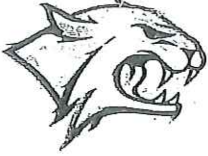


Carrizo Springs Consolidated Independent School District

300 N. 7th Street Carrizo Springs, Texas 78834

For Human Resources use only:

Leave Type: ________ FMLA Ends: ______________

Medical Certification: Yes No N/A

LEAVE OF ABSENCE REQUEST

Directions: Type or print the required information

THE MEDICAL CERTIFICATION MUST ACCOMPANY THIS FORM

1. EMPLOYEE NAME (First Name, Middle Initial, Last Name)		2. EMPLOYEE JOB TITLE
3. EMPLOYEE ID NUMBER	4. CAMPUS/DEPARTMENT	5. WORK SCHEDULE S M T W TH F S

6. REASON FOR REQUESTED LEAVE:
   a. ☐ Birth of a son or daughter of the employee and in order to care for such son or daughter after birth. *(Attach birth certificate if requesting parental leave)*
   b. ☐ Placement of a son or daughter with employee for adoption or foster care. *(Attach a copy of legal documentation)*
   c. ☐ In order to care for spouse, child, or parent with a serious health condition.
   d. ☐ Because of employee's own serious health condition that makes him/her unable to perform job function.
   e. ☐ Military Leave *(Attach a copy of military orders)*

7. IF "C", PLEASE CHECK ONE: ☐ Spouse ☐ Child ☐ Parent		8. If "C", STATE NAME AND ATTACH MEDICAL CERTIFICATION.
9. REQUEST START DATE: ____/____/____	LAST DAY TO WORK: ____/____/____	10. ANTICIPATED RETURN DATE: ____/____/____ OR UNKNOWN (select one only)
11. ARE YOU REQUESTING LEAVE ON A FULL-TIME OR INTERMITTENT BASIS? ________Full-Time ________Intermittent		12. IF "INTERMITTENT", PLEASE GIVE SCHEDULE OF WHEN YOU ANTICIPATE YOU WILL BE UNAVAILABLE FOR WORK. (APPLIES ONLY IF ELIGIBLE FOR FML) ____________________

Employees seeking leave because of reason 6(a), 6(c), or 6(d) above, **must provide medical certification within 15 days** or as soon as practicable. Employees seeking to return to work after a leave because of birth of a son or daughter or their own serious illness must also provide the Human Resources Department a fitness for duty certification of an ability to perform essential functions before they are authorized by the Human Resources Department to return to work.

I hereby agree that while I am on leave, I will continue to pay my share of health insurance premiums, unless I elect to discontinue such coverage. I also agree that if I fail to return to work at the end of the leave period, I will reimburse the District for the cost of health benefits provided during my leave, unless I fail to return to work because of the continuation, recurrence, or onset of a serious health condition or because of other circumstances beyond my control. If I am unable to return to work because of a serious health condition, I will provide medical certification from the appropriate health care provider stating that I am unable to perform the functions of my position on the date that my leave expired or that I am needed to care for my spouse if he/she has a serious health condition on the date that my leave expired. I understand that I may not be permitted to resume my position with the District until I provide medical certification, as appropriate.

THE MEDICAL CERTIFICATION MUST ACCOMPANY THIS FORM

EMPLOYEE AND SUPERVISOR SIGNATURES

____________________ Employee Signature

____________________ Date

____________________ Principal/Supervisor Signature

____________________ Date

Carrizo Springs Consolidated Independent School District

300 N. 7th Street Carrizo Springs, Texas 78834

MEDICAL CERTIFICATION

A complete medical certification is required to determine whether your health condition or the health condition of your Spouse, Son, Daughter or Parent qualifies for leave under FMLA regulations.

Instructions to Employee: Complete Sections I and II. If you are requesting leave to care for your Spouse, Son, Daughter or Parent who has serious health condition also complete Section III. Your health care provider or your family member's health care provider must complete Sections IV through VII. It is your responsibility to ensure that the health care provider completes this form and is returned to the appropriate address or fax number provided below within 15 calendar days.

Instructions to Health Care Provider: Your patient or a family member of your patient has requested a Family and Medical Leave. In order for us to verify that this qualifies under FMLA, please complete Sections IV though VII of this form.

For completion by the Employee

Section I-Patient Information (Print)

Employee's Name: ______________________________

Patient's Name (if other than employee): ______________________________

Relationship to Employee (if son or daughter, provide date of birth): ______________________________

Section II – Employee Signature

I authorize Carrizo Springs CISD of Human Resources or its designated health care provider/third party administrator to contact my health care provider or my family member's health care provider for purposes of obtaining clarifying information and authenticity of the medical certification, if necessary.

______________________________ ______________

Employee Signature Date

Section III – Care for Family Member (Print)

State the care you will provide for your family member (if designated above).

