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.

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, flexible spending account 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 Long Term Disability.

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 /work year (excluding 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
Fax 416-6463

Dana Jackson-Dortch
Locations L - Z
416-5514
Fax 416-6463

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 6/29/18

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.

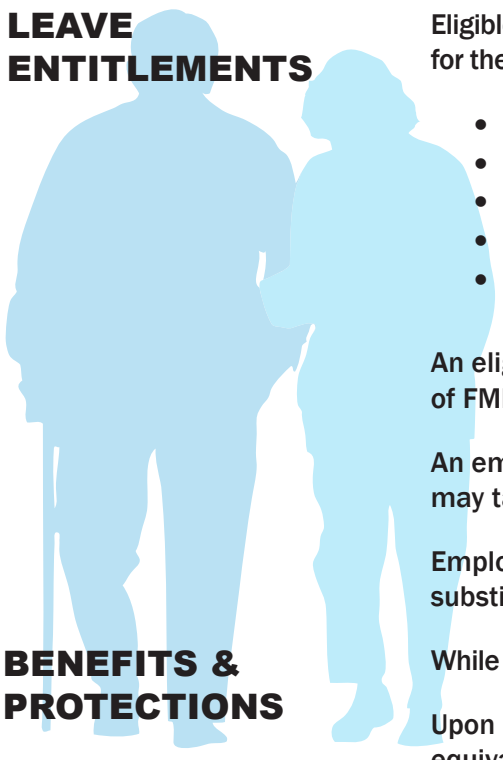
4. For an Adoption or bonding Leave of Absence, please contact the appropriate Leaves of Absence Administrator.

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.

Revised 6/29/18

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.

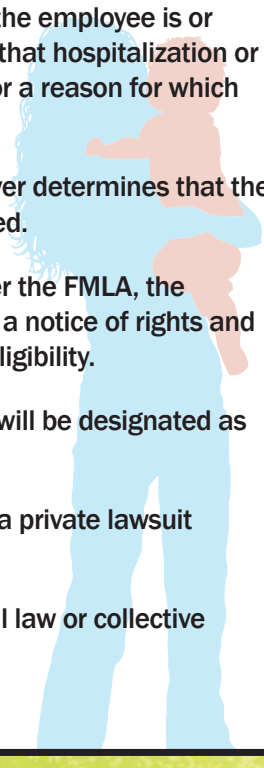
*Special "hours of service" requirements apply to airline flight crew employees.

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

To bond with a child (leave must be taken within 1 year of the child's birth or placement)

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, Care of a Newborn or Bonding

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, foster care placement and bonding. 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 delay your pay check.

If you are released to return back to work earlier than anticipated; you must submit a statement from your physician indicating the revised return to work date.

If you have been released by your physician to return to work with restrictions; you must submit a statement from your physician identifying the limitations and the timeframe (specific dates) in which limitations are effective.

Family and Medical Leave Act

Employee Documents Checklist

All completed leave requests must be accompanied by appropriate documentation as required in the Board policies of Shelby County Schools and submitted at least thirty (30) days in advance or as soon as possible and practicable. The following documents should be submitted to the Office of Employee Benefits, room 108 for leave approval:

- ☐ Leave of Absence Request form (signed by manager/administrator)
- ☐ **Certification of Health Care Provider for Employee's Serious Health Condition**-this form is required if you are requesting continuous or intermittent leave for your own serious health condition. (Please give the entire form to your health care provider).

Section I – will be completed by the Leave Administrator upon receipt

Section II – to be completed by the Employee

Section III – to be completed by the Health Care Provider

Note: For continuous absences an estimated beginning date and return to work date is required by the Health Care Provider. (Part B, #5, page 3)

For Intermittent leave requests, an estimate of the intermittent frequency, duration and the from/through dates must be provided by the Health Care Provider. Intermittent leave requests cannot be evaluated without this information. (Part B, #6, page 3)

- ☐ **Certification of Health Care Provider for Family Member's Serious Health Condition**-this form is required if you are requesting continuous or intermittent leave to care for a child, spouse or parent with a serious health condition. (Please give the entire form to the family member's health care provider).

Section I – will be completed by the Leave Administrator upon receipt

Section II – to be completed by the Employee

Section III- to be completed by the Health Care Provider

Note: For continuous absences, an estimated beginning date and return to work date is required by the Health Care Provider (Part B, #4, page 3)

For Intermittent leave requests, an estimate of the intermittent frequency, duration and the from/through dates must be provided by the Health Care Provider. Intermittent leave requests cannot be evaluated without this information. (Part B, #6, page 3)

****The confidential health information provided on the Employee and/or the Family Member's Health Care Provider form should not be shared with your manager/administrator.**

Parenting/Bonding Request Form

- ☐ Please complete and submit the Parenting/Bonding Request form to request additional time off for bonding purposes. The form should be submitted with the initial leave of absence paperwork.
- ☐ The Parenting/Bonding Request may also be submitted if you are requesting bonding time off within the first year of the birth, adoption or foster care placement of a child. This form should be submitted with the Leave of Absence Request form.

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, Bonding)***

____ 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 and you are returning prior to the end of the current school year, upon your return to work your salary will be recalculated (lowered) due to the number of scheduled workdays and pay periods remaining in the school year (excluding 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.

