THE LEAVE PROCEDURES INFORMATION APPLIES TO ALL EMPLOYEE LEAVE TYPES UNLESS OTHERWISE NOTED.

EMPLOYEE

It is the responsibility of the employee to read and follow all leave instructions. This information is available on the District website or will be provided to you by your supervisor or the Leave Administrator.

- Employees must give 30-days' advance notice of the need for FMLA or non-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; and
- Complete required paperwork. Refer to "LDocumentation"; and
- Verify leave documentation is completed and returned to Human Resources; and
- Maintain contact with Supervisor as required; and
- If leave extends beyond initial physician certification, provide physician note to Leave Administrator and notify Supervisor stating extended dates. This must be completed prior to initial return to work date; and
- Prior to return to work complete "Return to Work" steps; and
- Provide required release documentation to the Leave Administrator.

SUPERVISOR

Once notified by the employee of the need for leave greater than five (5) consecutive days, or if an employee misses five (5) consecutive days of work, or three (3) intermittent days of work due to the same serious health condition:

- Direct employee to Joplin Schools website, Staff tab, Human Resources for leave paperwork; and
- Notify Leave Administrator of absences. Provide full name and employee's current phone number; and
- Upon receipt of employee's Fitness for Duty release or Return to Work, the Leave Administrator will email you to notify you of release status, full-release, modified duty or not released. If employee provides this information to you send original to Leave Administrator.

LEAVE ADMINISTRATOR

Once notified of employee need for leave:

- If leave paperwork has not been provided to employee contact employee by phone to determine best option for sending leave paperwork; and
- Provide "Employee Rights Under the Family and Medical Leave Act", "FMLA Request Form", "Physician Certification"; and

Upon return of physician documentation:

- Provide employee with "Designation Notice" within 5 days of receipt of documentation; and
- Include "Fitness-for-duty" release and/or for specific positions whose leave will or may continue for 45 consecutive days or more, provide instructions regarding the "OccuMed Return to Work Release".

Upon receipt of release:

- Notify supervisor of full release, modified duty or not released.

LEAVE ENTITLEMENT

- The district requires accrued leave (sick, personal, vacation) to run concurrently with leave qualifying under FMLA.
- When both spouses are employed by the district and eligible for FMLA leave, the leave will be limited to an aggregate total of 12 workweeks during a 12-month period in cases where the leave is taken for the birth or first year care of the employees' child, adoption or foster placement of a child with the employee, or to care for a parent with a serious health condition.

LEAVE DOCUMENTATION

- A "FMLA Request Form" must be completed by the employee for absences greater than 5 days or for 3 intermittent absences for the same reason. Forms are available on the Joplin Schools website under the Staff tab, Human Resources or through the Leave Administrator.
- "Employee FML Request" is for the employee's own serious health condition. "Family Member FML Request" is for the employee's spouse, parent or child's serious health condition. Please note that the District's definition of family member exceeds that of Family and Medical Leave. This documentation is used for all medical leave regardless of qualification of Family and Medical Leave.
- All employee medical leaves will require that certification be completed by the healthcare provider (or family members' healthcare provider). Failure to submit paperwork may result in denial of FMLA or non-FMLA leave.

RETURN TO WORK BY POSITION – Does not apply to minor illness*, maternity, paternity or family member leave.

Teacher, Administrator, Administrative Support, Clerical:

- Provide your physician with a copy of your job description and Fitness-for-duty release form to complete prior to your return to work date, and;
- Prior to return to work provide Fitness-for-duty release to the Leave Administrator.
- You must provide a Fitness-for-duty release from your physician to the Leave Administrator in order to return to work. Failure to provide this release will delay your return to work.

Paraprofessional/Behavior Support, Transportation, Facilities, Food Service:

For leave less than forty-five (45) days:

- Provide your physician with a copy of your job description and Fitness-for-duty release form to complete prior to your return to work date, and;
- Prior to return to work provide Fitness-for-duty release to the Leave Administrator.
- You must provide a Fitness-for-duty release from your physician to the Leave Administrator in order to return to work. Failure to provide this release will delay your return to work.

For leaves forty-five (45) days or more:

- Prior to return to work contact your Leave Administrator to request a Return to Work physical with OccuMed. You must have a release to return to work from your physician prior to scheduling.
- You must provide a Return to Work release from OccuMed to the Leave Administrator in order to return to work.

RETURN TO WORK FOR MINOR PERSONAL ILLNESS, MATERNITY, PATERNITY OR FAMILY MEMBER LEAVE – All positions

- Minor personal illness (cold or flu) with absences of 5 or less days are required to provide a physician's release to return to work. Absences that fall in this category are not required to provide a Fitness for Duty release.
- A physician release must be provided to the Leave Administrator for maternity leave less than 6 weeks for normal delivery or 8 weeks for Caesarean Section.
- For maternity leave greater than 6 or 8 weeks as described or paternity or family member leave, this leave is considered bonding leave and is not subject to physician documentation.
- For family member leave, this leave is subject to the leave timeframe provided by the patient's physician.