CONTINUE ON NEXT PAGE

MEDICAL CERTIFICATION

For completion by the Health Care Provider

Section IV – Patient Information (Print)

1. Employee's Name: ______________________________

2. Patient's Name: ______________________________

3. Patient's relationship to employee (check one): ☐ Self ☐ Spouse ☐ Son or Daughter ☐ Parent

Section V _ Designation of Serious Health Condition

4. Under FMLA a "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves one or more of the categories below. Does the patient's condition for which he/she is requesting FMLA leave qualify under any of the categories described? If so check the applicable category(ies):

☐ **Inpatient Care** *(Overnight stay in hospital, hospice, or residential medical care facility)*
☐ **Continuing Treatment** (*Incapacity lasting more than three consecutive, full calendar days, and any subsequent treatment)*

☐ **Pregnancy**

☐ **Chronic Serious Health Condition** *(i.e., asthma, diabetes, epilepsy, etc.)*

☐ **Perm./Long-term Condition Requesting Supervision** *(i.e., Alzheimer, severe stroke, terminal stages of disease)*

☐ **Multiple Treatment** *(i.e., for cancer, severe arthritis, kidney disease, etc.)*

☐ **Not a serious condition** *(proceed to Section VII)*

Section VI – Duration of Incapacity and Treatments

5. Indicates Specific Diagnosis:

____

6. State the approximate date the condition commenced:

____

7. Estimate the probable duration of condition:

______________ to ______________

8. Nature and estimated duration of treatment prescribed:

____

____

____

____

____

Section VII – Physician Information

Name of Health Care Provider (please print) : ______________________________

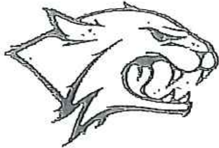
Provider's Signature: ______________________________

Date: ______________ Type of Practice: ______________________________

Address: ______________________________

____

Telephone Number: ______________ Fax Number: ______________



Carrizo Springs Consolidated Independent School District

300 N. 7th Street Carrizo Springs, Texas 78834

FOR HUMAN RESOURCES USE ONLY:

☐ ____________________
☐ Return Confirmation Letter
☐ Copy to________________

RETURN TO WORK REQUEST

Directions: Type or print the required information.

1. EMPLOYEE NAME (First Name, Middle Initial, Last Name)		
2. EMPLOYEE JOB TITLE	3. EMPLOYEE ID NUMBER	4. CAMPUS/DEPARTMENT
5. EMPLOYEE ADDRESS		
6. CITY STATE ZIP CODE	7. TELEPHONE NUMBER (___) ______________ ☐HOME ☐MOBILE	
8. TYPE OF LEAVE GRANTED: (Select one) * Requires submission of *Work Status Form*		

☐ Adoption ☐ Personal Illness* ☐ Family Illness ☐ Other ____________

☐ Maternity* ☐ Military ☐ Parental

THIS IS TO NOTIFY THE OFFICE OF HUMAN RESOURCES OF MY REQUEST TO RETURN FROM A LEAVE OF ABSENCE EFFECTIVE _____/_____/_____.

If my family medical leave was due to personal illness or maternity, I understand that I must provide medical clearance signed by my medical provider indicating my fitness for duty as well as my release date. Prior to my return to work, I shall provide to the Office of Human Resources proper documentation of such release from my health care provider. In the event that my doctor indicates any work restrictions on the Fitness for Duty Certification/Medical Release, I am aware that it may take up to 10 workdays for a determination to be reached as to if restrictions can be accommodated.

Employee Signature

I have read and understand the content of this Return to Work Request. I do certify that the above information is true and correct to the best of my knowledge.

______________________________ ____________________

Employee Signature Date

CARRIZO SPRINGS C.I.S.D WORK STATUS FORM

Dear Medical Provider: It is our understanding that you are currently treating the below-named employee. In order to obtain accurate work status information, please complete the information below and return this form to our office. Thank you for your assistance.

Sincerely,
Human Resources Director
300 N. Seventh St., Carrizo Springs, TX 78834 Tel: (830) 876-3503 **Fax: (830) 876-3619**

PART I: General Information (Items 1 – 8 MUST be completed for processing)		5. Employee's Campus/Department Location	(for transmission purposes only)	Date Being Sent
1. Employee's Name		6. Doctor's Name and Degree	9. Employer's Name Carrizo Springs CISD	
2. Employee's Job Title	3. Social Security Number	7. Clinic/Facility /Doctor Phone & Fax	10. Employer's Address 300 N. Seventh St., Carrizo Springs, TX 78834	
4. Employee's Medical Condition		8. Clinic/Facility/Doctor Address:	11. Employer's FAX # (830) 876-3619	
		City State Zip	12. Attention Human Resources Director	

PART II: Work Status Information (Fully complete one including estimated dates and description in 13(c) as applicable)

13. The employees medical condition:

☐ (a) will allow the employee to return to work as of ________(date) without restrictions – ONLY COMPLETE THIS LINE IF THERE ARE NO RESTRICTIONS INDICATED IN PART III.

