LUCIA MAR UNIFIED SCHOOL DISTRICT

INFORMATION AND APPLICATION PACKET

LEAVES

- ***California Family Rights Act,***
- ***Family Medical Leave***
- ***Parental Bonding Leave***
- ***Pregnancy Disability Leave***
- ***Unpaid Leaves of Absence***
- ***Worker's Compensation Leave***

Human Resources Office
602F Orchard St.
Arroyo Grande, CA 93420
Phone: 805-474-3000 x 1195
Fax: 805-473-4308

Leave of Absence
Application Process

To determine if you qualify for leave under FMLA, please complete Section I (below):

Section I – FMLA Eligibility

A. Have you been employed by Lucia Mar Unified School District for 12 months? ☐**Yes** ☐**No**

- ***If you answered Yes,*** *please continue to "B" below.*
- ***If you answered No,*** *you are not eligible for leave under FMLA.*

B. Are you an employee who has worked 1250 hours within the 12-month period prior to the commencement of the requested FMLA leave? ☐**Yes** ☐**No**

- ***If you answered Yes to both A and B,*** *you are eligible and need to submit a written request for FMLA leave along with all other applicable forms (see Section II below).*
- ***If you answered No,*** *you are not eligible for leave under FMLA.*

Section II – Leave of Absence/Documentation Required

If you wish to take leave for any of the following reasons, you will need to submit a **WRITTEN (*Leave Request Form*)** request for your leave including the dates and reasons for the leave along with the required supporting documentation for your leave. **It is important to notify Human Resources immediately, if the dates change from your original request!**

If you do not request leave under FMLA and it is determined by LMUSD that your leave qualifies under one or more of the following FMLA qualified absences, LMUSD may automatically designate your leave as FMLA.

Along with a written request (as stated above), please include the additional required documentation for a leave due to:

- **Birth of a child:** medical certification (please use the attached Healthcare Provider Certification Form) indicating the expected date of birth.
- **Placement of a child for adoption or foster care:** a copy of placement papers.
- **A serious health condition of your spouse, child or parent:** medical certification (please use the attached Healthcare Provider Certification Form).
- **Your own serious health condition** (including absence due to Worker's Compensation): medical certification (please use the attached Healthcare Provider Certification From). A serious health condition may include and run concurrently with Worker's Compensation absences.
- **Intermittent leave or a leave on a reduced schedule:** medical certification (please use the attached Healthcare Provider Certification Form) indicating the leave has been determined to be medically necessary.

To return to work from leave for your own personal illness: You must submit a medical release from your healthcare provider (please use the attached ''Return to Work Medical Certification Form'') prior to reporting for duty.

Section III - Approval

You will be notified as to the approval of your leave request once a determination has been made. Please refer to the attached ''Family and Medical Leave Act Procedures'' for information on the *retention of your benefits* during your leave.

***If you wish to extend your leave past the 12 weeks allowed under FMLA*, you must submit a revised "Leave Request Form" (available in your school or from the Human Resources Office). Please note that extending your leave beyond 12 weeks may affect the cost of your benefits.**

For further information please contact Cyndie Clark @ Human Resources: 805-474-3000 ext. 1195.

Your Rights

under the
Family and Medical Leave Act of 1993

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to "eligible" employees for certain family and medical reasons. Employees are eligible if they have worked for their employer for at least one year, and for 1,250 hours over the previous 12 months, and if there are at least 50 employees within 75 miles. The FMLA permits employees to take leave on an intermittent basis or to work a reduced schedule under certain circumstances.

Reasons for Taking Leave:

Unpaid leave must be granted for *any* of the following reasons:

- to care for the employee's child after birth, or placement for adoption or foster care;
- to care for the employee's spouse, son or daughter, or parent who has a serious health condition; or
- for a serious health condition that makes the employee unable to perform the employee's job.

At the employee's or employer's option, certain kinds of *paid* leave may be substituted for unpaid leave.

