Framingham Public Schools

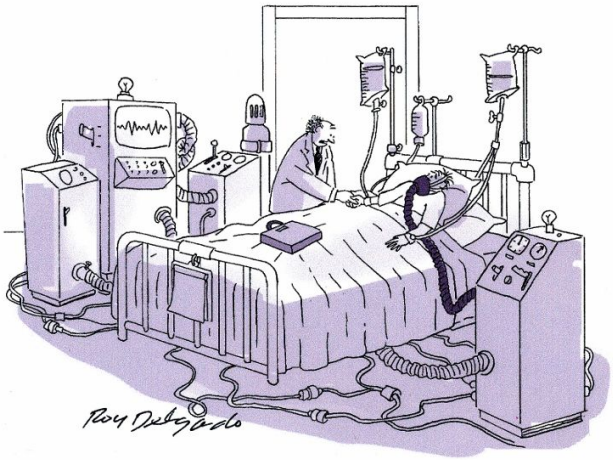
Family Medical Leave Act (FMLA)

Office of Human Resources

Responsiveness, Commitment, Efficiency and Compassion

FMLA: What is it?

- It is a Federal Law President Clinton signed into legislation in 1993
- It requires certain employers to grant eligible employees up to 12 workweeks of unpaid leave during a 12-month period for one or more qualifying reasons
- To help balance the demands of work with personal and family needs



" Squeeze my hand if you want us to hold your job for you."

Why are we contacting you?

NOTE: The employer's obligations are triggered as soon as it receives notice that an employee needs leave, and that the leave "may be" for a qualifying reason. The burden is on the employer here – the employee does not need to use any "magic words" or definitively prove that the leave qualifies under the FMLA. If there's a chance that the leave "may" qualify, the employer must provide the notice.

Who can use FMLA leave?

- You must work for a covered employer
- Your employer must have at least 50 employees within 75 miles of their worksite
- You must have worked for your employer for at least 12 months
- You must have worked for the employer for at least 1250 hours in the 12 months before you take your leave

Qualifying leave reasons:

- Eligible employees may take FMLA leave:
    - For the birth or placement of a child for adoption or foster care
    - To care for a spouse, son, daughter, or parent with a serious health condition
        - If an adult son or daughter is determined to be incapable of self-care because of a disability, he or she will be considered a “son or daughter” under FMLA. In order for a parent to take FMLA leave to care for an adult child the son or daughter must also:
            - Have a serious health condition, and
            - Need care because of the serious health condition

Qualifying leave reasons (Cont.):

- For your own serious health condition
- Because of a qualifying reason arising out of the covered active duty status of a military member who is the employee's spouse, son, daughter, or parent
- To care for a covered servicemember with a serious injury or illness when the employee is the spouse, son, daughter, parent, or next of kin of the covered servicemember

- Family members do not include- siblings, in-laws, grandparents and any other extended family members

What is a serious health condition?

There are six categories of what qualifies as a serious health condition:

1. Inpatient care at a hospital, hospice, or residential medical care facility
2. Incapacity for more than 3 days with continuing treatment by a health care provider (Pneumonia, viral infection)
3. Incapacity relating to pregnancy or prenatal care
4. Chronic serious health condition (Asthma,Diabetes, MS)
5. Permanent or long-term incapacity (Cancer, Stroke)
6. Certain kinds of conditions requiring multiple treatments (Surgery to reset a broken bone or a torn ligament)