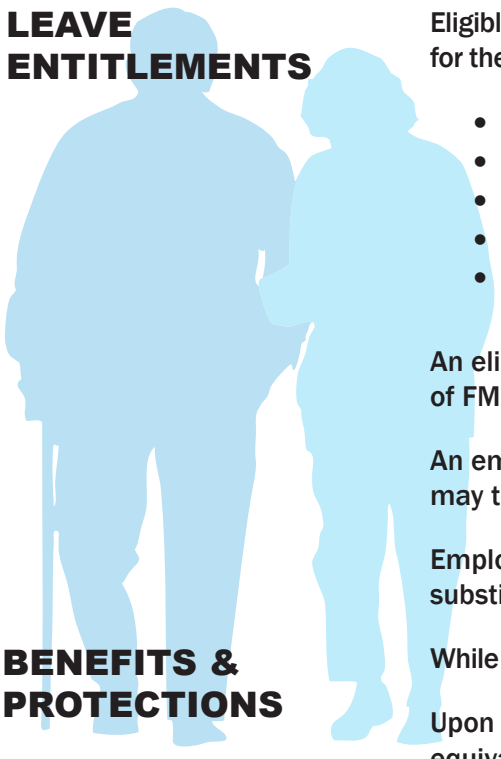
ABSENCE AND LEAVE POLICIES

GBBDA – Family and Medical Leave
GBCBC - Staff Absences and Tardiness
GCBDA – Professional Staff Short-Term Leaves
GDBDA - Support Staff Leaves

Leave Administrator: Ariana Valade – arianavalade@joplinschools.org, 417-625-5200 ext. 2009.

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 one 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.

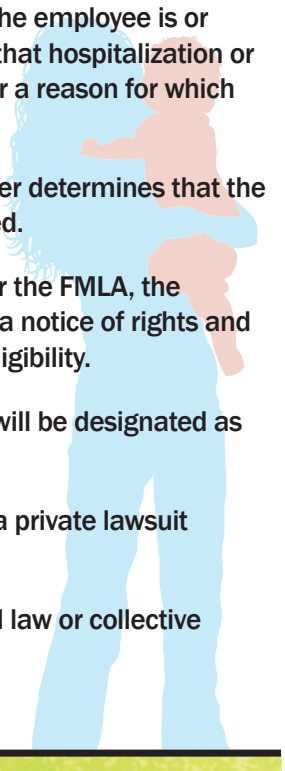
*Special "hours of service" requirements apply to airline flight crew employees.

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

WAGE AND HOUR DIVISION

WH1420 REV 04/16

EMPLOYEE'S REQUEST
FOR FMLA LEAVE
(Family and Medical Leave Act)

Joplin Schools
825 S Pearl Ave
Joplin, MO 64801
(417) 625-5200 Ext.2001

The Family and Medical Leave Act (FMLA) provides protections for an employee seeking leave due to; a serious health condition, a family member's serious health condition, a qualifying exigency for Military Family Leave, and injury or illness of a covered servicemember for Military Family Leave.

Employer name and contact: Joplin Schools - Ariana Valade, (p) 417-625-5200 x 2001 (f) 417-781-2859

SECTION II: For Completion by the EMPLOYEE: Please complete Section II before returning this form to your employer. 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 and/or a family members 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. Military Family Leave requires additional forms to be completed to determine qualification. Contact your Employer for additional forms. Your employer must give you at least 15 calendar days to return any of these forms. 29 C.F.R. § 825.305(b).

NAME: _____
FIRST MIDDLE LAST

ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE NUMBER(S): _____

JOB TITLE & SCHOOL: _____

I request FMLA leave for the following reason:

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

_____ Your own serious health condition;
Please Explain: _____

_____ Because you are needed to care for your __spouse; __child; or __ parent due to his/her serious health condition;

_____ Because of a qualifying exigency arising out of the fact that your __spouse; __ child; __ parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves.

_____ Because you are the ___ spouse; ___ child; ___ parent; ___ next of kin of a covered service member with a serious injury or illness.

Leave will be: _____ Continuous _____ Intermittent

Leave start date: _____ **Expected Return date:** _____

_____
EMPLOYEE'S SIGNATURE DATE

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

U.S. Department of Labor
Wage and Hour Division

WAGE AND HOUR DIVISION

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

OMB Control Number: 1235-0003
Expires: 6/30/2026

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. 29 U.S.C. §§ 2613, 2614(c)(3); 29 C.F.R. § 825.305. The employer must give the employee at least 15 calendar days to provide the certification. If the employee fails to provide complete and sufficient medical certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

SECTION I - EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, this form asks the health care provider for the information necessary for a complete and sufficient medical certification, which is set out at 29 C.F.R. § 825.306. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308.** Additionally, you **may not** request a certification for FMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care.

Employers must generally maintain records and documents relating to medical information, 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.

(1) Employee name: First Middle Last

(2) Employer name: Date: (mm/dd/yyyy)
(List date certification requested)

(3) The medical certification must be returned by (mm/dd/yyyy)
(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee's diligent, good faith efforts.)

(4) Employee's job title: Job description ☐ is / ☐ is not attached.