Advance Notice and Medical Certification:

The employee may be required to provide advance leave notice and medical certification. Taking of leave may be denied if requirements are not met.

- The employee ordinarily must provide 30 days advance notice when the leave is "foreseeable."
- An employer may require medical certification to support a request for leave because of a serious health condition, and may require second or third opinions (at the employer's expense) and a fitness for duty report to return to work.

Job Benefits and Protection:

- For the duration of FMLA leave, the employer must maintain the employee's health coverage under any "group health plan."
- Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.
- The use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Unlawful Acts by Employers:

FMLA makes it unlawful for any employer to:

- interfere with, restrain, or deny the exercise of any right provided under FMLA; or
- discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement:

- The U.S. Department of Labor is authorized to investigate and resolve complaints of violations.
- An eligible employee may bring a civil action against an employer for violations.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

For Additional Information:

If you have access to the Internet, visit our FMLA website: http://www.dol.gov/esa/whd/fmla. To locate your nearest Wage-Hour Office, telephone our Wage-Hour toll-free information and help line at 1-866-4USWAGE (1-866-487-9243): a customer service representative is available to assist you with referral information from 8am to 5pm in your timezone;or log onto our Home Page http://www.wagehour.dol.gov

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division
Washington, D.C. 20210

WH Publication 1420
Revised August 2001

NOTICE

Military Family Leave

On January 28, President Bush signed into law the National Defense Authorization Act for FY 2008 (NDAA), Public Law 110-181. Section 585(a) of the NDAA amended the FMLA to provide eligible employees working for covered employers two important new leave rights related to military service:

(1) **New Qualifying Reason for Leave.** Eligible employees are entitled to up to 12 weeks of leave because of "any qualifying exigency" arising out of the fact that the spouse, son, daughter, or parent of the employee is on active duty, or has been notified of an impending call to active duty status, in support of a contingency operation. By the terms of the statute, this provision requires the Secretary of Labor to issue regulations defining "any qualifying exigency." In the interim, employers are encouraged to provide this type of leave to qualifying employees.

(2) **New Leave Entitlement**. An eligible employee who is the spouse, son, daughter, parent, or next of kin of a covered servicemember who is recovering from a serious illness or injury sustained in the line of duty on active duty is entitled to up to 26 weeks of leave in a single 12-month period to care for the servicemember. This provision became effective immediately upon enactment. This military caregiver leave is available during "a single 12-month period" during which an eligible employee is entitled to a combined total of 26 weeks of all types of FMLA leave.

Additional information on the amendments and a version of Title I of the FMLA with the new statutory language incorporated are available on the FMLA amendments Web site at http://www.dol.gov/esa/whd/fmla/NDAA_fmla.htm.

Lucia Mar Unified School District

Human Resources, 602 Orchard St. Arroyo Grande, Ca 93420* Phone (805) 474-3000 ext. 1195 *Fax (805) 473-4308

Leave Request Form

☐ New Request ☐ Revised Request ☐ A&S ☐ Teacher / Instructional Staff ☐ Support Staff

Complete all information below and attach appropriate verification documentation and ***submit to Human Resources*** 30 days prior to the start of leave date. Refer to the negotiated agreements for policies regarding qualified leaves of absence. **Family/Medical leave (FMLA) will run concurrently with all qualified paid and unpaid leave requested.**

Employee Name:_____ SS #: _____

Employee Address:_____ Job Title:_____

☐Part-time employee (less than 7.5 hours daily) ☐Full-time employee (7.5+ hours daily) Work Site: _____

Member of Catastrophic Bank: ☐Yes ☐No Phone # *(while on leave)*: _____

Requested Leave Dates: _____/_____/_____ thru _____/_____/_____ *or # of weeks:* _____ Requesting Intermittent Leave: ☐Yes ☐ No

Reason(s) for leave **–** please check all that apply: Email *(while on leave):* _____ ☐