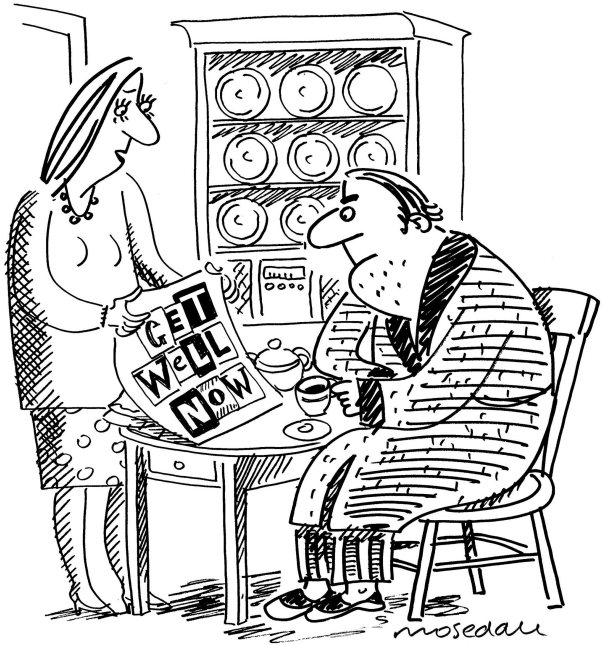
Caring for a family member:

You must actually provide care:

- Physical care
  - Helping with hygiene/administering medication
- Psychological Care
  - Family members comfort and assurance
- Providing necessary transportation
- Arranging for care or changes in care
- Filling in for others providing care

How much leave is available to you?

- Entitled to take up to 12 workweeks of leave in a 12 month period
- Up to 26 weeks of military caregiver leave in a 12 month period
- All at once
- Intermittently
- Reduced schedule leave



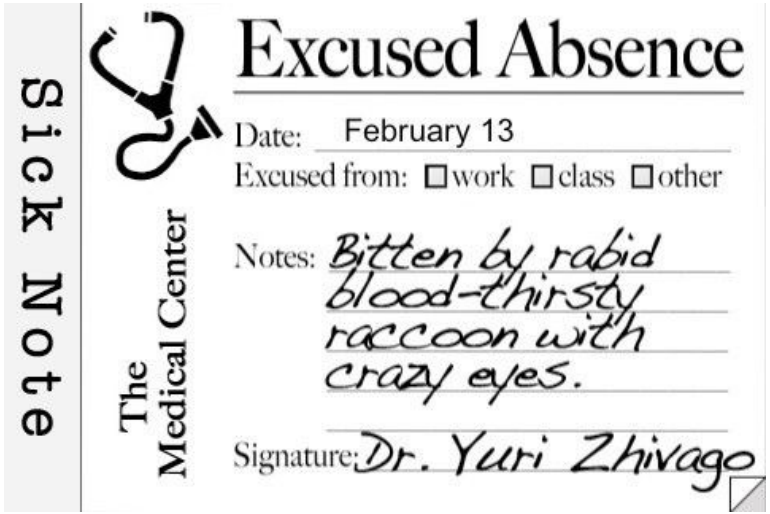
'Another sick note from your employer!'

Notice requirements

- If foreseeable, the employee must give the employer at least 30 days advance notice of the need to take FMLA leave
- Less than 30 days notice must be given as soon as possible
- For planned medical treatment, the employee must consult with the employer and try to schedule the appointment at a time that minimizes the disruption to the employer.
- The employee should consult with the employer prior to scheduling the treatment in order to arrange a schedule that best suits the needs of both the employee and employer
- Schedule of treatment is subject to the approval of the treating health care provider

DOCUMENTS:

1. FMLA Request Form
2. Notice of Eligibility and Rights & Responsibilities
3. Certification of Health Care Provider
4. Designation Notice
5. Fitness for Duty Form



FMLA request form:

Framingham Public Schools
Dr. Robert A. Tremblay, Superintendent of Schools

OFFICE OF HUMAN RESOURCES
Ms. Inna Kantor London, Assistant Superintendent for Human Resources
73 Mount Wayte Avenue, Suite #5
Framingham, Massachusetts 01702
Telephone: 508-626-9107 Fax: 508-877-4048

Employee Request for Family or Medical Leave

An employee seeking (or confirming) **a family or medical leave** must check all applicable boxes, sign, and submit to the Office of Human Resources **at least thirty (30) days** prior to the desired start date of the leave (if practicable because the leave is foreseeable) or as soon as practible if the leave has already begun or was not foreseeable. Leave requests for any **qualifying exigency for military family leave** must be submitted as soon as practicable.

