

**DUVAL COUNTY PUBLIC SCHOOLS
LEAVE OF ABSENCE
INSTRUCTIONS**

WHO TO CALL:

- Leave of Absence information – Human Resources: 390-2065 or 390-2055
390-2395 (fax)
- Insurance questions (see page 6) - Risk Management: 390-2353
390-2566 (fax)
- Short Term Disability – Call Unum Claims 1-888-857-0157
- Hospital Indemnity – Call American Heritage 1-800-348-4489
- Sick/Annual Leave Balances – Call Payroll 390-2022

WHAT YOU NEED:

- Family Medical Leave Act (FMLA): Employee completes page 2
Certification of Health Care Provider (completed by Physician)
- Personal Health Leave: Employee completes page 2
A note from your physician
- Personal Leave: Employee completes pages 2 and 3
- Professional/Educational Leave: Employee completes pages 2 and 3
Copy of registration for full-time classes

WHERE TO SEND LEAVE OF ABSENCE PAPERWORK:

SCHOOL MAIL

Bldg. # 3001
Human Resources
Attn: Extended Leave Office

FAX TO: 390-2395

US MAIL

Duval County Public Schools
Attn: Extended Leave Office
1701 Prudential Drive
Jacksonville, FL 32207

READ ALL INSTRUCTIONS CAREFULLY AND COMPLETELY

Duval County Public Schools
EXTENDED LEAVE APPLICATION

Revised 04/01/10

PLEASE PRINT:

Name	Work Location #	Personnel #	Date
Position	Principal/Supervisor Name	School Name or Work Location	

ADDRESS: *New* *Temporary* *Home*

Street Address	City State Zip	Home Phone
		Cell Phone

TYPE OF LEAVE: **(FOR ALL MEDICAL LEAVE, A DOCTOR'S STATEMENT MUST BE INCLUDED)**

FAMILY MEDICAL LEAVE ACT Illness of Employee Illness of Family Member Maternity (due date _____)

PERSONAL HEALTH Illness of Employee Maternity (due date _____)

PERSONAL PROFESSIONAL/EDUCATIONAL (include copy of registration for full-time classes)

MILITARY (include a copy of official orders) ON THE JOB INJURY (OJI) Date of Injury _____

READ EACH STATEMENT BELOW AND INITIAL:

- Extended leave will be subject to rules of the DCPS, Civil Service Board and/or employee bargaining agreements in effect the date my leave is approved.
- I have the option while on an approved leave of absence, to continue all my existing insurance plans. Call 390-2353.
- I must notify Risk Management of my exact return to work date.
- If I am on the optional pay plan (12 mo), I will automatically be on the regular pay plan (10 mo) upon returning from leave.
- I must not seek employment and/or be employed while on an approved extended personal leave.
- I must report to the Extended Leave Office to complete the necessary paperwork PRIOR to returning to work.**
- Failure to return from leave will be considered a resignation.

DATES ABSENT:

Start date: _____ End date: _____ **(IF DATES ARE UNKNOWN, LEAVE BLANK)**

REASON FOR REQUEST: _____

Employee Signature	Date	Principal/Supervisor Signature	Date
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FOR EXTENDED LEAVE OFFICE USE ONLY:

LOA Start date: _____	End date: _____	Type of leave approved: _____
Extend Start date: _____	End date: _____	Type of leave approved: _____
Extend Start date: _____	End date: _____	Type of leave approved: _____
Extend Start date: _____	End date: _____	Type of leave approved: _____

Human Resources Administrator Signature	Date
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**Duval County Public Schools
Extended Leave Office
Personal Leave of Absence Requirement**

FOR PERSONAL LEAVE OF ABSENCE USE ONLY

Concerning your request for a Personal Leave of Absence, certain polices apply. These board policies can be found on the school web site www.duvalschools.org School Board, Policy Manual, Chapter 6 Human Resources, File: 6.51 Leave of Absence, Policies 1 and 4 (in part).

Policy 1: Leave shall be officially granted in advance and shall be used for the purposes set forth in the leave application. The School Board shall have the right to cancel any leave of absence which is used for purposes other than for which it was granted. Any request for leave to be granted retroactively shall be denied.

Policy 4: Leave shall not be approved by the School Board for the purpose of employment, or seeking employment elsewhere, unless covered by approved accrued annual leave or unless approved in writing pursuant to established procedures by the Chief Officer, Human Resource Services, which may be obtained by contacting that office.

Personal leave of absence must be applied for by the last working day of the school year prior to the year in which you are applying for leave. This form must be signed and received in the Extended Leave Office along with your extended leave application approved by your principal/supervisor before your request for leave can be processed.

By signing below, I am stating that I have read and understand the above information concerning a Personal leave of absence.

(Print name)

(Signature)

(Date)

Revised 11/07/07

LEAVE OF ABSENCE INFORMATION

All paperwork must be submitted to the Extended Leave Office as soon as possible when leave is foreseen (such as maternity). Bring or mail all documents to DCPS, Extended Leave Office at 1701 Prudential Drive, Jacksonville, Florida 32207. You may also mail paperwork in the school mail to Building #3001, Attention Extended Leave Office or fax it to 390-2395.

APPLYING FOR THE FAMILY MEDICAL LEAVE ACT (FMLA) up to 12 weeks

To be eligible for FMLA, an employee must satisfy all parts of the three-prong test:

1. Has worked for the employer for at least 12 months at the time the leave is to commence.
2. Has worked at least 1,250 hours during the 12-month period prior to leave start date.
3. Work at a work site that employs at least 50 employees at or within a 75-mile radius of that work site.

You must submit: A completed extended leave form signed by your principal/supervisor (page 2).