Family/Medical Leave Act (FMLA)

☐ **Personal or Family Illness to care for a seriously ill ☐ Self ☐ Spouse ☐Child ☐ Parent** Name:

☐**Pregnancy Disability Leave** (leave without pay immediately following birth or adoption of a child; runs concurrent to paid leaves and FMLA)
*If adding a child to insurance must do so within 30 days of birth, contact Anastacia Malm @ ext. 1192

☐**California Family Rights Act (CFRA)** (leave without pay runs consecutive to PDL)

☐**Parental bonding leave (**differential pay following the birth/adoption of a child; runs consecutive to PDL/FMLA)

☐**Workers' Compensation Leave** (Unable to work due to injury or required surgery-employee must contact Cyndie Clark @ ext. 1195)

☐ **Military Leave** (attach orders) ☐**Bereavement** ☐**Study** ☐ **Other** Reason:

☐**Unpaid Leave of Absence** (Any other type of leave not included on this form) **Reason:**

If you wish your child to be covered under any healthcare coverage, proof and application must be completed within 30 days of adoption or birth of the child. Employees who are seeking leave because of family or personal illness must provide medical certification (please use the "Healthcare Provider Certification Form" attached) within 15 days of your request or as soon as practical. I understand that failure to provide medical certification may result in denial of FMLA leave until such certification is provided.

I understand, if I am eligible, I may take unpaid FMLA leave for up to 12 weeks. A 12 month period is defined as July 1st to June 30th. I have read and understand all material on FMLA sent with this form. I am also aware that I am responsible for my normal contribution for health, dental and life insurance benefits while on leave. Further, I understand that if at any time I do not receive enough in my paycheck to cover my health insurance premiums I may be responsible for a portion or the full amount to keep my insurance coverage in effect. Contact Anastacia Malm, Human Resources Technician for information regarding health benefits @ 474-3000 ext. 1192.
For information regarding payroll contact 474-3000 Certificated @ ext. 1050/Classified @ ext 1056.

(S*ee reverse side for additional information – signature required on page 2)*

Additional information:_____

I agree and understand the following:

- It is my responsibility to ***immediately*** notify my Principal/Supervisor and the Human Resources Office of any change(s) in connection with this request (including an address change) while I am on leave.
- FMLA is leave without pay unless the situation qualifies me to use my own accrued sick, personal or annual leave. If I am a member of the Catastrophic Leave Bank and I run out of my own leave, it is my responsibility to contact Human Resources to request and submit for the days I qualify for under Catastrophic Leave if I am unable to return to work due to illness or a non work related accident. I understand that any private disability coverage may disqualify me for Catastrophic Leave.
- I understand that while I am on leave I may not work for Lucia Mar Unified School District in any capacity.
- It is my responsibility to contact Anastacia Malm, Human Resources Technician regarding health benefits while on leave. Changes in benefits, including the addition of a newborn or adopted child, must be made within 30 days of the childbirth, adoption or family status change for coverage to be effective.
- I understand that in accordance with federal law, the District may recover District contributions to my insurance if I fail to return from leave. Except if the reason is the continuation, recurrence, or onset of a serious health condition, or something beyond my control. (Per LMUTA/LMUSD bargaining agreement Article V-Leaves, item M; and CSEA/LMUSD bargaining agreement Article IX-Leaves, item 10. Attached.)

