Monroe City Schools

Human Resources

Application for Requesting Leave Under the Family and Medical Leave Act of 1993

Leave Without Pay

Requesting Leave Under the Family and Medical Leave Act of 1993: Leave Without Pay

It is the policy of the Monroe City School System to comply with the Family and Medical Leave Act of 1993 and to otherwise grant leave without pay in accordance with the following procedures:

Eligible Employees:

Any employee who has been employed for at least twelve (12) months from which leave is requested and has worked at least 1,250 hours during the previous twelve (12) month period.

Amount of Leave:

Any eligible employee is entitled to a maximum of twelve (12) work weeks of leave during any twelve (12) month period. The Monroe City School Board will continue to pay the employer portion of medical insurance for all approved leave up to twelve (12) weeks. For any leave extending beyond a twelve week period the employee will be responsible for 100% of all medical premiums to include both the employer and employee portions.

Purposes of Leave:

1. To care for the employee's newborn child after birth.
2. To care for a child after placement of the child with the employee for adoption or foster care.
3. To care for an employee's spouse, son, daughter, or parent if such relative has a "serious health condition".
4. Because of a "serious health condition" that makes the employee unable to perform the functions of his/her job.

Advance Notice and Medical Certification:

1. Monroe City School Board requires the employee to provide advance leave and medical certification. The leave may be denied if the requirements are not met as set forth below.

2. The Monroe City School Board will require timely medical certification from a health care provider in support of the request for leave because of a serious health condition and may require second or third opinions (at the expense of the School Board). The certification must contain, at a minimum:

   a. The date on which the serious health condition began,
   b. The probable duration,
   c. The "Appropriate medical facts" about the condition, and
   d. If leave is sought to care for a family member, that the employee is needed to care for the relevant family member and an estimate of how long such care will be needed.
   e. If leave is sought for a serious health condition, that the employee is unable to perform the functions of his/her position.
   f. If the request is made for intermittent leave or leave on a reduced schedule, the statement must also state the dates on which treatment will be given and the duration of such treatments.

3. The Monroe City School Board will require an employee on leave to periodically report regarding his/her intention to return to work at such times as are reasonable.

4. As a condition of restoring the employee returning from medical leave to employment, the employee must provide a certification from a health care provider stating that the employee has the physical ability to resume work. This certification is limited to the condition that entitled the employee to the leave and

complies with job relatedness of the employee’s work condition.

Confidentiality:

All records regarding medical certification, like all other employee medical records, will be treated and maintained in a confidential manner.

Monroe City Schools

Request For Leave Under the Family and Medical Leave Act

[To be completed by Employee and Submitted to Human Resources]

Employee:________________________________ School/Department_________________________

Mailing Address:____ Phone:_________________________

I am requesting the school board's approval to take a leave without pay under the Family and Medical Leave Act for the following reason:

❑ Because of a personal health condition.

❑ To care for my newborn child.

❑ To care for my _______ newly adopted child or _______ recently placed foster child.

❑ To care for a family member with a serious illness: ____
(Name & Relationship to Employee.)

I am requesting this leave from ______________________ To _________________________.

Employee Signature:____ Date:_____________________

NOTE: When requesting leave for a personal medical condition or to care for a family member with a serious medical condition, the "Medical Certification" form completed by the physician must be attached to this request.

Monroe City Schools

Human Resources Department

P. O. Box 4180
2006 Tower Drive
Monroe, LA 71211-4180
(318) 325-0601 extension 3007
FAX: 812-3603
Phedra Brantley, Director Human Resources

Medical Certification
Required for the Family and Medical Leave Act

All records regarding medical certification, like all other employee medical records, will be treated as confidential and kept in separate files.

Employee Name:_______________________________Date:____________________

Patient Name (if different from above)________________________________Relationship:____________

1. Date on which the serious health condition began:______________________________________

2. The probable duration of the condition:____

3. Appropriate medical facts regarding the condition:_______________________________________

4. If the request is for intermittent leave or leave on a reduced schedule, the dates on which treatment will be given and the duration of such treatments must be stated here:

   ____

The physician may make any additional comments deemed necessary on the lines below:

____

Physician's Name and Address:

____

____

____

____

____

Physician's Signature:

____

Must have physician's original signature. No Stamps are allowed. Nurses or nurse practitioners cannot sign.

Medical Release to Return to Work

To be completed by employee:

Name:____

Social Security Number:____

School/Department:____

To be completed by physician:

This is to verify that the above named patient, under my care, will be medically able to return to work on ____.
Additional Comments: ____

Physician's Name and Address: Physician's Signature:

_____________________________ _____________________________
_____________________________ Date:________________________
____

To be completed by school principal or immediate supervisor:

This is to verify that the above named individual returned to full time work on:
____

Signature:__________________________________ Date:______________________
Submit the original of this form to the personnel office no later than two (2) days following the employee's return to work.