Section I

Name: _____

Position/Department/Location: _____

Employee Email Address: _____

I request leave for the following reason:

- ☐ Because of the (anticipated) birth of my child (including prenatal care medical visits).
- ☐ Because of the placement of a child with me for adoption or for foster care.
- ☐ Expected date of birth or placement of child: _____
- ☐ In order to care for my spouse, parent, son or daughter who has a serious health condition.
- ☐ Because of my own serious health condition that makes me unable to work or unable to perform the functions of my job.
- ☐ Because of a qualifying exigency arising out of the fact that my spouse, parent, son or daughter is on (or has been notified of an impending call to) covered active duty in the Armed Forces.
- ☐ To care for my:
  - o Spouse
  - o Son or daughter
  - o Parent
  - o Next of kin who is a covered service member with a serious injury or illness.

Section II Amount of Leave

Please indicate below whether the leave requested is for a single period of time, intermittent leave, or reduced schedule leave (or a combination of those).

☐ I request the following **single period** of leave beginning and ending on the following dates:

Anticipated date leave will start: _____
(actual date if leave already begun)

Anticipated (or actual) return to work date: _____

☐ I request that leave be granted on an intermittent or reduced work schedule basis for the following reason (e.g., own serious health condition; to care for a parent, spouse, son or daughter with a serious health condition; to care for a covered service member with a serious illness or injury):

_____

If **intermittent leave is requested**, please state the proposed leave schedule (i.e., blocks of time needed; days of week with hours needs; or list actual dates If known and amount of time needed or taken on each date): _____

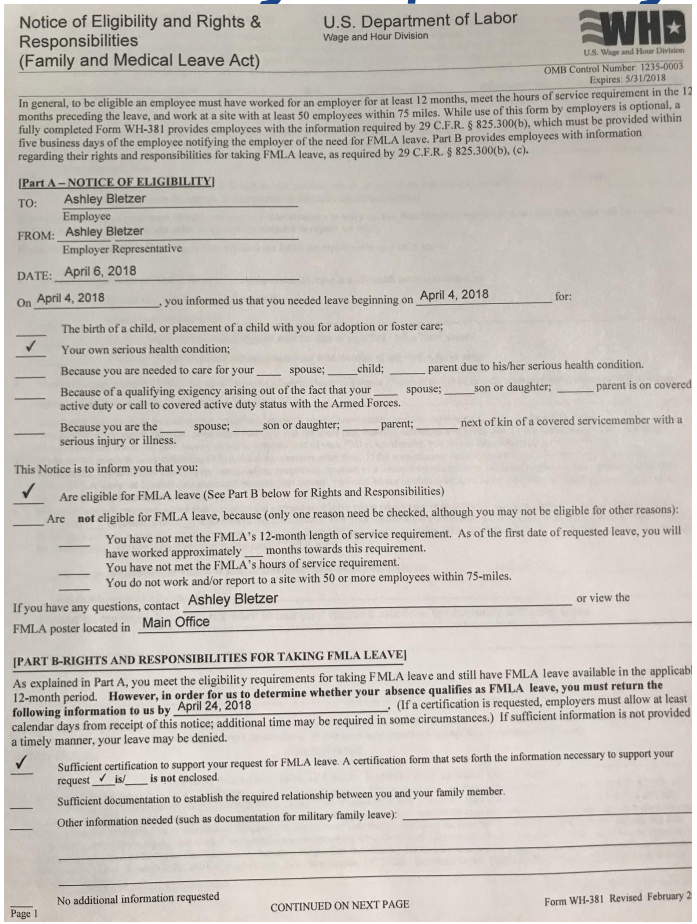
If **reduced schedule** leave is requested, please state the proposed leave schedule:

- Monday _____
- Tuesday _____
- Wednesday _____
- Thursday _____
- Friday _____

I request the above leave schedule from _____ through _____.

