

FAMILY MEDICAL LEAVE (FMLA) OVERVIEW

*****Keep this Overview for your own reference*****

PLEASE READ THOROUGHLY

This packet includes the necessary forms to request FMLA. Eligible employees may request this leave for their own serious health condition, eligible family member's serious health condition and reasons of exigency while the military member (immediate family) is on active duty status. The law allows eligible employees to take **up to** 12 weeks (60 days) of unpaid leave per 12 month period for reasons related to you or an eligible family members serious medical condition and up to 26 weeks to care for a family member who is recovering from a serious illness or injury sustained in the line of duty on active duty. Those employees eligible have entitlement to leave, maintenance of health benefits during leave, and job restoration after leave.

ELIGIBILITY REQUIREMENTS

- Employed with City Schools for 12 months or longer, 20 hours per week or more (0.5 or more)
- **AND** 1,250 hours of Actual Hours Worked prior to request for leave date.

Employee may request leave during any 12-month period for one or more of the following reasons:

- For the birth and care of the newborn child of the employee;
- For placement with the employee of a son or daughter for adoption or foster care;
- A serious health condition that makes the employee unable to perform the essential functions of his or her job;
- To care for an eligible family member (spouse, child, or parent) with a serious health condition; or
- For 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.

NOTIFICATION REQUIREMENTS - Foreseeable and Unforeseeable Absences

- **Foreseeable absences - 30 days or "as soon as practicable."**
You are required to give City Schools a 30-day advanced notice for planned leaves, but if that is not possible, notice must be given as soon as practicable (within one or two business days of when you learn of your need for leave).
Example: Your doctor tells you today that your son must have surgery next week, you should inform your location of your need for leave within the next two business days.
- **Unforeseeable absence - "As soon as practicable" / within one or two business days**
Since advanced notice is impossible for unplanned absences, you are required to give notice "as soon as practicable" (within one or two business days) after you become aware of the seriousness of the condition. Notice may be given in person, in writing, by telephone, or fax machine.

In either case, you must give City Schools adequate and timely notice when FMLA is needed. Otherwise leave can be disallowed or delayed and the absences counted towards discipline.

Leave IS NOT authorized unless approved by Leaves Management. Failure to receive prior approval may result in denial of payment for the days in question and in appropriate disciplinary action. FMLA is an unpaid leave, City Schools requires that any accrued leave time available to you be used as compensation during this leave.

**A Complete Packet consists of: 1) Acknowledgement Form 2) Request
3) Complete and Sufficient Health Care Provider Certification (MUST be returned within 15 days from the date of notification)**

If at any time the requested and/or required documentation is not received timely, sufficiently or completely, your request for FMLA leave may be denied. In addition you may not receive any type of **PAID** time off for days preceding the receipt of the required documents, and absences incurred may be subject to disciplinary action.

Return COMPLETED documents to:

**Baltimore City Public Schools / Leaves Management
200 E. North Avenue, Room #110 ~ Baltimore, Maryland 21202
Attention: Paula Thomas**

Phone Number: 410-396-8885 leaves@bcps.k12.md.us Fax Number: 410-545-0897

Completed requests will be processed within 5-10 business days. **EMAIL IS THE PRIMARY FORM OF COMMUNICATION**, if another form of communication is necessary, please note on Acknowledgement Form. Please check your email frequently for status of your request. An approval/denial correspondence will be sent via email to you and your Principal/Supervisor. Pertinent health benefits and return to work information will be included. *Incomplete forms and/or insufficient documentation will delay leave processing.* If you have any questions, please feel free to contact me.

BALTIMORE CITY PUBLIC SCHOOLS

This form **MUST** be signed and submitted with Request form.
Request **WILL NOT** be processed without a signed Acknowledgement form.

- ACKNOWLEDGEMENT -

I acknowledge responsibility for reading and complying with the Processes and Policies associated with my requested leave.

Email is Leaves Management's primary and quickest means of communications. All communication involving leave requests, leave determinations and designations will be sent through your **City Schools email address**.

