

ARLINGTON INDEPENDENT SCHOOL DISTRICT
DEFINITIONS
FOR FAMILY AND MEDICAL LEAVE

1. **Incapacity:** the inability to work, attend school or perform other regular daily activities due to the serious health condition and treatment for or recovery from.
2. **Treatment:** includes examinations to determine if a serious health condition exists and evaluations of the condition but does not include routine physical and eye or dental examinations.
3. **A 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 or antihistamines that can be initiated without a visit to a health care provider.
4. **Serious Health Condition:** an illness, injury, impairment or physical or mental condition involving hospital care, absence plus treatment, pregnancy, a chronic condition requiring treatment or permanent/long term conditions requiring supervision, as described above.
5. **Hospital Care:** inpatient care (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.
6. **Absence plus Treatment:** A period of incapacity of more than three consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition) which also involves:
 - a. 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
 - b. Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of health care provider.
7. **Pregnancy:** A period of incapacity due to pregnancy or for prenatal care.
8. **Chronic Conditions Requiring Treatment:** A chronic condition which:
 - a. Requires periodic visits for treatment by a health care provider or by a nurse or physicians 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.).
9. **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.

ARLINGTON INDEPENDENT SCHOOL DISTRICT ELIGIBILITY AND REQUIREMENTS FOR FAMILY AND MEDICAL LEAVE

The following is important information regarding Arlington I.S.D. policies and procedures for leave under Family and Medical Leave Act (FMLA) and your rights and responsibilities. It is important that you are aware of your obligations and the consequences if you fail to meet these obligations.

Please read this notice carefully and contact the Benefits Office for more information.

INFORMATION

1. You are eligible for leave under FMLA if you are a district employee and:
 - a. have been employed by the district for at least twelve months prior to commencement of leave, AND
 - b. have been in a pay status with the district at least 1,250 hours during the twelve months immediately preceding the date FMLA leave begins.
2. If you are eligible as indicated above, you are entitled to use leave under FMLA when taken:
 - a. for the birth of your child or placement of a child in your home for adoption or foster care, and to care for the child upon birth or placement in your home (must be taken within twelve months following birth or placement);
 - b. to care for your spouse, son, daughter, or parent, with a serious health condition; or
 - c. for your own serious health condition that prohibits you from performing the functions of your position.
3. You are entitled to use up to twelve work weeks leave for FMLA purposes during any twelve-month period from the first day leave was taken. The twelve-month period shall be measured backward from the date an employee uses any family medical leave. Leave with or without pay that you use that is FMLA-qualifying will be counted against your annual FMLA entitlement.
4. You are required to give the district 30 days notice or as much notices as feasible if leave is to begin in less than 30 days. Any leave approved will require the use of all applicable sick leave and vacation time.
5. You are required to use all accrued leave as part of the twelve weeks of FMLA leave to which you are entitled.
6. Group health insurance at the same level of contributions and benefits as was provided prior to the FMLA leave will continue for the duration of the FMLA leave period. Any share of health plan premiums paid by the employee prior to FMLA leave must continue to be paid by the employee while on FMLA leave. Failure to pay your portion of the unpaid premiums when due will result in termination of health insurance coverage.

INTERMITTENT OR REDUCED LEAVE

1. You may request intermittent or reduced leave. The request must be approved by your department head AND the Coordinator of Benefits.
2. When FMLA leave is taken on an intermittent or reduced leave schedule, the leave may be measured in increments of not less than one hour.
3. Intermittent or reduced leave may be given when taken for the birth of your child or placement of a child for adoption or foster care; however, it is not required that the district grant sick leave.

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Please read this notice carefully and contact the Benefits Office for more information.

MEDICAL CERTIFICATION

1. You will be provided a form that must be completed by your health care provider or, in the case of a seriously ill spouse, son, daughter, or parent, their health care provider.
2. The following medical certification requirements will apply to any request for leave under FMLA:
 - a. When requesting FMLA leave due to your serious health condition or the serious health condition of your spouse, son, daughter, or parent, you may be required to provide medical certification by a health care provider.
 - b. The district may require periodic medical certification during any FMLA leave.

