## 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.

***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).

**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.**

**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**

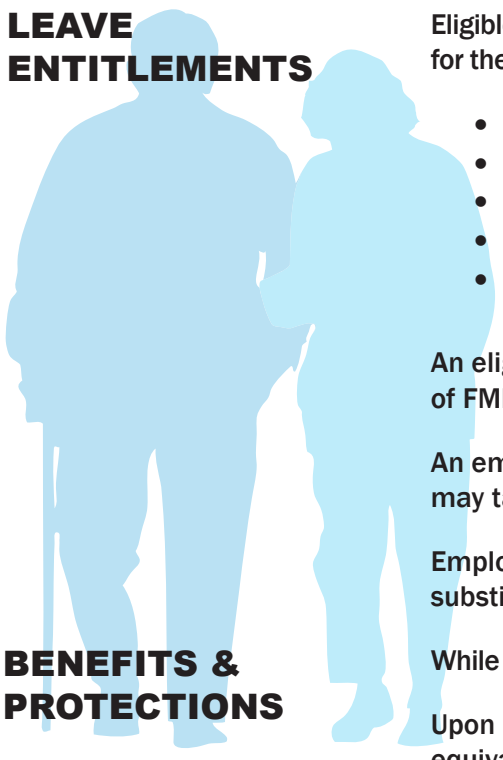
**Dana Jackson-Dortch**
**Locations L - Z**
**416-5514**


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.

Revised 8/30/16

# 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.

### BENEFITS & PROTECTIONS

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.

### ELIGIBILITY REQUIREMENTS

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.

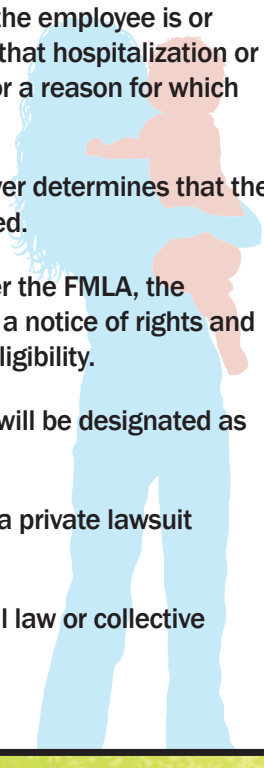
*Special "hours of service" requirements apply to airline flight crew employees.

### REQUESTING LEAVE

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.



### EMPLOYER RESPONSIBILITIES

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.

### ENFORCEMENT

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.

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

WH1420 REV 04/16

# 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:

**_____ Military**
**(**Covered Service Member, Qualifying Exigency**)**

____ 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)***

***** 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.**

## Requested date to return to work ___/___/___

**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).**

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

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

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.

## HUMAN RESOURCES ONLY

____ **Approved** _____ **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: _____ Date Approved _____/_____/_____
Signature of Leave Administrator

**Leave Extension Dates**

_____/_____/_____

_____/_____/_____

_____/_____/_____

_____/_____/_____

_____/_____/_____

_____/_____/_____

Revised 8/3/16

Shelby County Board of Education

# Certification of Qualifying Exigency For Military Family Leave (Family and Medical Leave Act)

**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 leave due to a qualifying exigency to submit a certification. Please complete Section I before giving this form to your employee. Your response is voluntary, and 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 CFR 825.309.

Employer name: _____

Contact Information: _____

**SECTION II: For Completion by the EMPLOYEE**

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

Your Name: _____
First Middle Last

Name of military member on covered active duty or call to covered active duty status:

_____
First Middle Last

Relationship of military member to you: _____

Period of military member's covered active duty: _____

A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes written documentation confirming a military member's covered active duty or call to covered active duty status. Please check one of the following and attach the indicated document to support that the military member is on covered active duty or call to covered active duty status.

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

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

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

PART A: QUALIFYING REASON FOR LEAVE

1. Describe the reason you are requesting FMLA leave due to a qualifying exigency (including the specific reason you are requesting leave):

_____

_____

_____

_____

2. A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes any available written documentation which supports the need for leave; such documentation may include a copy of a meeting announcement for informational briefings sponsored by the military; a document confirming the military member's Rest and Recuperation leave; a document confirming an appointment with a third party, such as a counselor or school official, or staff at a care facility; or a copy of a bill for services for the handling of legal or financial affairs. Available written documentation supporting this request for leave is attached.

Yes ☐ No ☐ None Available ☐

PART B: AMOUNT OF LEAVE NEEDED

1. Approximate date exigency commenced: _____

Probable duration of exigency: _____

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

Yes☐ No☐

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

_____

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

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

_____

_____

_____

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

Frequency: _____times per _____ week(s) _____month(s)

Duration: _____ hours ___ day(s) per event.

