

Miller Place Teachers' Association

Family and Medical Leave Act (FMLA) Handbook

Prepared by FMLA Committee Chairperson Amanda L. Saulle, 2018

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Summary Provisions of FMLA

- FMLA provides up to 12 weeks of unpaid leave during any 12-month period for childbirth, adoption or foster child placement or for the serious health condition of a spouse, parent, child or eligible employee.
- The employer must continue the employee's health benefits during the period of leave under the same conditions that exist for active employees.
- Upon the expiration of the leave, the employee is entitled to be restored to the same position held before the leave was taken or to an equivalent position with the same pay, benefits and working conditions.
- In order to be eligible for FMLA leave, an employee must work for an employer who employs 50 or more employees, be employed by the same employer for at least 12 months and have worked at least 1,250 hours (about 24 hours per week) over the 12 months prior to the leave.
- Special leave rules apply for teachers and other instructional employees in elementary and secondary schools. These special rules do not apply to colleges and universities, trade schools, preschools, or other types of educational institutions. (Abraham, Strom, Sloan, & McElroy, A Guide to the Family & Medical Leave Act, 1995, 3)

How to Apply for FMLA Leave

- When you are ready to discuss your FMLA leave, please email Coreen Moschella at Central Office to schedule a meeting with Deputy Superintendent, Mr. Seth Lipshie.
- If an employee's family or medical leave is foreseeable (e.g., childbirth, adoption, placement in foster care or planned medical treatment), the employee must provide the employer with at least 30 days' notice. (Abraham, Strom, Sloan, & McElroy, A Guide to the Family & Medical Leave Act, 1995, 6)
- In the event that the need for FMLA leave is unforeseeable (e.g., premature childbirth, unanticipated early adoption, or a medical emergency), an employee only has to provide the employer with such notice "as soon as practical" under the facts and circumstances of the specific case. (Abraham, Strom, Sloan, & McElroy, A Guide to the Family & Medical Leave Act, 1995, 7)

Explanation of Necessary Forms

- Page 3: A sample letter addressed to Deputy Superintendent, Mr. Seth Lipshie regarding application for FMLA leave.
- Page 4: "Application for Family Medical Leave." This form will be sent to you after your FMLA request letter has been received. Complete and bring to your FMLA meeting with Mr. Lipshie.
- Pages 5 and 6: "Family and Medical Leave Notice of Eligibility." You will receive this letter from Mr. Lipshie at your FMLA meeting.
- Page 7-10: "Certification of Health Care Provider for Employee's Serious Health Condition." This form will be given to you at your meeting with Mr. Lipshie and must be completed by your doctor and returned to Coreen Moschella, at the Personnel Office by the date indicated on the "Notice of Eligibility" form.
- Page 11: "FMLA Checklist." Checklist given by Mr. Lipshie at your FMLA meeting.

NORTH COUNTRY ROAD MIDDLE SCHOOL

191 North Country Road
Miller Place, New York 11764

(631) 474-2710

Fax (631) 474-5178

Marianne F. Higuera, Ed.D., Superintendent of Schools
Seth A. Lipshie, Deputy Superintendent
Susan G. Hodun, Assistant Superintendent
Sandra Wojnowski, Executive Director for Educational Services

Matthew C. Clark, Principal
Christopher Herrschaft, Assistant Principal
Christopher Cherouvis, Dean of Students

June 21, 2018

Dear Mr. Lipshie,

I am writing in reference to my upcoming maternity leave. As I am planning for the upcoming arrival of my baby, I would like to notify you of the maternity leave I will be taking. My expected due date is currently September 18th and I am planning on beginning my Family and Medical Leave Act leave on or around this date. I would like to use my sick days to cover the first 6 weeks of my 12 week leave. With this estimated due date, I plan on returning to work on December 11, 2018. I will be in contact with the district after my child is born to solidify the actual birth date and date I will be returning to work. Please feel free to contact me with any questions or concerns.

Thank you,

Employee's Name

Miller Place Union Free School District

7 Memorial Drive, Miller Place, New York 11764-2036

Telephone: (631) 474-2700 Fax: (631) 474-9892

Board of Education

Johanna Testa, President
Richard Panico, Vice President
Noelle Dunlop, Trustee
Keith Frank, Trustee
Lisa Reitan, Trustee

Superintendent of Schools

Dr. Marianne F. Cartisano

Deputy Superintendent

Seth A. Lipshie

Assistant Superintendent

Susan G. Hodun

Executive Director for

Educational Services

Sandra A. Wojnowski

Application for Family Medical Leave

Name: _____ School/Building _____

Address: _____

Home Phone: _____ Cell Phone: _____

Expected Start Date of Leave: _____

Expected Date of Return to Work: _____

Were you on a FMLA Leave during the past 12 months? ___ Yes ___ No

Reason for Leave (explain): _____

Please indicate:

Administrator

Teacher

TA

Aide

Clerical

Operations

Other

If the leave is approved and you wish to use sick and or personal days, please explain how you would you like to utilize the available days:

Sick _____ Personal _____

Note: In addition to this application, a "Certification of Health Care Provider" form must be provided within *ten* business days after the onset of the medical condition. Failure to comply with this requirement may jeopardize your FMLA request.