_____ _____

Signature of Employee: Date

To be completed by Human Resources:

Employee: _____ School/Location: _____

This leave request has been reviewed for the period of absence listed above. The decision to approve/disapprove this request is as follows:

□ Approved Type of Leave Approved (FMLA, Unpaid LOA):_____

□Not eligible

Comments: _____

□ Qualifies for FMLA- Total FMLA Days:_____ □Copy sent to Payroll Office ____/____/____

_____

Signature of Human Resources Representative / Date

Leave Balances in Hours – Effective Date:_____ (SL/VL) Member of Catastrophic Leave Bank Verified: Yes No (circle one)

CONFIRMATION FROM PAYROLL -> Unpaid Leave Beginning:_____ Payroll Clerk: _____ Date:_____

Payroll: Employee will continue to receive a paycheck during leave □**Yes** □**No If NO:** Please indicate month this will take effect**:_____**

HR: Effective Dates of Leave _____/_____/_____ thru _____/_____/_____ Return to Work Date:_____

*Return a COPY of this form to Human Resources once completed by payroll

FAIR EMPLOYMENT & HOUSING COUNCIL
CERTIFICATION OF HEALTH CARE PROVIDER
(California Family Rights Act (CFRA) & Family Medical Leave Act (FMLA)

IMPORTANT NOTE: The California Genetic Information Nondiscrimination Act of 2011 (CalGINA) prohibits employers and other covered entities from requesting, or requiring, genetic information of an individual or family member of the individual except as specifically allowed by law. To comply with the Act, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information," as defined by CalGINA, includes information about the individual's or the individual's family member's genetic tests, information regarding the manifestation of a disease or disorder in a family member of the individual, and includes information from genetic services or participation in clinical research that includes genetic services by an individual or any family member of the individual. "Genetic Information" does not include information about an individual's sex or age.

1. Employee's Name: _____

2. Patient's Name (If other than employee): _____

   Patient's relationship to employee: _____

   If patient is employee's child, is patient either under 18 or an adult dependent child:

Yes No
☐ ☐

3. Date medical condition or need for treatment commenced
[NOTE: THE HEALTH CARE PROVIDER IS NOT TO DISCLOSE THE UNDERLYING DIAGNOSIS WITHOUT CONSENT OF THE PATIENT:]

_____

4. Probable duration of medical condition or need for treatment (first day of disability or date of delivery):

_____

5. Below is a description of what constitutes a "serious health condition" under both the federal Family and Medical Leave Act (FMLA) and the California Family Rights Act (CFRA). Does the patient's condition qualify as a serious health condition:

Yes No

☐ ☐

6. If the certification is for the serious health condition of the employee, please answer the following:

Yes No

☐ ☐ Is the employee able to perform work of any kind? (If "No," skip next question.)

☐ ☐ Is employee unable to perform any one or more of the essential functions of employee's position? (Answer after reviewing statement from employer of essential functions of employee's position, or, if none provided, after discussing with employee.)

7. If the certification is for the serious health condition of the employee's family member, please answer the following:

Yes No

☐ ☐ Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety, or transportation?

☐ ☐ After review of the employee's signed statement (See Item 10 below), does the condition warrant the participation of the employee? (This participation may include psychological comfort and/or arranging for third-party care for the family member.)

8. Estimate the period of time care is needed or during which the employee's presence would be beneficial:

_____

9. Please answer the following questions only if the employee is asking for intermittent leave or a reduced work schedule.

Yes No

☐ ☐ Intermittent Leave: Is it medically necessary for the employee to be off work on an intermittent basis due to the serious health condition of the employee or family member?

If yes, please indicate the estimated frequency of the employee's need for intermittent leave due to the serious health condition, and the duration of such leaves (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

Yes No

☐ ☐ Reduced Schedule Leave: Is it medically necessary for the employee to work less than the employee's normal work schedule due to the serious health condition of the employee or family member?

If yes, please indicate the part-time or reduced work schedule the employee needs:
_____Hour(s) per day; ____ days per week, from _____ through _____

Yes No

☐ ☐ Time Off for Medical Appointments or Treatment: Is it medically necessary for the employee to take time off work for doctor's visits or medical treatment, either by the health care practitioner or another provider of health services?