A US Dept of Labor form (WH-380E) completed by your physician (attached).

Note: A regular leave form for any available sick and/or annual leave you have must be submitted to your work site payroll clerk before your leave begins.

APPLYING FOR PERSONAL HEALTH LEAVE

You must submit: Completed extended leave form signed by your principal/supervisor (page 2).

Note from your physician indicating the start date & duration of your leave.

APPLYING FOR PERSONAL LEAVE

You must submit: Leave must be applied for by the end of the prior year of which your leave will start.

Completed extended leave form signed by your principal/supervisor (page 2).

Signed Personal Leave of Absence Requirement form (page 3).

APPLYING FOR PROFESSIONAL/EDUCATIONAL LEAVE (full time students only)

You must submit: Completed extended leave form signed by your principal/supervisor (page 2).

Signed Personal Leave of Absence Requirement form (page 3).

Copy of your registration for full time classes.

APPLYING FOR MILITARY LEAVE (without pay)

You must submit: Completed extended leave form signed by your principal/supervisor.

Copy of your official orders (no memos).

RETURNING FROM LEAVE employees are required to report to the Extended Leave Office prior to returning to their work site. If leave is for medical reasons, a physician's note releasing the employee must be submitted. Also, a voided check from your bank account is required to reinstate direct deposit.

NOTES OF INTEREST:

If you opted to purchase Short Term Disability Insurance, you may apply for coverage by calling Unum Claims at 1-888-857-0157.

Once a leave of absence is processed, the employee is taken off direct deposit.

Any employee on an Optional Pay Plan (12 month) prior to leave, will be removed for the remainder of the work year and will have to resubmit an election form for the following year to return to an optional pay status.

FAMILY MEDICAL LEAVE ACT HIGHLIGHTS

WHAT THE FAMILY MEDICAL LEAVE ACT (FMLA) DOES FOR EMPLOYEE:

Approved FMLA:

- Provides for the continuation of employer paid basic medical coverage (employee only) for up to 12 weeks.
- Holds a position at the school/work site where I am currently located except when FMLA is being used at the end of a work period such as summer break and will continue when the work period resumes. At such time, it is the principal/supervisors decision to hold your position or fill it.

APPLYING FOR THE FAMILY MEDICAL LEAVE ACT (FMLA) up to 12 weeks:

To be eligible for FMLA, an employee must satisfy all parts of the three-prong test:

- Has worked for the employer for at least 12 months at the time the leave is to commence.
- Has worked at least 1,250 hours during the 12-month period prior to leave start date.
- Work at a work site that employs at least 50 employees at or within a 75-mile radius of that work site.

RULES:

A leave of absence under this policy shall be provided for up to 12 weeks for the following reasons:

- Birth of a child
- Adoption of a child
- Care for a spouse, child, step child, foster child, parent of the employee, if care is necessary for a serious health condition
- A serious health condition of employee
- Qualifying exigency arising out of the fact that the employee's spouse, son, daughter, or parent is a covered military member on active duty (Check with the Extended Leave Office about special paperwork that is required.)

All sick leave and/or annual leave accrued must be used prior to starting FMLA. Required paperwork (regular leave form) should be completed at your school/work site and submitted to your payroll clerk prior to going on leave.

FMLA for Maternity or Adoption allows you 12 weeks of leave for recovery and bonding. You are not required to take all 12 weeks, but you must be released by your physician and are **required** to report to the Extended Leave Office with a release note from the physician and a voided check for direct deposit purposes before returning to your work site.

FMLA for Health Reasons allows you up to 12 weeks of leave for recovery. However, as soon as you are released during those 12 weeks, you are **required** to report to the Extended Leave Office with a physician's note releasing you and a voided check for direct deposit purposes, and then you must return to work immediately.

FOR COMPLETE INFORMATION ON THE FAMILY MEDICAL LEAVE ACT

Go to: www.dol.gov

MEDICAL/OPTIONAL INSURANCE BENEFITS

PLEASE CONTACT RISK MANAGEMENT AT 390-2353 FOR THE FOLLOWING:

- The continuation, or request for termination, of any insurance benefit plan during any type of unpaid leave of absence from Duval County Public Schools. **REMEMBER SHORT TERM DISABILITY INCOME IS NOT CONSIDERED INCOME FROM DUVAL COUNTY PUBLIC SCHOOLS.**
- Any changes, including adding/deleting a dependent or any insurance benefit. You must complete a new enrollment form **WITHIN 30 DAYS** of the qualifying event.
- For claims information on short/long term disability or call UNUM Claims at 1-888-857-0157.
- You **MUST** notify Risk Management (390-2353) of your exact return to work date.

PAYMENT INFORMATION:

- Duval County Public Schools, 1701 Prudential Drive, Risk Management – 2nd Floor, Jacksonville, Florida, 32207-8182, (904-390-2353) will bill you for Health, Life and Voluntary AD&D Insurance only. All payments are due the 1st of each month while you are on an unpaid leave of absence.
- Fringe Benefits Management Company, Post Office Box 1878, Tallahassee, Florida, 32302-1878, (1-800-342-8017) will bill you for any of the optional plans listed below that you may wish to continue for yourself and any of your dependents.

Dental
Vision
Short Term Disability
Long Term Disability
Hospital Indemnity

Hospital Intensive Care
AFLAC Cancer
Medical FSA
Dependent FSA
UNUM Whole Life

Trustmark Cancer
Trustmark Premier Select
Trustmark Universal Life
Critical Illness

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

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division



OMB Control Number: 1215-0181
Expires: 12/31/2011

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.

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, 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. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: _____
First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. 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 FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. 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: _____

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):

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.