RETURN TO WORK CERTIFICATION

1. Upon return from FMLA leave, not to exceed twelve weeks, you will be restored to your original or equivalent position with equivalent pay, benefits, and other employment terms. After twelve weeks of leave, if you are not able to return to work, you must contact your supervisor and the personnel department to report my status. Your position is not guaranteed after twelve weeks.
 - a. The district may require you to submit medical certification that you are able to return to work.

**ARLINGTON INDEPENDENT SCHOOL DISTRICT
REQUEST
FOR FAMILY AND MEDICAL LEAVE**

Request for Family and Medical Leave (FMLA) must be made at least 30 days prior
to the date the requested leave is to begin.

**Complete this form; obtain the signature of your principal/supervisor
and submit all FMLA forms to the A.I.S.D. Benefits Office**

Employee's Name: _____

Phone: _____

Job Title/Position: _____

Location: _____

Employee ID: _____

Hire Date: _____

Date of Application: _____

I request family and medical leave for one or more of the following reasons:

Birth/Adoption of a child

Care for Family Member

Serious Health Condition

Estimated Leave Start Date: _____

Estimated Return to Work Date: _____

I understand and agree to the following provisions:

I have worked for my employer at least one year and at least 1,250 hours in the previous 12 months.

I will be required to exhaust my paid vacation, personal, or sick leave as part of my 12 weeks of leave.

All days not covered by sick leave or vacation will be unpaid.

After 12 weeks of leave, if I am unable to return to work, I must contact the Benefits Department to report my status.

If I do not return to work after the leave, A.I.S.D. will recover the cost of any unpaid benefits incurred during the time of the leave.

Employee Signature: _____

Date: _____

Supervisor Signature: _____

Date: _____

Principal Signature: _____

Date: _____

Personnel Signature: _____

Date: _____

Fax Completed Form to A.I.S.D. Benefits Office – 817-459-7162

**ARLINGTON INDEPENDENT SCHOOL DISTRICT
CERTIFICATION OF HEALTH CARE PROVIDER FORM
FOR FAMILY AND MEDICAL LEAVE**

Employee's Name: _____ Location: _____

Patient's Name: _____ Relationship to Employee: _____

The following is to be completed by the attending physician or practitioner:

Birth of a child: (If Pregnancy, Complete this section only)

Estimated Date of Delivery _____ Date first unable to work: _____

Length of time your patient will have to be out due to this condition, keeping him/her from essential job functions:

From: _____ to _____

Care for Family Member:

Do you believe the physical presence of the employee named above is necessary or beneficial in the care of the patient?

Yes No If Yes, for how long? _____

Serious Health Condition: Describe _____

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

Yes No If so, dates of admission: _____ to _____

Chronic/Permanent Condition: Describe _____

Expected frequency of absence: _____ days per month, lasting _____ hours per absence

Length of time your patient has had/will have this condition, keeping him/her from essential job functions:

From: _____ to _____

Describe the regimen of treatment to be prescribed indicating the number of visits, general nature and duration of treatment, including referral to other provider(s) of health services.

Include Schedule of visits or treatment, if medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal schedule of hours per day or days per week.

Name of Healthcare Provider: _____ **Practice:** _____

Street and Mailing Address: _____

Telephone Number: _____ **Fax Number:** _____

Provider Signature: _____ **Date:** _____

**ARLINGTON INDEPENDENT SCHOOL DISTRICT
RELEASE TO WORK CERTIFICATION
FOR FAMILY AND MEDICAL LEAVE**

Employee's Name: _____ Location: _____

Job Title/Position: _____ Employee ID: _____

The following is to be completed by the attending physician or practitioner:

Date employee was first unable to work: _____

Date employee is able to return to work: _____

The employee is able to perform the essential functions of his/her job.

Yes No

If No, list any restrictions or accommodations necessary to allow the employee to return to work.

Name of Healthcare Provider: _____ **Practice:** _____

Street and Mailing Address: _____

Telephone Number: _____ **Fax Number:** _____

Provider Signature: _____ **Date:** _____

Fax Completed Form to A.I.S.D. Benefits Office – 817-459-7162