/31/2016.

Frequently Asked Questions

Leave Entitlement

What is my entitlement under the Family Medical Leave Act?

If you are an “eligible” employee, you are entitled up to twelve (12) workweeks of leave in a 12-month period for one or more of the following reasons:

- for the birth of a son or daughter, and to care for a newborn child;
- or the placement with the employee of a child for adoption or foster care, and to care for the newly placed child;
- to care for an immediate family member (spouse, child, or parent) with a serious health condition; and
- if the employee is unable to work due to a serious health condition.

Spouses employed by the District may be limited to a combined total of 12 workweeks of family leave for the following reasons:

- birth and care of a child;
- for the placement of a child for adoption or foster care, and to care for the newly placed child; and
- to care for an employee's parent who has a serious health condition.

What is the definition of a serious health condition?

A “serious health condition” is defined as an illness, injury, impairment, or physical or mental condition that involves inpatient care or continuing treatment by a health care provider. The “continuing treatment” for a serious health condition that qualifies for FMLA leave is:

- 1) A period of incapacity of more than three consecutive full calendar days plus treatment by a health care provider twice, or once with a continuing regimen of treatment;
- 2) Any period of incapacity related to pregnancy or for prenatal care;
- 3) Any period of incapacity or treatment for a chronic serious health condition;
- 4) A period of incapacity for permanent or long-term conditions for which treatment may not be effective;

5) Any period of incapacity to receive multiple treatments (including recovery from treatments for restorative surgery, or for a condition which would likely result in incapacity of more than three consecutive full calendar days absent for medical treatment).

Which employees are eligible to take FMLA leave?

Employees are eligible to take FMLA leave if they have worked for the district for at least one (1) year and have 1,250 hours of service in the previous 12 months.

Generally, part-time employees are not eligible for FMLA leave due to the 1,250 hours eligibility requirement. Part-time employees may qualify for FLMA leave by working overtime, additional work assignments, etc. Request for time off work for part-time employees should be addressed with the supervisor/manager and approval may be granted at the discretion of the supervisor/manager.

What is a “rolling” 12-month period?

The rolling 12-month period is measured backwards beginning with the date the employee uses FMLA leave.

Example: An employee takes time off work due to the birth of a child in May. The leave period taken is for 12 weeks. In November, the employee is scheduled for surgery. The request for leave in November will not be counted towards FMLA due to the 12 weeks entitlement previously used during the leave in May.

Can leave be taken to care for children of any age?

FMLA leave is only available to care for a child under the age of 18 years or older with a disability where the child is unable to perform activities of daily living without assistance. An eligible employee covered by Military Family Leave can take the leave to care for spouse, son, daughter, parent, or next of kin.

Can leave for childbirth or adoption be taken at any time?

Leave must be taken within 12 months after the birth or placement for adoption or foster care. In many circumstances, however, the leave may start before the birth or placement for adoption, such as leave needed for pre-natal care or for home studies in connection with an adoption.

May I take additional time off work to bond with my new born?

You must submit a request in writing to your designated Leave Administrator indicating the actual date you will be returning back to work. The request for bonding time must be submitted with the initial leave request.

Can the District deny Family Medical Leave?

The following reasons would apply:

- If you do not meet the eligibility requirements
- Employees who give unequivocal notice that they do not intend to return to work lose their entitlement to FMLA leave.
- Employees who are unable to return to work and have exhausted their 12 weeks of FMLA leave in the designated "12 month period" no longer have FMLA protections of leave or job restoration.

How can I be compensated during my approved Leave of Absence?

Employees will use accrued sick time to cover the FMLA leave taken.

If applicable, employees are required to request the use of any accrued vacation/personal days at the beginning of the approved leave. Accrued sick/vacation/personal time will be exhausted before unpaid leave can be taken.

If a recognized holiday falls during an employee's paid absence, holiday pay will be received. Employees eligible for paid holidays must be in paid status (available sick/vacation/personal) the last scheduled workday preceding the holiday and the first scheduled workday following the holiday.

- **Note to all employees (excluding 12-month salaried and hourly employees): If any portion of your Leave of Absence is unpaid, upon your return to work your salary will be recalculated according to the number of scheduled workdays and pay periods remaining in the school year.**

Employer Notice Requirements

The designated Leave Administrator will notify the employee of FMLA eligibility within five (5) business days of the employee requesting leave.