Check which is applicable to you, *if unchecked all correspondence will be by email.*

- I **DO** have access to my city schools email and want my leaves correspondence to be sent by email.
- I **DO NOT** have access to my City Schools email and want my leaves correspondence to be sent by U.S. Mail.

Signature

Date

Print Name – First, MI, Last

Employee ID#

Supervisor's Name

Department/School

Position

BTU Employee Evaluations

In keeping with section 15.22 of the BTU contract, BTU employees who are absent more than 60 days in the school year shall receive an annual rating of "Administrative Effective/Satisfactory" on their annual evaluation with no Achievement Units (AUs). This rating can be used for certification purposes.

BCPS Board Rules

Article 4 section 404.03, All absences of educational staff members shall be with loss of full pay unless otherwise provided for in these Rules, or by special action of the Board. "With loss of full pay" shall mean that the person concerned shall receive no salary for the full time included in such a leave. Such shall also include the earning of a salary from another source by the staff person on a leave without express approval of the Board and the Chief Executive Officer.

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Division of Leaves Management
200 E. North Avenue, Room #110
Baltimore, Maryland 21202**

Email: leaves@bcps.k12.md.us

Attn: Ms. Paula Thomas

Fax: 410-545-0897

Falsification of any Leave of Absence documentation may lead to disciplinary action up to and including termination of employment.

Request for Family and Medical Leave of Absence (FMLA)

Please Print Legibly

Name _____ Emp. ID _____ Title _____
Dept./School _____ 10 or 12 month Emp. _____ P/T or F/T _____
Union _____

Falsification of any Leave of Absence documentation may lead to disciplinary action up to and including termination of employment.

To determine the designation of your absences and leave status, attached you will find a FMLA packet that you and the treating health care provider are **required** to fill out **completely, sufficiently and timely** and return to:

You have **within 15 calendar days of date sent** in which to get the attached application to Leaves Management. It is your responsibility to obtain from the attending physician a **complete, sufficient and timely certification** as to not delay the processing of your request.

*Failure to return requested documentation in the time required **and** receive prior approval may result in denial of request*

I am requesting FMLA from Baltimore City Public Schools for the following reason:

Type of Leave

- Care of Own Serious Health Condition Placement of Newly Adopted or Foster Child
 Birth of a Newborn Child (Maternal/Parental) No Intermittent Use Care of Child's Serious Health Condition
 Care of Spouse's/Domestic Partner's Serious Health Condition Care of Parent's Serious Health Condition

_____ **Continuous FMLA** _____ **Intermittent FMLA**

*An eligible employee who has complied with the Family and Medical Leave Act regulations and verification requirements must be granted FMLA (see Benefits Handbook), **up to** 60 days within a 12 month period.*

If Currently Enrolled in Baltimore City Public School's Health Care Plans:

Paid Status: Healthcare Premiums will be deducted from your paycheck as normal

Unpaid Status: If your status is unpaid or you lapse into unpaid status you **must** continue to pay your **EMPLOYEE** contributions. Finance will invoice you your premium amounts.

Two unpaid **EMPLOYEE** contributions will result in termination of your health care insurance coverage.

If your status is unpaid or you lapse into an unpaid status and your Employee contributions are not paid for more than two pay periods, you have a right to COBRA continuation coverage. A COBRA election form will be mailed to your address on file by our Third Party Administrator. COBRA is a temporary extension of coverage pursuant to the Consolidated Omnibus Reconciliation Act of 1985. COBRA continuation coverage can become available to you and to other covered members under your plan when you would otherwise lose your group health care coverage.

Employee Signature _____ Date _____

*All documents **MUST** be submitted at the same time to avoid possibility of misplacement:**

1) Acknowledgement Form 2) Request

3) Complete and Sufficient Health Care Provider Certification (**MUST** be returned within 15 calendar days from the date of notification).

If at any time the requested and/or required documentation is not received timely, sufficiently or completely, your request for FMLA leave may be denied. In addition you may not receive any type of PAID time off, and absences incurred may be subject to disciplinary action.

