Timelines

Request for leave- (1st page) within 30 days of foreseeable leave.

Medical Certification- (2-4 pages) within 15 days of request.

Return to work form- (5th page) within one week of returning back to work.

FMLA

REQUEST PACKET

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FAMILY/MEDICAL LEAVE
EMPLOYEE REQUEST FOR LEAVE FORM

1. Name of employee.	**2. Campus and position.**
3. Employee mailing address.	
4. Reason for requested leave. a. [ ] Birth of a son or daughter of the employee and in order to take care of such son or daughter. b. [ ] Placement of a son or daughter with employee for adoption or foster care. c. [ ] In order to care for spouse, child or parent with a serious health condition. d. [ ] Because of employee's own serious health condition that makes him/her unable to perform job functions	
5. If "c" please check one" [ ] Spouse [ ]Child [ ] Parent	**6. If "c" state name and address of relation.**
7. Date on which you wish to commence leave.	**8. Date of anticipated return to work (REQUIRED).**
9. Are you requesting leave on an intermittent or reduced leave schedule? [ ] Yes [ ] No	**10. If "Yes," please give schedule of when you anticipate you will be unavailable for work.**
Employee seeking leave because of reason "4(c)" or "4(d)" above must provide medical certification within 15 days or as soon as practicable. Employees seeking to return to work after a leave because of their own serious illness [reason "4(d)"], also must provide a medical certification of ability to perform job duties before they are allowed to resume to work.	
I hereby agree that while I am on leave, I will continue to pay my share of health insurance premiums, unless I elect to discontinue such coverage. I also agree that if I fail to return to work at the end of the leave period, I will reimburse the District for the cost of health benefits provided during my leave, unless I fail to return to work because of the continuation, recurrence or onset of a serious health condition or because of other circumstances beyond my control. If I am unable to return to work because a serious health condition, I will provide medical certification from the appropriate health care provider stating that I am unable to perform the functions of my position on the date that my leave expired or that I am needed to care for my spouse/parent/child because he/she has a serious health condition on the date that my leave expired. I understand that I may not be permitted to resume my position with the District, until I provide medical certification, as appropriate. **Signed**_____ **Dated**_____	

Medical Certification Statement for Employee

This form must be completed when requesting Family and Medical Leave on Application for Leave form.

SECTION I: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete this section 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 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).

Employee's name: _____ Date _____

SECTION II: 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. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b). Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____)_____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Approximate length of absence or length of time necessary to provide care:
   _____

   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: _____

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Return to:
Calallen ISD Human Resources
4205 Wildcat Dr.
Corpus Christi, TX 78410

Office: 361-242-5600 ext. 1016
Fax: 361-242-7552
Email: msaldana@calallen.org

Medical Certification Con't

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. 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):

   _____

   _____

   _____

   _____

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: _____

6. Will the employee need to attend follow-up treatment appointments because of the employee's medical condition? ___ 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:

   _____

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Continue on next page

Medical Certification Con't

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

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Health Care Provider **Date**

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FAMILY/MEDICAL LEAVE

Employee Return to Work Form

This form must be handed in to the personnel department one (1) week prior to the anticipated date of return.

Section A. To be completed by Employee.

1. Name of employee:_____
2. Employee's campus and position:_____
3. Reason for original request of leave was:

a. [ ] Birth of a son or daughter of the employee and in order to take care of such son or daughter.
b. [ ] Placement of a son or daughter with employee for adoption or foster care.
c. [ ] In order to care for spouse, child or parent with a serious health condition.
d. [ ] Because of employee's own serious health condition that makes him/her unable to perform job functions

4. Original date requested for leave to commence:_____
5. Actual date you have been released to return to work:_____

Section B. To be completed by health care provider.

[ ] the employee is able to return to work as of_____(date) without restrictions.

[ ] the employee can return to work as of_____(date) with the following restrictions, which are expected to last through_____(date).

Restrictions:

_____
_____
_____

_____ _____

Signature of Health Care Provider **Date**

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