- The total period of leave will not exceed one (1) year. FMLA provides up to twelve (12) weeks of job-protected leave. Additional leave- beyond twelve (12) weeks may be granted; however the absences will be Non-FMLA.

Employee Notice Requirements

If you are absent or expecting to be absent for ten (10) consecutive workdays and/or more, you will be required to file a Leave of Absence packet with the Office of Employee Benefits at 160 South Hollywood Street.

Consecutive absences of nine (9) days or less will be handled by the Administrator/Supervisor. You will be required to submit documentation supporting your absences.

Failure to provide supporting documentation for any absences will result in further disciplinary action.

The Leave of Absence packets are available in the Office of Employee Benefits or online <http://www.scsk12.org/uf/benefits>. Please submit the original copies.

What is considered reasonable notice before taking FMLA leave?

When the need for leave is foreseeable based on the expected birth, placement for adoption or foster care, or planned medical treatment, an employee must give at least thirty (30) days notice. When the need for leave is unforeseeable, employees are required to provide reasonable notice.

What happens if the 30 days' notice is not provided?

Where leave is foreseeable and there is no reasonable excuse for not giving 30 days' notice, the employer can deny FMLA leave, and presumably apply its other policies, for up to 30 days after the notice is provided.

May I extend my medical leave? The employee will be required to submit an updated [Certification of Healthcare Provider Form](#) completed by the attending physician to the Benefits office. The request for extension must be submitted five (5) days prior to the expiration of the initial leave request.

What paperwork is required before returning back to work? You must report to the Office of Employee Benefits five (5) business days prior to the end of your approved leave of absence. The reinstatement form must be signed by the Leave Administrator upon returning back to work. Failure to comply may result in a delay of the processing of your leave return which could affect your paycheck or employment status.

Benefits Continuation while on a Paid Leave of Absence

While on an approved paid leave of absence, the premiums for medical, dental, vision, basic life, and long term disability (Standard) insurance will continue to be deducted from your paycheck.

Benefits Continuation while on an Unpaid Leave of Absence

While on an approved unpaid leave of absence, you will be responsible for paying medical, dental, vision, basic life, and voluntary long-term (Standard) disability insurance premiums.

Each voluntary benefit is administered by the corresponding insurance carrier. You will be required to make payments for supplemental and voluntary premiums directly to the outside carriers. The carriers include: MetLife (supplement life), AFLAC, American Fidelity, NEA, NTA, etc.

Making Payments

If you are on an approved leave of absence and go into unpaid status, you will receive a monthly invoice for medical, dental, vision, basic life, and long term disability until your return to active employment.

Failure to receive an invoice does not relieve you from your responsibility of making timely premium payments. Failure to submit your payments will result in the termination of the insurance coverage for non-payment.

The payments should be made every pay period directly to the Office of Employee Benefits, room 108. Checks and money orders are made payable to: Shelby County Schools. Failure to submit your payments will result in the termination of the insurance coverage for non-payment. You will have the option to re-elect health insurance coverage within thirty (30) days of your return from the approved leave of absence. If you miss the thirty (30) day window, you will have the opportunity to re-elect coverage during the next health insurance open enrollment period.

A Statement of Health form must be completed and submitted to MetLife for re-enrollment approval in the Basic Group Life Insurance. The Statement of Health forms are available in the Benefits Office, room 108.

A Statement of Health form must be completed and submitted to Standard Insurance Company for re-enrollment approval in the Long Term Disability plan.

- Flexible Spending and Dependent Care accounts will be suspended while on an unpaid leave of absence. Upon return to paid status, the accounts are reactivated with no lapse in coverage and the premiums will be recalculated to include missed deductions. (Any expenses incurred while suspended can be reimbursed to the employee through Corporate Planning Network).

****Note to Teachers/Instructional employees only:***

If leave is taken more than five (5) weeks prior to the end of the semester, and the return to employment is within three (3) weeks of the ending semester, the teacher will not be able to return until the first day of the next semester.

If the leave is taken five (5) weeks prior to the end of the semester, and the return of employment is within two (2) weeks of the ending semester, the teacher will not be able to return until the first day of the next semester.

Approved leaves will not exceed June 30th of each academic year. Recertification will be required by submitting new Leave of Absence paperwork.