***(Please do not submit multiple packets, use one (1) form of submittal, if 5 work days have passed and you have not received a response of receipt of your packet or leave designation, then contact the below. Submitting multiple packets delays in processing and creates confusion for Leaves**

Return COMPLETED documents to: Baltimore City Public Schools / Leaves Management 200 E. North Avenue, Room #110 ~ Baltimore, Maryland 21202

leaves@bcps.k12.md.us

Attention: Paula Thomas

Phone Number: 410-396-8885

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**BALTIMORE CITY PUBLIC SCHOOLS
 CERTIFICATION OF FAMILY AND MEDICAL LEAVE
 FOR EMPLOYEE'S SERIOUS HEALTH CONDITION**



SECTION I: For Completion by the EMPLOYEE (PLEASE PRINT LEGIBLY)

Employee's Name:	Job Title: _____ P/T or F/T _____ 10 mo or 12 mo employee
Location:	Name of Supervisor/Principal:
(1) Obtain Job Description from Location or Leaves Management.	(2) Employees essential job functions <i>(if no job description was able to be obtained)</i> _____ _____

INSTRUCTIONS to the EMPLOYEE: Please give this form to your Health Care Provider for completion. The Family and Medical Leave Act (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. Your response is required to obtain or retain the benefit of FMLA protections. Failure to provide a timely, complete and sufficient medical certification may result in a denial of your FMLA request. Your employer must give you at least 15 calendar days to return this form.

For more information on the FMLA, visit the Department of Labor's website at <http://www.dol.gov/compliance/laws/comp-fmla.htm>

SECTION II: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the TREATING HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. **Fully and completely** answer all applicable parts, paying attention to the specific points listed here *(complete and sufficient responses will eliminate having the form returned to you for clarity)*. Limit your responses to the condition for which the employee is seeking leave.

***Please be sure to sign the last page.**

- Your answers 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.* **You may be requested to clarify your answer if these terms are used.**

[PLEASE READ THE ABOVE, PRIOR TO COMPLETING FORM]

Treating Health Care Provider's name: _____
 (please print)

Treating Health Care Providers business address: _____

Type of practice/ Medical specialty: _____

Telephone (_____) _____ Fax: (_____) _____

Name of Employee: _____

PART A: MEDICAL FACTS

1. I certify that _____

Does have a *serious health condition* (see definitions described on page 4). * and qualifies under the category checked below:

1) _____ 2) _____ 3) _____ 4) _____ 5) _____ 6) _____

Does not have a *serious health condition* (see definitions described on page 4). * Provide signature and return form to employee.

*Page 4 describes what is meant by a "serious health condition" under the Family and Medical Leave Act.

2. Approximate date condition commenced: _____

Most Recent Date(s) you treated the patient for this condition: _____

Probable duration of condition*: _____

* **Be as specific as you can;** terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. You may be requested to clarify your answer if these terms are used.

If for pregnancy, indicate expected delivery date: _____

3. Describe the medical facts regarding the serious health condition that impede the employee's ability to work (e.g. symptoms, diagnosis, or any regimen of continuing treatment):

4. Is the employee unable to perform any of his/her job functions due to the condition? YES ___ NO ___

If YES, explain the specific limitations preventing the employee from performing his/her job functions, and identify the job functions the employee is unable to perform (if necessary, use additional space on the last page of the form):

PART B: AMOUNT OF LEAVE NEEDED (5-Continuous, 6-Intermittent, 7-Reduced Work Schedule)

Continuous Leave

5a. 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? YES _____ NO _____

If YES: Estimated Incapacitation **Begin Date:** _____ Estimated Incapacitation **End Date:** _____

5b. Will it be medically necessary for the employee to attend follow-up treatment appointments at the end of the continuous (incapacitation) leave?