Signature: _____ *Date:* _____

Notice of Eligibility and Rights & Responsibilities:



Notice of Eligibility and Rights & Responsibilities
(Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

WHD
U.S. Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 5/31/2018

In general, to be eligible an employee must have worked for an employer for at least 12 months, meet the hours of service requirement in the 12 months preceding the leave, and work at a site with at least 50 employees within 75 miles. While use of this form by employers is optional, a fully completed Form WH-381 provides employees with the information required by 29 C.F.R. § 825.300(b), which must be provided within five business days of the employee notifying the employer of the need for FMLA leave. Part B provides employees with information regarding their rights and responsibilities for taking FMLA leave, as required by 29 C.F.R. § 825.300(b), (c).

[Part A – NOTICE OF ELIGIBILITY]

TO: Ashley Bletzer
Employee

FROM: Ashley Bletzer
Employer Representative

DATE: April 6, 2018

On April 4, 2018, you informed us that you needed leave beginning on April 4, 2018 for:

____ The birth of a child, or placement of a child with you for adoption or foster care;

✓ Your own serious health condition;

____ Because you are needed to care for your ____ spouse; ____child; _____ parent due to his/her serious health condition.

____ Because of a qualifying exigency arising out of the fact that your ____ spouse; ____son or daughter; _____ parent is on covered active duty or call to covered active duty status with the Armed Forces.

____ Because you are the ____ spouse; ____son or daughter; _____ parent; _____ next of kin of a covered servicemember with a serious injury or illness.

This Notice is to inform you that you:

✓ Are eligible for FMLA leave (See Part B below for Rights and Responsibilities)

____ Are **not** eligible for FMLA leave, because (only one reason need be checked, although you may not be eligible for other reasons):

____ You have not met the FMLA's 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately ___ months towards this requirement.
____ You have not met the FMLA's hours of service requirement.
____ You do not work and/or report to a site with 50 or more employees within 75-miles.

If you have any questions, contact Ashley Bletzer or view the FMLA poster located in Main Office

[PART B-RIGHTS AND RESPONSIBILITIES FOR TAKING FMLA LEAVE]

As explained in Part A, you meet the eligibility requirements for taking FMLA leave and still have FMLA leave available in the applicab 12-month period. **However, in order for us to determine whether your absence qualifies as FMLA leave, you must return the following information to us by** April 24, 2018. (If a certification is requested, employers must allow at least calendar days from receipt of this notice; additional time may be required in some circumstances.) If sufficient information is not provided a timely manner, your leave may be denied.

✓ Sufficient certification to support your request for FMLA leave. A certification form that sets forth the information necessary to support your request ___✓___ **is/____ is not** enclosed.