If yes, please indicate the estimated frequency of the employee's need for leave for doctor's visits or medical treatment, and the time required for each appointment, including any recovery period:

Frequency: _____times per ____ week(s) _____ month(s)

Duration: _____ hours or _____ day(s) per appointment/treatment

ITEM 10 IS TO BE COMPLETED BY THE EMPLOYEE NEEDING FAMILY LEAVE.
****TO BE PROVIDED TO THE HEALTH CARE PROVIDER UNDER SEPARATE COVER.

10. When family care leave is needed to care for a seriously-ill family member, the employee shall state the care he or she will provide and an estimate of the time period during which with care will be provided, including a schedule if leave is to be taken intermittently or on a reduced work schedule:

_____
_____
_____

11. Printed name of health care provider:

_____

Signature of health care provider:

_____

Date: _____

12. Signature of Employee:

_____

Date: _____

****

*Fax completed documents to:

Lucia Mar Unified School District
Human Resources Department
Attn: Cyndie Clark
FAX: (805) 473-4308

Serious Health Condition

"Serious health condition" means an illness, injury (including, but not limited to, on-the-job injuries), impairment, or physical or mental condition of the employee or a child, parent, or spouse of the employee that involves either inpatient care or continuing treatment, including, but not limited to, treatment for substance abuse. A serious health condition may involve one or more of the following:

1. Hospital Care
   Inpatient care in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care. A person is considered an "inpatient" when a health care facility formally admits him or her to the facility with the expectation that he or she will remain at least overnight and occupy a bed, even if it later develops that such person can be discharged or transferred to another facility and does not actually remain overnight.

2. Absence Plus Treatment

   (a) A period of incapacity of more than three consecutive days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:

      (1) Treatment two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or

      (2) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider.

3. Pregnancy [NOTE: An employee's own incapacity due to pregnancy is covered as a serious health condition under FMLA but not under CFRA]

   Any period of incapacity due to pregnancy, or for prenatal care.

4. Chronic Conditions Requiring Treatment
   A chronic condition which:

   (1) Requires periodic visits for treatment by a health care provider, or by a nurse of physician's assistant under direct supervision of a health care provider;

   (2) Continues over an extended period of time (including recurring episodes of a single underlying condition); and

   (3) May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.)

5. Permanent/Long-term Conditions Requiring Supervision

   A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

6. Multiple Treatments (Non-Chronic Conditions)

Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.) severe arthritis (physical therapy), or kidney disease (dialysis).

Note: Authority cited: Section 12935(a), Government Code. Reference: Section 12945.2, Government Code; California Genetic Information Nondiscrimination Act, Stat. 2011, ch. 261; Family and Medical Leave Act of 1993, 29 U.S.C. § 2601 et seq.; and 29 C.F.R. § 825.

Please complete and return to:

Lucia Mar Unified School District Human Resources Office
602 Orchard St. Arroyo Grande, CA 93420
Phone: 805-474-3000 ext. 1195
Fax: 805-473-4308

Return to Work Medical Certification Form

This form is to be completed when you have been released by your physician to return to work from your medical leave. You must have your healthcare provider certify that you are able to return to work and the effective date. You will **not** be permitted to resume work until your healthcare provider certifies that you are able to perform the essential functions of your job. Return the form to the Human Resources Office **prior** to your request to return to work.

To be completed by EMPLOYEE:

Employee Name: _____

Location/School: _____
Job Title: _____

Date leave began: _____/_____/_____

Returning to work on: _____/_____/_____ *(list the actual date that you will return)*

Employee's Signature: _____ Date:_____

To be completed by HEALTHCARE PROVIDER:

I certify that _____ is able to perform the essential
Employee's Name

functions of his/her job without restrictions effective _____/_____/_____.

If restrictions apply **–** describe limitations: _____
_____
_____

Actual return to work date: _____/_____/_____

Comments:_____

Healthcare Provider's Name: _____

Address: _____

Telephone: _____

Healthcare Provider's Signature **(Do NOT use stamp or designee signature)**

_____ Date: _____