***Note Maternity Leave Only:** Following the birth of your baby, please forward a letter to the Personnel Office from your doctor stating the date of delivery and the date that your disability will end. If there are any changes to your original requested leave dates (i.e. expected date of delivery), please forward a letter to the Personnel Office stating your amended dates. Please call the Health Benefits Coordinator at ext. 724 to enroll your child for benefits.

I have received and have reviewed the District FMLA Guidelines. I understand that this form is an application for a FMLA Leave and that in order for this request to be considered, I must meet the requirements of the FMLA as the law stipulates. Furthermore, I understand that my request must be approved by the Superintendent and the Board of Education.

Signature: _____ Date: _____

**MILLER PLACE UNION FREE SCHOOL DISTRICT
FAMILY MEDICAL LEAVE NOTICE OF ELIGIBILITY**

TO: Employee

FROM: Seth Lipshie, Deputy Superintendent_
Employer Representative

DATE:

On _____, you informed us that you needed leave beginning on _____ 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/daughter; _____ parent is on covered active duty or call to covered active duty status with the Armed Forces.
- Because you are the _____ spouse; _____ son/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 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 Seth Lipshie, Deputy Superintendent, (631) 474-2700 x723.

IRIGHTS AND RESPONSIBILITIES FOR TAKING FMLA LEAVE

As explained above, you meet the eligibility requirements for taking FMLA leave and still have FMLA leave available in the applicable 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 _____.** If sufficient information is not provided in 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

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

- Contact Nadine Steffens at (631) 474-2700 x724 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.
- While on leave you will be required to furnish us with periodic reports of your status and intent to return to work every 4 weeks.

If the circumstances of your leave change, and you are able to return to work earlier than the date indicated on 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 qualifies as FMLA leave your unpaid leave in a 12-month period is calculated as 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.

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: Seth Lipshie, Deputy Superintendent at (631) 474-2700 x723.

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



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: MPUSD, Seth Lipshie, Deputy Superintendent, (631) 474-2700 x736

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 _____

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 as medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

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.

Estimate the beginning and ending dates for the period of incapacity: _____

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.

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 COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**

FMLA CHECKLIST

Employee's Name: _____

The following documents have been given to the employee:

REQUIRED DOCUMENTS & INFORMATION		
COMPLETED APPLICATION		S.L. Collect
CERTIFICATION OF HEALTH CARE PROVIDER FOR EMPLOYEE OR FAMILY MEMBER		S.L. Handout
NOTICE OF ELIGIBILITY OF RIGHTS & RESPONSIBILITIES		S.L. Handout
Please submit FMLA request letter with the dates of your leave.		S.L. Reminder
Please remember to enter your FMLA leave into AESOP		S.L. Reminder
PAYROLL AND BENEFITS NOTIFIED		C.M. Email Post Mtg.
The Completed Application and Certification of Health Care Provider have been received back from the Employee.		Return to C.M.

Items to Keep in Mind

- If a holiday occurs during a week of FMLA leave, the entire week is still counted against the employee's total leave entitlement. However if FMLA leave occurs during a normally scheduled school break (i.e., spring break or summer vacation) when the employee would not have been required to report for duty for a week or more, it is not counted against the employee's FMLA leave. (Abraham, Strom, Sloan, & McElroy, A Guide to the Family & Medical Leave Act, 1995, 36)
- You are entitled to take a 12 week FMLA within the 12 month rolling calendar year. You may also use up to 6 weeks' worth of your sick and personal days.
- After 6 weeks of using your own days you will no longer receive pay but your normal health benefits will continue until the end of the 12th week of our leave. Upon returning to work, the percentage normally taken out of your salary for health insurance will be made up for when you return, resulting in smaller pay checks until it is payed off.
- If you use the school's provided Empire insurance, you must contact the insurance provider before the baby is born to announce your upcoming hospital stay.
- Once the baby is born, contact Nadine Steffens (Employee Benefits) in Central Office if you plan on putting the new baby under your insurance.