____ Sufficient documentation to establish the required relationship between you and your family member.

____ Other information needed (such as documentation for military family leave): _____

____ No additional information requested

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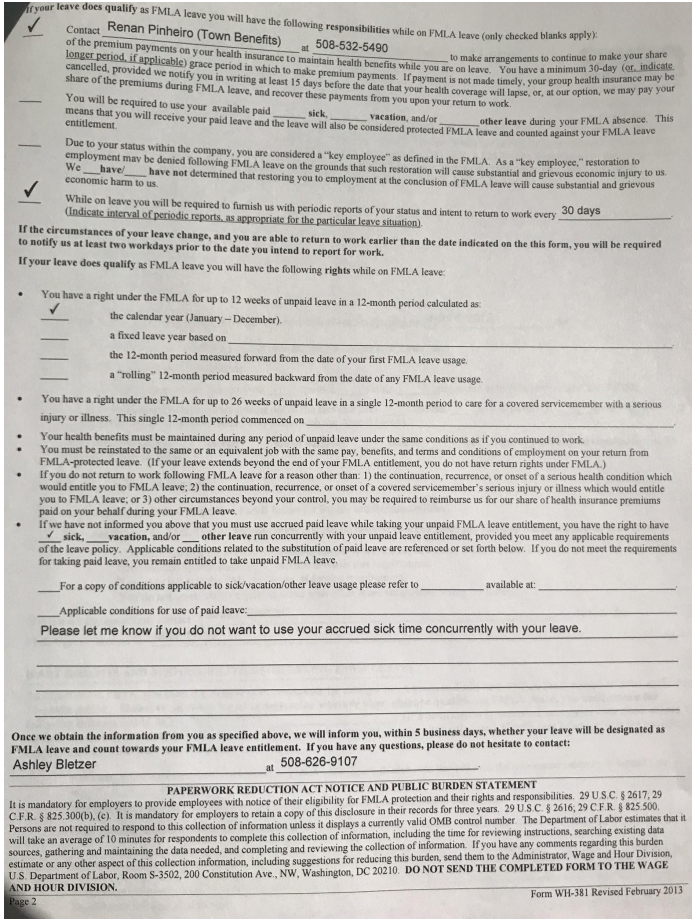
Form WH-381 Revised February 2



If your leave does qualify as FMLA leave you will have the following **responsibilities** while on FMLA leave (only checked blanks apply):

✓ Contact Renan Pinheiro (Town Benefits) at 508-532-5490 to make arrangements to continue to make your share of the premium payments on your health insurance to maintain health benefits while you are on leave. You have a minimum 30-day (or, indicate longer period, if applicable) grace period in which to make premium payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse, or, at our option, we may pay your share of the premiums during FMLA leave, and recover these payments from you upon your return to work.

____ You will be required to use your available paid _____ **sick**, _____ **vacation**, and/or _____ **other leave** during your FMLA absence. This means that you will receive your paid leave and the leave will also be considered protected FMLA leave and counted against your FMLA leave entitlement.

____ Due to your status within the company, you are considered a "key employee" as defined in the FMLA. As a "key employee," restoration to employment may be denied following FMLA leave on the grounds that such restoration will cause substantial and grievous economic injury to us. We ___**have**/____ **have not** determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic harm to us.

✓ While on leave you will be required to furnish us with periodic reports of your status and intent to return to work every 30 days (Indicate interval of periodic reports, as appropriate for the particular leave situation).

If the circumstances of your leave change, and you are able to return to work earlier than the date indicated on the this form, you will be required to notify us at least two workdays prior to the date you intend to report for work.

If your leave does qualify as FMLA leave you will have the following **rights** while on FMLA leave:

- You have a right under the FMLA for up to 12 weeks of unpaid leave in a 12-month period calculated as:
  - ✓ the calendar year (January – December).
  - ____ a fixed leave year based on _____.
  - ____ the 12-month period measured forward from the date of your first FMLA leave usage.
  - ____ a "rolling" 12-month period measured backward from the date of any FMLA leave usage.
- You have a right under the FMLA for up to 26 weeks of unpaid leave in a single 12-month period to care for a covered servicemember with a serious injury or illness. This single 12-month period commenced on _____.
- Your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work.
- You must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA-protected leave. (If your leave extends beyond the end of your FMLA entitlement, you do not have return rights under FMLA.)
- If you do not return to work following FMLA leave for a reason other than: 1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; 2) the continuation, recurrence, or onset of a covered servicemember's serious injury or illness which would entitle you to FMLA leave; or 3) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave.
- If we have not informed you above that you must use accrued paid leave while taking your unpaid FMLA leave entitlement, you have the right to have ___✓___ **sick,** ____**vacation,** and/or ___ **other leave** run concurrently with your unpaid leave entitlement, provided you meet any applicable requirements of the leave policy. Applicable conditions related to the substitution of paid leave are referenced or set forth below. If you do not meet the requirements for taking paid leave, you remain entitled to take unpaid FMLA leave.

___For a copy of conditions applicable to sick/vacation/other leave usage please refer to _____ available at: _____.

___Applicable conditions for use of paid leave: _____

Please let me know if you do not want to use your accrued sick time concurrently with your leave.