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

____ **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

_____/_____/_____
_____/_____/_____
_____/_____/_____
_____/_____/_____
_____/_____/_____
_____/_____/_____

Parenting/Bonding Request Form

Please select one of the following options:

☐ If you are requesting additional time off for bonding purposes; please complete the information below and submit this form with your Leave of Absence request form and the Employee-Health Care Provider form completed by your health care provider.

Name: _____

Work Location: _____

Return to Work Date: _____

☐ To request bonding time within the first 12 months of the birth, adoption or foster care placement of a child, please complete the information below and submit this form with the Leave of Absence Request form only.

Name: _____

Work Location: _____

Begin Date for Leave: _____

Requested Return to work Date: _____

RETURN TO BENEFITS, ROOM 108

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

Shelby County Board of Education

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

OMB Control Number 1235-0003
Expires: 8/31/2021

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 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 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, recertification's, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact number: _____

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions: _____

Check if job description is attached: _____

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 ON NEXT PAGE

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

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

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

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ___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

CONTINUED ON NEXT PAGE

Continued: Name of Employee (Print): _____
First Middle Last

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

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.

RETURN TO BENEFITS RM 108

Shelby County Board of Education

Certification of Health Care Provider for

Family Member's Serious Health Condition

(Family and Medical Leave Act)

SECTION I: For Completion by the EMPLOYER OMB Control Number 1235-0003 Expires: 08/31/2021

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 ON NEXT PAGE

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

(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:

_____

_____

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ____No ____Yes.

Continued: Name of Employee (Print): _____

First Middle Last

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.
DO NOT SEND COMPLTED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT. Form WH-380-F Revised May 2015

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.

If you are released to return back to work earlier than anticipated; you must submit a statement from your physician indicating the revised return to work date.

If you have been released by your physician to return to work with restrictions; you must submit a statement from your physician identifying the limitations and the timeframe (specific dates) in which limitations are effective.

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. **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.**

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

2020 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	$125.81	$155.81	$104.85	$129.85
Employee + 1	$280.39	$310.39	$233.66	$258.66
Family	$391.13	$421.13	$325.95	$350.95
OAP BASIC Option				
Employee	$88.09	$118.09	$73.41	$98.41
Employee + 1	$215.32	$245.32	$179.43	$204.43
Family	$300.36	$330.36	$250.30	$275.30
CHOICE FUND HRA Option				
Employee	$55.80	$85.80	$46.50	$71.50
Employee + 1	$147.76	$177.76	$123.13	$148.13
Family	$206.12	$236.12	$171.77	$196.77

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	$3.06	$2.55
Employee + 1	$5.86	$4.89
Family	$9.50	$7.92

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

Please submit a check or money order 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: 1/01/2020 – 12/31/2020.*

Frequently Asked Questions

What is FMLA?

FMLA is leave entitlement for reasonable, job-protected leave for specified family and or medical reasons. Under the federal Family and Medical Leave Act (FMLA) eligible employees have a right for up to 12 weeks of job-protected leave per 12-month period for the following reasons:

- For incapacity due to pregnancy, prenatal care or child birth
- To care for the employee's child after birth, placement for adoption, foster care and bonding
- To care for the employee's spouse, son or daughter, or parent with a serious health condition
- For a serious health condition that makes the employee unable to perform the employee's job

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;
- to bond with a child (leave must be taken within 1 year of the child's birth or placement);
- 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;
- to bond with 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. Therefore, requests 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.

Part-time employees may qualify for FMLA leave by working overtime, additional work assignments, etc. If this applies to you, please contact a Leave Administrator to confirm additional hours worked and the possibility of FMLA eligibility.

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 the Parenting/Bonding request form 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 or within the first year of the birth of a child.

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?

If applicable, employees are required to request the use of 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 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.

  Exceptions to the one (1) year restriction may apply for leaves granted as a reasonable accommodation under the American with Disabilities Act (ADA).

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, room 108.

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. The statement should only indicate the beginning/ending dates of care by the attending physician.

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

The Leave of Absence packets are available in the Office of Employee Benefits room 108 or online http://www.scsk12.org/benefits-for-active-employees/leave-of-absence

Please submit the original documents.

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 prior to returning back to work. Failure to comply may result in a delay of the processing of your leave return which could delay your paycheck.

If you are released to return back to work earlier than anticipated; you must submit a statement from your physician indicating the revised return to work date.

If you have been released by your physician to return to work with restrictions; you must submit a statement from your physician identifying the limitations and the timeframe (specific dates) in which limitations are effective.

After the reinstatement form has been signed by the Leave Administrator, you will receive a copy for your records and a copy to submit to your supervisor/manager upon your return to work.

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, flexible spending account, Minnesota life (supplement life) and Standard (long term disability) 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, flexible spending account, Minnesota life (supplement life) and Standard (voluntary long-term disability) insurance premiums.

Each voluntary benefit is administered by the corresponding insurance carrier. You will be required to make payments for voluntary premiums directly to the outside carriers. The carriers include: 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, flexible spending account, Minnesota life (supplement life) and Standard (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 Minnesota Life 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.

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.