PART C:

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

Name of Individual: _____ Title: _____

Organization: _____

Address: _____

Telephone: (_____) _____ Fax: (_____) _____

Email: _____

Describe nature of meeting: _____

_____

_____

_____

_____

_____

_____

_____

PART D:

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

Signature of Employee _____ 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 CFR 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. T he 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 AV, NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE EMPLOYER.**

# Certification for Serious Injury or Illness of a Current Servicemember - - for Military Family Leave (Family and Medical Leave Act)

**Notice to the EMPLOYER**

**INSTRUCTIONS to the EMPLOYER:** The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a serious injury or illness of a current servicemember to submit a certification providing sufficient facts to support the request for leave. 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 CFR 825.310. Employers must generally maintain records and documents relating to 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 CFR 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 CFR 1635.9, if the Genetic Information Nondiscrimination Act applies.

**SECTION I: For Completion by the EMPLOYEE and/or the CURRENT SERVICEMEMBER for whom the Employee Is Requesting Leave**

**INSTRUCTIONS to the EMPLOYEE or CURRENT SERVICEMEMBER:** Please complete Section I before having Section II completed. The FMLA permits an employer to require that an employee submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a serious injury or illness of a servicemember. If requested by the employer, your response is required to obtain or retain the benefit of FMLA-protected leave. 29 U.S.C. 2613, 2614(c)(3). Failure to do so may result in a denial of an employee's FMLA request. 29 CFR 825.310(f). The employer must give an employee at least 15 calendar days to return this form to the employer.

**SECTION II: For Completion by a UNITED STATES DEPARTMENT OF DEFENSE ("DOD") HEALTH CARE PROVIDER or a HEALTH CARE PROVIDER who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; (3) a DOD non-network TRICARE authorized private health care provider; or (4) a health care provider as defined in 29 CFR 825.125**

**INSTRUCTIONS to the HEALTH CARE PROVIDER:** The employee listed on Page 2 has requested leave under the FMLA to care for a family member who is a current member of the Regular Armed Forces, the National Guard, or the 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. For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty in the Armed Forces or that existed before the beginning of the member's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces that may render the servicemember medically unfit to perform the duties of his or her office, grade, rank, or rating.

A complete and sufficient certification to support a request for FMLA leave due to a current servicemember's serious injury or illness includes written documentation confirming that the servicemember's injury or illness was incurred in the line of duty on active duty or if not, that the current servicemember's injury or illness existed before the beginning of the servicemember's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces, and that the current servicemember is undergoing treatment for such injury or illness by a health care provider listed above. 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 servicemember's condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 CFR 1635.3(f), or genetic services, as defined in 29 CFR 1635.3(e).


CONTINUED ON NEXT PAGE

**SECTION I: For Completion by the EMPLOYEE and/or the CURRENT SERVICEMEMBER for whom the Employee Is Requesting Leave:**

(This section must be completed first before any of the below sections can be completed by a health care provider.)

Part A: EMPLOYEE INFORMATION

Name and Address of Employer (this is the employer of the employee requesting leave to care for the current servicemember):

_____

Name of Employee Requesting Leave to Care for the Current Servicemember:

_____

First Middle Last

Name of the Current Servicemember (for whom employee is requesting leave to care):

_____

First Middle Last

Relationship of Employee to the Current Servicemember:

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

Part B: SERVICEMEMBER INFORMATION

(1) Is the Servicemember a Current Member of the Regular Armed Forces, the National Guard or Reserves?
Yes☐ No☐

If yes, please provide the servicemember's military branch, rank and unit currently assigned to:

_____

Is the servicemember assigned to a military medical treatment facility as an outpatient or to a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients (such as a medical hold or warrior transition unit)?
Yes☐ No☐

If yes, please provide the name of the medical treatment facility or unit:

_____

(2) Is the Servicemember on the Temporary Disability Retired List (TDRL)?
Yes☐ No☐

Part C: CARE TO BE PROVIDED TO THE SERVICEMEMBER

Describe the Care to Be Provided to the Current Servicemember and an Estimate of the Leave Needed to Provide the Care:

_____

_____

 CONTINUED ON NEXT PAGE

**SECTION II: For Completion by a United States Department of Defense ("DOD") Health Care Provider or a Health Care Provider who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; (3) a DOD non-network TRICARE authorized private health care provider; or (4) a health care provider as defined in 29 CFR 825.125. If you are unable to make certain of the military-related determinations contained below in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator).**

(Please ensure that Section I above has been completed before completing this section. Please be sure to sign the form on the last page.)