Employee's regular work schedule:

Statement of the employee's essential job functions:

(The essential functions of the employee's position are determined with reference to the position the employee held at the time the employee notified the employer of the need for leave or the leave started, whichever is earlier.)

SECTION II - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form. Your patient has requested leave under the FMLA. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of the employee. For FMLA purposes, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves **inpatient care** or **continuing treatment by a health care provider**. For more information about the definitions of a serious health condition under the FMLA, see the chart on page 4.

You also may, but are **not required** to, provide other appropriate medical facts including symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment. Please note that some state or local laws may not allow disclosure of private medical information about the patient's serious health condition, such as providing the diagnosis and/or course of treatment.

Employee Name: _____

Health Care Provider's name: (Print)

Health Care Provider's business address:

Type of practice / Medical specialty:

Telephone: Fax: E-mail:

PART A: Medical Information

Limit your response to the medical condition(s) for which the employee is seeking FMLA leave. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. **After completing Part A, complete Part B to provide information about the amount of leave needed.** Note: For FMLA purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. 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).

(1) State the approximate date the condition started or will start: (mm/dd/yyyy)

(2) Provide your **best estimate** of how long the condition lasted or will last:

(3) Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

☐ **Inpatient Care**: The patient (☐ has been / ☐ is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s):

☐ **Incapacity plus Treatment**: (e.g. outpatient surgery, strep throat)

Due to the condition, the patient (☐ has been / ☐ is expected to be) incapacitated for **more than** three consecutive, full calendar days from: (mm/dd/yyyy) to (mm/dd/yyyy).

The patient (☐ was / ☐ will be) seen on the following date(s):

The condition (☐ has / ☐ has not) also resulted in a course of continuing treatment under the supervision of a health care provider (e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment).

☐ **Pregnancy**: The condition is pregnancy. List the expected delivery date: (mm/dd/yyyy).

☐ **Chronic Conditions**: (e.g. asthma, migraine headaches) Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

☐ **Permanent or Long Term Conditions**: (e.g. Alzheimer's, terminal stages of cancer) Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

☐ **Conditions requiring Multiple Treatments**: (e.g. chemotherapy treatments, restorative surgery) Due to the condition, it is medically necessary for the patient to receive multiple treatments.

☐ **None of the above**: If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed. Go to page 4 to sign and date the form.

Employee Name: _____

(4) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. (e.g., use of nebulizer, dialysis)

PART B: Amount of Leave Needed

For the medical condition(s) checked in Part A, complete all that apply. 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.

(5) Due to the condition, the patient (☐ had / ☐ will have) **planned medical treatment(s)** (scheduled medical visits) (e.g.psychotherapy, prenatal appointments) on the following date(s):

(6) Due to the condition, the patient (☐ was / ☐ will be) **referred to other health care provider(s)** for evaluation or treatment(s).

State the nature of such treatments: (e.g. cardiologist, physical therapy)

Provide your **best estimate** of the beginning date (mm/dd/yyyy) and end date (mm/dd/yyyy). for the treatment(s).

Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery (e.g. 3 days/week)

(7) Due to the condition, it is medically necessary for the employee to work a **reduced schedule**.

Provide your **best estimate** of the reduced schedule the employee is able to work. From (mm/dd/yyyy) to (mm/dd/yyyy) the employee is able to work: (e.g., 5 hours/day, up to 25 hours a week)

(8) Due to the condition, the patient (☐ was / ☐ will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.

Provide your **best estimate** of the beginning date (mm/dd/yyyy) and end date (mm/dd/yyyy). for the period of incapacity.

(9) Due to the condition, it (☐ was / ☐ is / ☐ will be) medically necessary for the employee to be absent from work on an intermittent basis (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, episodes of incapacity are estimated to occur times per (☐ day ☐ week ☐ month) and are likely to last approximately (☐ hours ☐ days) per episode.

Employee Name: _____

PART C: Essential Job Functions

If provided, the information in Section I question #4 may be used to answer this question. If the employer fails to provide a statement of the employee's essential functions or a job description, answer these questions based upon the employee's own description of the essential job functions. An employee who must be absent from work to receive medical treatment(s), such as scheduled medical visits, for a serious health condition is considered to be **not able** to perform the essential job functions of the position during the absence for treatment(s).

(10) Due to the condition, the employee (☐ was not able / ☐ is not able / ☐ will not be able) to perform **one or more** of the essential job function(s). Identify at least one essential job function the employee is not able to perform:

Signature of Health Care Provider _____ Date: _____ (mm/dd/yyyy)

Definitions of a Serious Health Condition (See 29 C.F.R. §§ 825.113-.115)
Inpatient Care
• An overnight stay in a hospital, hospice, or residential medical care facility. • Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.
Continuing Treatment by a Health Care Provider (any one or more of the following)
Incapacity Plus Treatment: A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either: o Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or, o At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.
Pregnancy: Any period of incapacity due to pregnancy or for prenatal care.
Chronic Conditions: Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.
Permanent or Long-term Conditions: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.
Conditions Requiring Multiple Treatments: Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.

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 15 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 Avenue, N.W., Washington, D.C. 20210.

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