Once we obtain the information from you as specified above, we will inform you, within 5 business days, whether your leave will be designated as FMLA leave and count towards your FMLA leave entitlement. If you have any questions, please do not hesitate to contact:

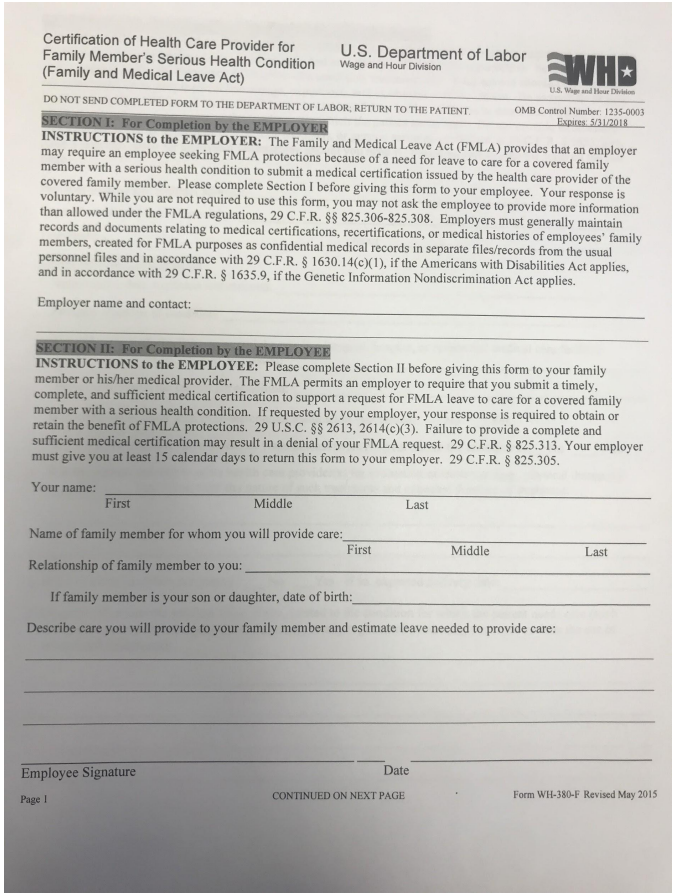
Ashley Bletzer at 508-626-9107

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

It is mandatory for employers to provide employees with notice of their eligibility for FMLA protection and their rights and responsibilities. 29 U.S.C. § 2617; 29 C.F.R. § 825.300(b), (c). 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 10 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.**

Form WH-381 Revised February 2013

Certification of Health Care Provider:



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

U.S. Department of Labor
Wage and Hour Division

WHD
U.S. Wage and Hour Division

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

OMB Control Number: 1235-0003
Expires: 5/31/2018

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: _____

SECTION II: For Completion by the EMPLOYEE

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

Your name: _____
First Middle Last

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

Relationship of family member to you: _____

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

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

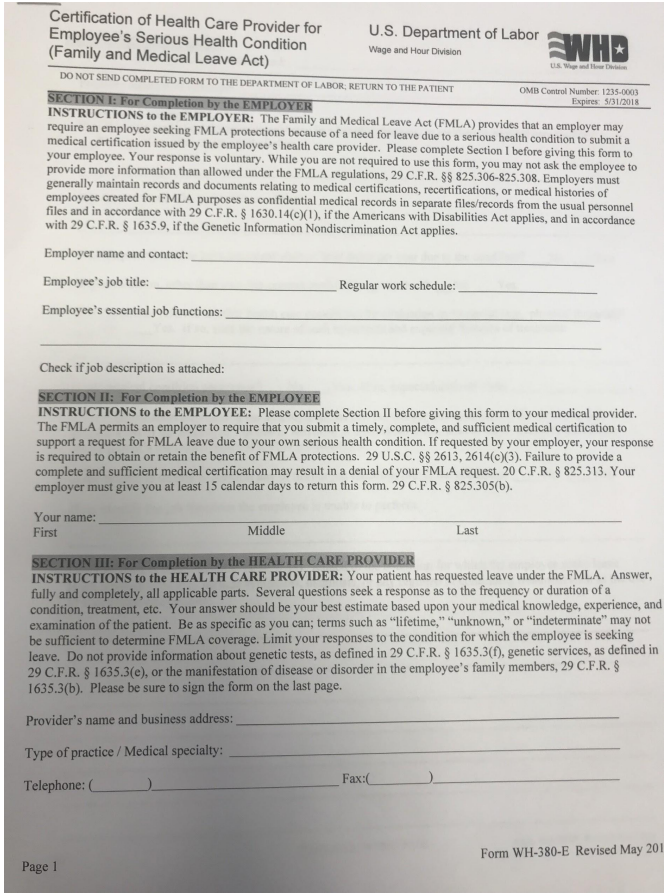
_____

_____

_____

_____ _____
Employee Signature Date

Page 1 CONTINUED ON NEXT PAGE Form WH-380-F Revised May 2015



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

U.S. Department of Labor
Wage and Hour Division

WHD
U.S. Wage and Hour Division

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

OMB Control Number: 1235-0003
Expires: 5/31/2018

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, recertifications, 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: _____

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 denial of your FMLA request. 20 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

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. 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: (_____)_____ Fax:(_____)_____

Page 1 Form WH-380-E Revised May 201

Designation Notice:

- If your leave is continuous the District may ask for additional medical certification during your absence

- If your leave is **intermittent**, it is your responsibility to notify HR and your school's office staff that the requested time off is in relation to this particular leave

    - The employee must try to schedule the appointment outside of working hours
    - If an appointment is necessary during working hours, the employee must provide advance notice, 30 days if possible
    - If the employer says that the appointment will be unduly disruptive, the employee must attempt to reschedule

Designation Notice (Cont.):

- When a series of appointments is necessary, the employee must consult with the employer and attempt to agree on a schedule that will not be unduly disruptive, subject to the approval of the health care provider
- An employee whose appointment is for part of a day does not have a right to take the entire day off

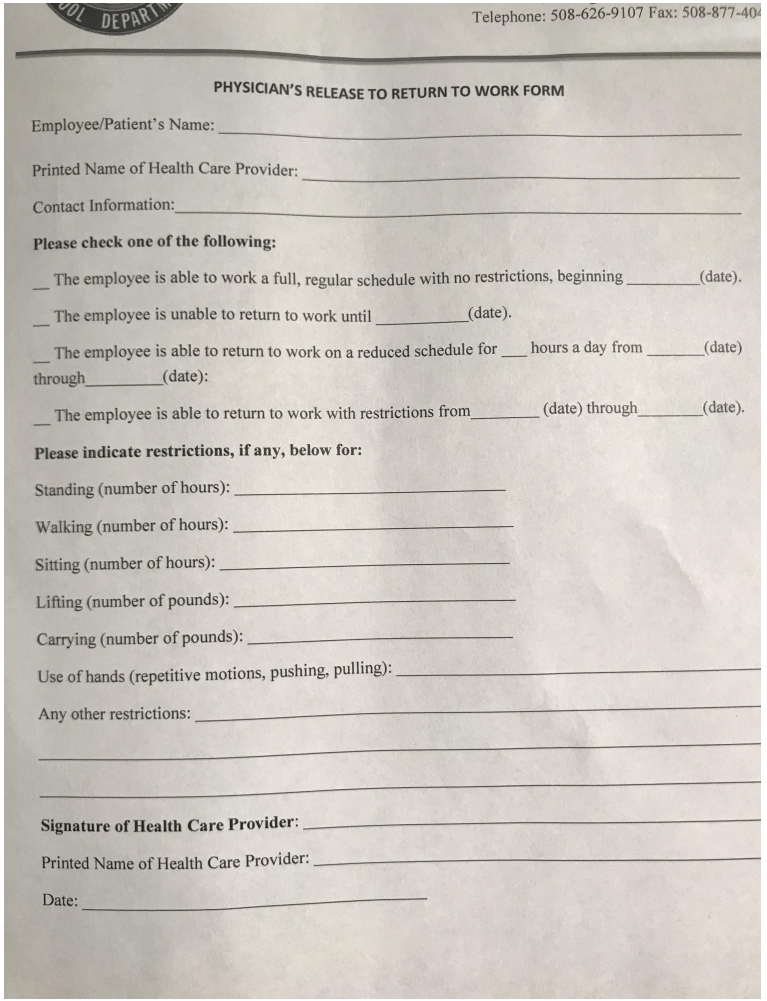
- All leave taken for this reason will be designated as FMLA leave