☐ (b) will allow the employee to return to work as of ________(date) with the restrictions identified in PART III, which are expected to last through ________(date)

☐ (c) has prevented and still prevents the employee from returning to work as of ________ (date) and is expected to continue through ________(date). The following describes how the condition prevents the employee from returning to work:

PART III: Activity Restrictions * (Only complete if 13(b) is checked)

14. POSTURE RESTRICTIONS (if any):

Max Hours per day:	0	2	4	6	8	Other
Standing	☐	☐	☐	☐	☐	______
Sitting	☐	☐	☐	☐	☐	______
Kneeling/Squatting	☐	☐	☐	☐	☐	______
Bending/Stooping	☐	☐	☐	☐	☐	______
Pushing/Pulling	☐	☐	☐	☐	☐	______
Twisting	☐	☐	☐	☐	☐	______
Other ________	☐	☐	☐	☐	☐	______

15. RESTRICTIONS SPECIFIC TO (if applicable):

- ☐ L Hand/Wrist ☐ R Hand/Wrist
- ☐ L Arm ☐ R Arm
- ☐ L Leg ☐ R Leg ☐ Back
- ☐ L Foot/Ankle ☐ R Foot/Ankle
- ☐ Other: ______________________

17. MOTION RESTRICTIONS (if any):

Max Hours per day:	0	2	4	6	8	Other
Walking	☐	☐	☐	☐	☐	______
Climbing stairs/ladders	☐	☐	☐	☐	☐	______
Grasping/Squeezing	☐	☐	☐	☐	☐	______
Wrist flexion/extension	☐	☐	☐	☐	☐	______
Reaching	☐	☐	☐	☐	☐	______
Overhead Reaching	☐	☐	☐	☐	☐	______
Keyboarding	☐	☐	☐	☐	☐	______
Other: __________	☐	☐	☐	☐	☐	______

18. LIFT/CARRY RESTRICTIONS (if any):

- ☐ May not lift/carry objects more than ____ lbs for more than ____ hours per day
- ☐ May not perform any lifting/carrying
- ☐ Other

19. MISC. RESTRICTIONS (if any):

- ☐ Max hours per day of work: ________
- ☐ Sit/Stretch breaks of ____ per ____
- ☐ Must wear splint/cast at work
- ☐ Must use crutches at all times
- ☐ No driving/operating heavy equipment
- ☐ Can only drive automatic transmission
- ☐ No work/- _______ hours/day work:
  - ☐ in extreme hot/cold environments
  - ☐ at heights or on scaffolding
- ☐ Must keep ________________
  - ☐ Elevated ☐ Clean & Dry
- ☐ No skin contact with: __________
- ☐ Dressing changes necessary at work
- ☐ No Running

16. OTHER RESTRICTIONS (if any):
FOR BUS DRIVERS ONLY: PLEASE INDICATE IF EMPLOYEE CAN DRIVE A SCHOOL BUS.

*These restrictions are based on the doctor's best understanding of the employee's essential job functions. If a particular restriction does not apply, it should be disregarded. If modified duty that meets these restrictions is not available, the patient should be considered to be off work. Note- these restrictions should be followed outside work as well as work.

20. MEDICATION RESTRICTIONS (if any):

- ☐ Must take prescription medication(s)
- ☐ Advised to take over-the-counter meds
- ☐ Medication may make drowsy (possible Safety/driving issues)

PART IV: Treatment/ Follow-up Appointment Information

21. Comments

____
____
____
____
____

22. Expected Follow-up Services Include:

- ☐ Evaluation by the treating doctor on________________ (date) at ______ ________am/pm
- ☐ Referral to/Consult with ________________ on______ (date) at ______ ________ am/pm
- ☐ Physical medicine X per week for _____ weeks starting on ______ (date) at ______ ________ am/pm
- ☐ Special studies (list): ________________ on______ (date) at ______ ________ am/pm
- ☐ None. This is the last scheduled visit for this problem. At this time, no further medical care is anticipated.

Date of Visit	EMPLOYEE'S SIGNATURE:	DOCTOR'S SIGNATURE:	Visitor Type: ☐ Initial ☐ Follow-up	

Carrizo Springs Consolidated Independent School District
Office of Human Resources and Student Services
300 N. 7th Street
Carrizo Springs, TX 78834
Phone: (830) 876-3503 x 1302
Fax: (830) 876-3619

Employee Rights and Responsibilities Under the Family and Medical Leave Act

WHD Publication 1420

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 protected 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