Part A: HEALTH CARE PROVIDER INFORMATION

Health Care Provider's Name and Business Address:

_____

Type of Practice/Medical Specialty: _____

Please state whether you are either: (1) a DOD health care provider; (2) a VA health care provider; (3) a DOD TRICARE network authorized private health care provider; (4) a DOD non-network TRICARE authorized private health care provider, or (5) a health care provider as defined in 29 CFR 825.125:

_____

Telephone: (  ) _____ Fax: (  ) _____ Email: _____

PART B: MEDICAL STATUS

(1) The current Servicemember's medical condition is classified as (Check One of the Appropriate Boxes):

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

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

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

☐ **NONE OF THE ABOVE** (Note to Employee: If this box is checked, you may still be eligible to take leave to care for a covered family member with a "serious health condition" under § 825.113 of the FMLA. If such leave is requested, you may be required to complete DOL FORM WH-380-F or an employer-provided form seeking the same information.)

(2) Is the current Servicemember being treated for a condition which was incurred or aggravated by service in the line of duty on active duty in the Armed Forces? Yes☐ No☐

(3) Approximate date condition commenced: _____

(4) Probable duration of condition and/or need for care: _____

 CONTINUED ON NEXT PAGE

(5) Is the servicemember undergoing medical treatment, recuperation, or therapy for this condition? Yes☐ No☐

If yes, please describe medical treatment, recuperation or therapy:

_____

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

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

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

(2) Will the servicemember require periodic follow-up treatment appointments? Yes☐ No☐

If yes, estimate the treatment schedule: _____

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

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

If yes, please estimate the frequency and duration of the periodic care:

_____

_____

**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, in accordance with 29 U.S.C. 2616; 29 CFR 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 AV, NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE PATIENT.**

*RETURN TO BENEFITS RM 108*

# Certification for Serious Injury Illness of a Veteran for Military Caregiver Leave (Family and Medical Leave Act)

## Notice to the EMPLOYER

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking military caregiver leave under the FMLA leave due to a serious injury or illness of a covered veteran to submit a certification providing sufficient facts to support the request for leave. 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 CFR 825.310. Employers must generally maintain records and documents relating to 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 CFR 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 CFR 1635.9, if the Genetic Information Nondiscrimination Act applies.

## SECTION I: For completion by the EMPLOYEE and/or the VETERAN for whom the employee is requesting leave

**INSTRUCTIONS to the EMPLOYEE and/or VETERAN:** Please complete Section I before having Section II completed. The FMLA permits an employer to require that an employee submit a timely, complete, and sufficient certification to support a request for military caregiver leave under the FMLA leave due to a serious injury or illness of a covered veteran. If requested by the employer, your response is required to obtain or retain the benefit of FMLA-protected leave. 29 U.S.C. 2613, 2614(c)(3). Failure to do so may result in a denial of an employee's FMLA request. 29 CFR 825.310(f). The employer must give an employee at least 15 calendar days to return this form to the employer.

(This section must be completed before Section II can be completed by a health care provider.)

Part A: EMPLOYEE INFORMATION

Name and address of employer (this is the employer of the employee requesting leave to care for a veteran):

_____

Name of employee requesting leave to care for a veteran:

_____
First Middle Last

Name of veteran (for whom employee is requesting leave):

_____
First Middle Last

Relationship of employee to veteran:

Spouse☐ Parent☐ Son☐ Daughter☐ Next of Kin ☐ (please specify relationship):

## Part B: VETERAN INFORMATION

(1) Date of the veteran's discharge:

_____

(2) Was the veteran **dishonorably** discharged or released from the Armed Forces (including the National Guard or Reserves)? Yes☐ No☐

(3) Please provide the veteran's military branch, rank and unit at the time of discharge:

_____

(4) Is the veteran receiving medical treatment, recuperation, or therapy for an injury or illness?
Yes☐ No☐

## Part C: CARE TO BE PROVIDED TO THE VETERAN

Describe the care to be provided to the veteran and an estimate of the leave needed to provide the care:

_____

_____

**SECTION II: For completion by: (1) a United States Department of Defense ("DOD") health care provider; (2) a United States Department of Veterans Affairs ("VA") health care provider; (3) a DOD TRICARE network authorized private health care provider; (4) a DOD non-network TRICARE authorized private health care provider; or (5) a health care provider as defined in 29 CFR 825.125.**

**INSTRUCTIONS to the HEALTH CARE PROVIDER:** The employee named in Section I has requested leave under the military caregiver leave provision of the FMLA to care for a family member who is a veteran. For purposes of FMLA military caregiver leave, a serious injury or illness means an injury or illness incurred by the servicemember in the line of duty on active duty in the Armed Forces (or that existed before the beginning of the servicemember's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces) and manifested itself before or after the servicemember became a veteran, and is:

(i) a continuation of a serious injury or illness that was incurred or aggravated when the covered veteran was a member of the Armed Forces and rendered the servicemember unable to perform the duties of the servicemember's office, grade, rank, or rating; or
(ii) a physical or mental condition for which the covered veteran has received a U.S. Department of Veterans Affairs Service Related Disability Rating (VASRD) of 50 percent or greater, and such VASRD rating is based, in whole or in part, on the condition precipitating the need for military caregiver leave; or
(iii) a physical or mental condition that substantially impairs the covered veteran's ability to secure or follow a substantially gainful occupation by reason of a disability or disabilities related to military service, or would do so absent treatment; or
(iv) an injury, including a psychological injury, on the basis of which the covered veteran has been enrolled in the Department of Veterans' Affairs Program of Comprehensive Assistance for Family Caregivers.

A complete and sufficient certification to support a request for FMLA military caregiver leave due to a covered veteran's serious injury or illness includes written documentation confirming that the veteran's injury or illness was incurred in the line of duty on active duty or existed before the beginning of the veteran's active duty and was aggravated by service in the line of duty on active duty, and that the veteran is undergoing treatment, recuperation, or therapy for such injury or illness by a health care provider listed above. 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 military caregiver leave coverage. Limit your responses to the veteran's condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 CFR 1635.3(f), or genetic services, as defined in 29 CFR 1635.3(e).

(Please ensure that Section I has been completed before completing this section. Please be sure to sign the form on the last page and return this form to the employee requesting leave (See Section I, Part A above). **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.**)

Part A: HEALTH CARE PROVIDER INFORMATION

Health care provider's name and business address:

_____

Telephone: (  ) _____ Fax: (  ) _____ Email: _____

Type of Practice/Medical Specialty: _____

Please indicate if you are:

☐ a DOD health care provider

☐ a VA health care provider

☐ a DOD TRICARE network authorized private health care provider

☐ a DOD non-network TRICARE authorized private health care provider

☐ other health care provider

## PART B: MEDICAL STATUS

Note: If you are unable to make certain of the military-related determinations contained in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as, DOD Recovery Care Coordinator) or an authorized VA representative.

(1) The Veteran's medical condition is:

☐ A continuation of a serious injury or illness that was incurred or aggravated when the covered veteran was a member of the Armed Forces and rendered the servicemember unable to perform the duties of the servicemember's office, grade, rank, or rating.

☐ A physical or mental condition for which the covered veteran has received a U.S. Department of Veterans Affairs Service Related Disability Rating (VASRD) of 50% or higher, and such VASRD rating is based, in whole or in part, on the condition precipitating the need for military caregiver leave.

☐ A physical or mental condition that substantially impairs the covered veteran's ability to secure or follow a substantially gainful occupation by reason of a disability or disabilities related to military service, or would do so absent treatment.

☐ An injury, including a psychological injury, on the basis of which the covered veteran is enrolled in the Department of Veterans' Affairs Program of Comprehensive Assistance for Family Caregivers.

☐ None of the above.

(2) Is the veteran being treated for a condition which was incurred or aggravated by service in the line of duty on active duty in the Armed Forces? Yes☐ No☐

(3) Approximate date condition commenced: _____

(4) Probable duration of condition and/or need for care: _____

(5) Is the veteran undergoing medical treatment, recuperation, or therapy for this condition? Yes☐ No☐

If yes, please describe medical treatment, recuperation or therapy:

_____

## PART C: VETERAN'S NEED FOR CARE BY FAMILY MEMBER

"Need for care" encompasses both physical and psychological care. It includes situations where, for example, due to his or her serious injury or illness, the veteran is unable to care for his or her own basic medical, hygienic, or nutritional needs or safety, or is unable to transport him or herself to the doctor. It also includes providing psychological comfort and reassurance which would be beneficial to the veteran who is receiving inpatient or home care.

(1) Will the veteran need care for a single continuous period of time, including any time for treatment and recovery? Yes☐ No☐

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

(2) Will the veteran require periodic follow-up treatment appointments? Yes☐ No☐

If yes, estimate the treatment schedule: _____

(3) Is there a medical necessity for the veteran to have periodic care for these follow-up treatment appointments?
Yes☐ No☐

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

If yes, please estimate the frequency and duration of the periodic care:

_____

_____

**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, in accordance with 29 U.S.C. 2616; 29 CFR 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. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE EMPLOYEE REQUESTING LEAVE (As shown in Section I, Part "A" above).**

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**



**Revised 7/2013**

## 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 |
|---|---|---|
| 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 |
|---|---|---|
| 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 30$^{th}$ of each academic year. Recertification will be required by submitting new Leave of Absence paperwork.