



Leave Requests

(FMLA, Leave of Absence and Worker's Compensation)

Information & Application Packet

Benefits Office

102 S. Hickory Ave., Bel Air, Maryland 21014

Phone: 410-588-5275

Fax: 410-588-5316

Rev. 7/2016 (HR/BEN.1)

EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- 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.

Military Family Leave Entitlements

Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings. FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms. Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave. **Eligibility Requirements** Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures. Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility. Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

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;
- 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

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

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.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.



For additional information:
1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627
WWW.WAGEHOUR.DOL.GOV



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 Harford County Public Schools 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 an **electronic** 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 an **electronic** leave request for your absence including the dates and reasons for the leave along with the required supporting documentation for your leave. **It is important to notify the HR-Benefits Office immediately if the dates change from your original request!** If you do not request leave under FMLA and it is determined by HCPS that your leave qualifies under one or more of the following FMLA qualified absences, HCPS may automatically designate your leave as FMLA.

Along with the **electronic** request (as stated above), please submit the additional required documentation for your 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 Form). 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.
- **Military Leave:** form WH-384 or form WH-385 – see Leave Request Checklist attached.

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”) at least two business days **prior** to reporting for duty.

Section III - Approval

You will be notified as to the approval of your leave request via email 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 electronic leave request. Please note that extending your leave beyond 12 weeks may affect the cost of your benefits.

For further information please contact the Benefits Office at 410-588-5275.

Leave Request Checklist

- Submit an electronic leave request via SharePoint:

The Leave Request can be accessed from all HCPS networked computers via [Benefits SharePoint site](#):



Or from home via my.hcps.org. Log in with your **HCPS username and password** and you will be directed to a page that has a short list of "Webmarks". Select **HCPS FMLA** and again, login using your **HCPS username and password**. You will then need to complete the leave request form. **[If neither of these options work for you, a computer is available in our office for you to complete this portion of the process and any of our staff can assist you with this process.]**

- Have the healthcare provider complete and submit the [Healthcare Provider Certification Form](#) to the Benefits Office within 15 days of your leave request submission.
- **If the absence is due to your own personal illness**, please make sure your doctor completes the [Return To Work Medical Certification Form](#) and that it is submitted to the Benefits Office **at least two business days PRIOR to your return to work date**.
- Stay in contact with your Benefits Specialist and keep the Benefits Office apprised of any changes to your leave status.
- **MILITARY ONLY**: If absence is due to Qualifying Exigency or Military Caregiver Leave, please complete the appropriate form or contact the Benefits Office for assistance (410-588-5275). Form WH-384: Certification of Qualifying Exigency For Military Family Leave OR Form WH-385: Certification for Serious Injury or Illness of Covered Service member -for Military Family Leave.

IMPORTANT: Correspondence regarding your request will be sent via email; all employees should regularly check their HCPS email account (and personal email account if provided by employee on the leave request).

Family/Medical Leave Healthcare Provider Certification Form

NOTE: The information sought on this form pertains only to the condition for which the employee is requesting leave under FMLA.

To be completed by the Employee	Employee Name:	Employee #:
	Patient Name (if not employee)	Relation to Employee: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Other: _____
	State the nature of the care you will provide if Family Leave is requested to care for a <u>family member</u> with a serious health condition:	
	State/estimate the time period for which such care will be provided. Include a schedule if requesting leave on an intermittent or reduced schedule.	
	Employee Signature	Date

To be completed by the Healthcare Provider	Physician/Practitioner Name:	Specialization/Type of Practice:		
	Address:	Phone:		
	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 or prescription medication): _____ _____ _____			
	If Pregnancy > projected date of delivery: _____			
	Illness – Date condition commenced:	Probable duration of condition:	Estimated return to work date:	
	Was the patient admitted for an overnight stay in a hospital, hospice or residential care facility? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES , please list DATES OF ADMISSION:			
	FOR INTERMITTENT LEAVE ONLY: Will it be medically necessary for the employee to work on an intermittent/reduced schedule due to the condition (including for treatment or episodic flare-ups)? <input type="checkbox"/> Yes <input type="checkbox"/> No If answer is "yes", please provide:			
	1. Probable # of treatments: _____	4. Period of recovery (if any): _____		
	2. Interval between treatments: _____	5. Probable duration of need: _____		
	3. Dates of treatments if known: _____	6. Frequency: _____ times per _____ week _____ month		
	7. Duration: _____ hours or _____ day(s) per episode			
FOR CONTINUOUS LEAVE DUE TO PERSONAL OR FAMILY ILLNESS:				
A. Is the employee unable to perform any of his/her job functions due to the condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, estimate the beginning and ending dates for the period of incapacity: _____ - _____				
B. If answer to Question A is YES , identify the job functions the employee is unable to perform: _____ _____				
C. Will the patient need to have treatment visits at least twice per year due to the condition? <input type="checkbox"/> Yes <input type="checkbox"/> No				
D. Was medication, other than over-the-counter medication, prescribed? <input type="checkbox"/> Yes <input type="checkbox"/> No				
E. Was the patient referred to other health care provider(s) for evaluation or treatment (e.g. physical therapist)? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, state the nature of such treatments and expected duration of treatment: _____ _____				
F. If leave is required to care for a family member with a serious health condition, does the patient require assistance for basic medical or personal needs, safety, or transportation? <input type="checkbox"/> Yes <input type="checkbox"/> No DATES: _____				
G. If "D" above is "No", would the employee's presence provide psychological comfort and be beneficial to the family member or assist in recovery? <input type="checkbox"/> Yes <input type="checkbox"/> No DATES: _____				
HEALTHCARE PROVIDER SIGNATURE (Do not use stamp or designee signature)			Date	

COMPLETE AND RETURN ORIGINAL FORM TO: HARFORD COUNTY PUBLIC SCHOOLS - BENEFITS OFFICE
102 S. Hickory Avenue, Bel Air, MD 21014
Phone: 410-588-5275 ✦ Fax: 410-588-5316



Please complete and return to:
Harford County Public Schools ♦ HR-Benefits Office
102 S. Hickory Avenue, Bel Air, MD 21014
Phone: 410-588-5275 Fax: 410-588-5316

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 this form to the Benefits Office at least two business days PRIOR to your scheduled return to work date.

To be completed by EMPLOYEE:

Employee Name: _____ Employee #: _____

Location/School: _____ Job Title: _____

Date leave began: ____/____/____ Returning to work on: ____/____/____
(the actual date that you will return to work)

Employee's Signature: _____ Date: _____

All questions below to be completed by HEALTHCARE PROVIDER:

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

essential functions of his/her job: **without restrictions** effective ____/____/____.

with restrictions effective ____/____/____.

If restrictions apply – describe limitations (including, but not limited to, weight bearing, lifting, any assistive devices such as a walker, scooter and/or other supports such as cast, sling, post-op shoe, cast boot, etc.):

Restriction(s) are to be in place from: ____/____/____ to ____/____/____

Healthcare Provider's Name: _____

Telephone: _____ Address: _____

Signature: _____ **Date:** _____

Healthcare Provider's Signature - Stamp or designee signature NOT ACCEPTABLE.