PATERSON PUBLIC SCHOOLS
Department of Human Resources

SAMPLE N

Leave Request Form Cover Sheet

Human Resources Department
90 Delaware Avenue
Paterson, NJ 07503
Telephone (973) 321-0748 or (973) 321-0745/Fax (973) 321-0478

Date: ____________________ Name: ______________________________________

Date of Hire: __________________________ Location: ___________________________

Position: __________________________ 10 Month__________12 Month__________

Please indicate if this injury is work related: Yes__________ **or No**__________

Number of accumulated sick or personal days to be utilized for paid leave ____________________

Paid leave dates from : __________________ to:__________________

12 weeks of unpaid leave with Health Benefits for: Maternity, Childcare, Medical (self) or Caregiver

Family Medical Leave Act: ____

New Jersey Family Leave Act: ____

Contractual Leave: ____

Unpaid leave dates from : ________________ to: ____________________

This leave runs concurrently with FMLA and NJFLA Acts (Caregiver-six weeks of paid leave from the State the of New Jersey) **New Jersey Family Insurance Act:**_____________________________

Unpaid leave dates from : ________________ to: ____________________

Cobra eligibility date: ___________________________________

Please complete the attached Department of Labor form pages 1-4 along with this request form to the Staff Attendance Office. This form is to be used for six (6) or more consecutive days of absence. Absences must be reported to the automatic system (Sub-Finder) 973-321-2370 on a daily basis. If you do not require a substitute you should contact your building administrator or immediate supervisor.

All leaves of absences with or without pay will not be approved for an indefinite period of time, therefore, a return to work or re-evaluation date must be provided. If the medical recommendation is not clear, the leave of absence may not be granted. **Also note that PEA members must fulfill the required 120 days for 10 month employees and 150 days for 12 month employees of active service (or paid leave) in order to receive an increment as per Article 12:5-2 and 12:5-3.**

Your return to work date must be reported to the Staff Attendance Office at ext. 10748 or 10745, so you will be placed back on payroll. If you do not call the Staff Attendance Office you will not be placed back on payroll and therefore, will not be paid promptly. Failure to report the return to work date to the Staff Attendance Office will result in discrepancies with your calendar bank and payroll. **Failure to respond to this notice will result in the loss of your Health Care Benefits within the next termination date.** If you have any questions please contact the Staff Attendance Office at 973 321-0748 or 973-321-0745

PATERSON PUBLIC SCHOOLS
HUMAN RESOURCE SERVICES
2015-2016 SCHOOL YEAR
FEDERAL AND NEW JERSEY MEDICAL LEAVE ACT

Federal Medical Leave Act permits an employee to take leave during any 12-month period for one or more of the following reasons:

- **One occurrence in a 12 month period: District allows for 12 weeks (3 months) of paid health benefits**
- **Employees must work a full 12 month period before being eligible for additional benefits under this law.**

For the following reasons:

- For the birth and care of a newborn child of the employee;
- For placement with the employee of a son or daughter for adoption or foster care;
- To care for a spouse, son daughter, or parent with a serious health condition;
- To take medical leave when the employee is unable to work because of a serious health condition (self); **or**
- for qualifying exigencies arising out of the fact that the employee's spouse, son, daughter, or parent is on active duty or call to active duty status as a member of the National Guard or Reserves in support of a contingency operation.

Employee eligibility:

- Have worked for the employer for a total of 12 months;
- Have worked at least 1,250 hours over the previous 12 months.

Employee notice: Employees seeking to use FMLA leave are required to provide 30-day advance notice of the need to take FMLA leave when the need is foreseeable and such notice practicable.

New Jersey Family Leave Act (Caregiver)

- **One occurrence in a 24 month period: District allows for 12 weeks (3 months) of paid health benefits**
- **Employees must work a full 12 month period before being eligible for additional benefits under this law.**
  For the following reasons:
- The care of a newly born or adopted child, as long as leave begins within one year of the date the child is born to or placed with the employee; or
- The care of a parent, child under 18, spouse, or civil union partner who has a serious health condition requiring in-patient care, continuing medical treatment or medical supervision. The Family Leave Act considers parents to be: in-laws, step-parents, foster parents, re

Employee Eligibility:

- Each eligible employee may take up to 12 weeks of continuous leave during a given 24-month period.

New Jersey Family Leave Insurance Benefits-Paid by the State of New Jersey

- Claim may be filed when you care for a spouse, son daughter, parent with a serious health condition, or bond with a newborn child
- Claims may be filed for six consecutive weeks, for intermittent weeks, or for 42 intermittent days during a 12 month period beginning with the first date of the claim
- Administered through existing State Disability Benefit Program

Rights and Responsibilities while on FMLA

- Employees are required to pay for their portion of medical coverage while out on leave. Please make arrangements within 30 days in which to make premium payments
- **At your option, we may pay your share of the premiums during FMLA leave, and recover these payments when you return to work.**

PATERSON PUBLIC SCHOOLS
Department of Human Resources

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

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, 261 4(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: ____
F Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FM LA. 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 FM LA 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: ____________________

F____________) ____________________ Fax:(________)

PART A: MEDICAL FACTS

1. Approximate date condition commenced:

   Probable duration of condition:

   Mark below as applicable:

   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:

   ____

   Will the patient need to have treatment visits at least twice per year due to the condition? ___No ___ Yes.

   Was medication, other than over-the-counter medication, prescribed? ___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. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

   Is the employee unable to perform any of his/her job functions due to the condition: ____ No ____ Yes.

   If so, identify the job functions the employee is unable to perform:

   ____

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

   ____

   ____

   ____

   ____

   ____

   ____

   ____

CONTINUED ON NEXT PAGE

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___No ___Yes.

   If so, estimate the beginning and ending dates for the period of incapacity: ____________________

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ___No ___Yes.

   If so, are the treatments or the reduced number of hours of work medically necessary?
   ___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:

   ____

   Estimate the part-time or reduced work schedule the employee needs, if any:

   __________hour(s) per day; _________ days per week from_____________ through____________

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ____No ____Yes.

   Is it medically necessary for the employee to be absent from work during the flare-ups? ____ No ____ Yes. If so, explain:

   ____

   ____

   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

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

____

____

____

____

____

____

CONTINUED ON NEXT PAGE

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.**