- If dates of scheduled leave change or are extended you need to let HR and your school's office staff know as soon as possible

Fitness for Duty Form:

- For an employee's own serious health condition, employers may require certification that the employee is able to resume work

- At least two days notice



DEPART

Telephone: 508-626-9107 Fax: 508-877-40

PHYSICIAN'S RELEASE TO RETURN TO WORK FORM

Employee/Patient's Name: _____

Printed Name of Health Care Provider: _____

Contact Information: _____

Please check one of the following:

__ The employee is able to work a full, regular schedule with no restrictions, beginning _____(date).

__ The employee is unable to return to work until _____(date).

__ The employee is able to return to work on a reduced schedule for ___ hours a day from _____(date) through_____(date):

__ The employee is able to return to work with restrictions from_____ (date) through_____(date).

Please indicate restrictions, if any, below for:

Standing (number of hours): _____

Walking (number of hours): _____

Sitting (number of hours): _____

Lifting (number of pounds): _____

Carrying (number of pounds): _____

Use of hands (repetitive motions, pushing, pulling): _____

Any other restrictions: _____

_____

_____

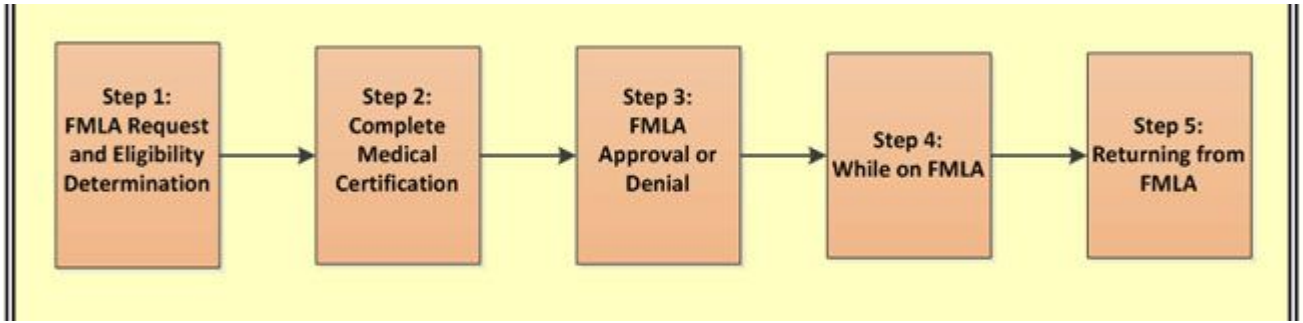
Signature of Health Care Provider: _____

Printed Name of Health Care Provider: _____

Date: _____

Other things to know:

- Employee is entitled to the same or equivalent job when they return to work after FMLA
- You should not feel any retaliation or discrimination for taking FMLA
- Communication is key
- Paid or Unpaid?
- Frontline/AESOP
- Sick Bank



Contact me!

Ashley Bletzer

Senior Human Resources Generalist

Office of Human Resources

Central Office

ableTzer@framingham.k12.ma.us

508-626-9107 ext. 26833