YES _____ NO _____ Unable to determine at this time _____

If YES, estimate treatment schedule, if any, including the estimated frequency of appointments and the estimated time required for each appointment, including any recovery period:

Estimated Treatment **Begin Date:** _____ **End Date:** _____

Frequency: _____ times per week **OR** _____ times per month

Duration: _____ hours per day **OR** _____ days per episode

Intermittent Leave

6. Will the condition make it medically necessary for the employee to take intermittent leave?

YES _____ NO _____

If YES, based upon the patient’s medical history and your knowledge of the medical condition, estimate the frequency of the 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):

Estimated Intermittent **Begin Date:** _____ **End Date:** _____

Frequency: _____ times per week **OR** _____ times per month

Duration: _____ hours per day **OR** _____ days per episode

Reduced Work Schedule

7. Will the employee need a reduced work schedule? YES _____ NO _____

If YES, estimate the part-time or reduced work schedule the employee needs, if any:

Estimated Reduced Schedule **Begin Date:** _____ **End Date:** _____

Frequency: _____ hours per episode **OR** _____ days per week

ADDITIONAL INFORMATION (Please identify question number when responding):

Signature of Health Care Provider

Date

TREATING PHYSICIAN: Please return a complete, sufficient and timely form to employee as to not delay in the processing of the FMLA request. In some cases employee may request documents be sent directly to employer:

**Baltimore City Public Schools
Attn: Leaves Management
200 E. North Ave., Rm. 110
Baltimore, MD 21202
Fax: 410-545-0897**

Family and Medical Leave Act of 1993: Section 825.800 Definitions-Subpart H

A “**Serious Health Condition**” means an illness, injury, impairment, or physical or mental condition that involves one of the following: A serious health condition involving continuing treatment by a health care provider includes any one or more of the following:

1. Hospital Care

Inpatient care (i.e., an overnight stay) 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.

2. Incapacity and Treatment

A period of incapacity (the term *incapacity* means inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery there from) of **more than three consecutive, full calendar days, and** any subsequent treatment or period of incapacity relating to the same condition, that also involves:

- a. **Treatment¹ two or more times**, within 30 days of the first day of incapacity, unless extenuating circumstances exist, 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
- b. **Treatment** by a health care provider on **at least one** occasion which results in a regimen of continuing **treatment²** under the supervision of a health care provider.

The requirement in (a) and (b) of this section for treatment by a health care provider means an in-person visit to a health care provider. The first (or only) in-person treatment visit must take place within seven days of the first day of incapacity.

Whether additional treatment visit or a regimen of continuing treatment is necessary within the 30-day period shall be determined by the health care provider.

The term “extenuating circumstances” in (a) of this section means circumstances beyond the employee’s control that prevent the follow-up visit from occurring as planned by the health care provider. Whether a given set of circumstances are extenuating depends on the facts. For example, extenuating circumstances exist if a health care provider determines that a second in-person visit is needed within the 30-day period, but the health care provider does not have any available appointments during that time period.

3. Pregnancy or Prenatal Care

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

4. Chronic Conditions

Any period of incapacity or treatment for such incapacity due to a chronic serious health condition.

A **chronic serious health condition** is one which:

- a. Requires **periodic visits** (defined as at least twice a year) for treatment by a health care provider, or by a nurse or physician’s assistant under direct supervision of a health care provider;
- b. Continues over an **extended period of time** (including recurring episodes of a single underlying condition);
- c. 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 there from) 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 injuries, or for a condition that **would likely result in a period of incapacity of more than three consecutive, full calendar days in the absence of medical intervention or treatment**, *such as* cancer (chemotherapy, radiation, etc), severe arthritis (physical therapy), or kidney disease (dialysis).

Absences attributable to incapacity under (3) or (4) qualify for FMLA leave even though the employee or the covered family member does not receive treatment from a health care provider during the absence, and even if the absence does not last more than three consecutive, full calendar days. *For example, an employee with asthma may be unable to report for work due to the onset of an asthma attack or because the employee's health care provider has advised the employee to stay home when the pollen count exceeds a certain level. An employee who is pregnant may be unable to report to work because of severe morning sickness.*

¹Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

²A regimen of continuing treatment includes, *for example*, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.