Leave Request Form and Instructions

1. Employee Must:

    a. Complete **Section I** (Employee Information).
    b. Notify Supervisor/Principal of anticipated absence.
    c. Have Medical Provider complete the enclosed Medical Certification. Ensure all fields are completed.
    d. Provide Verification of relationship, if applicable.

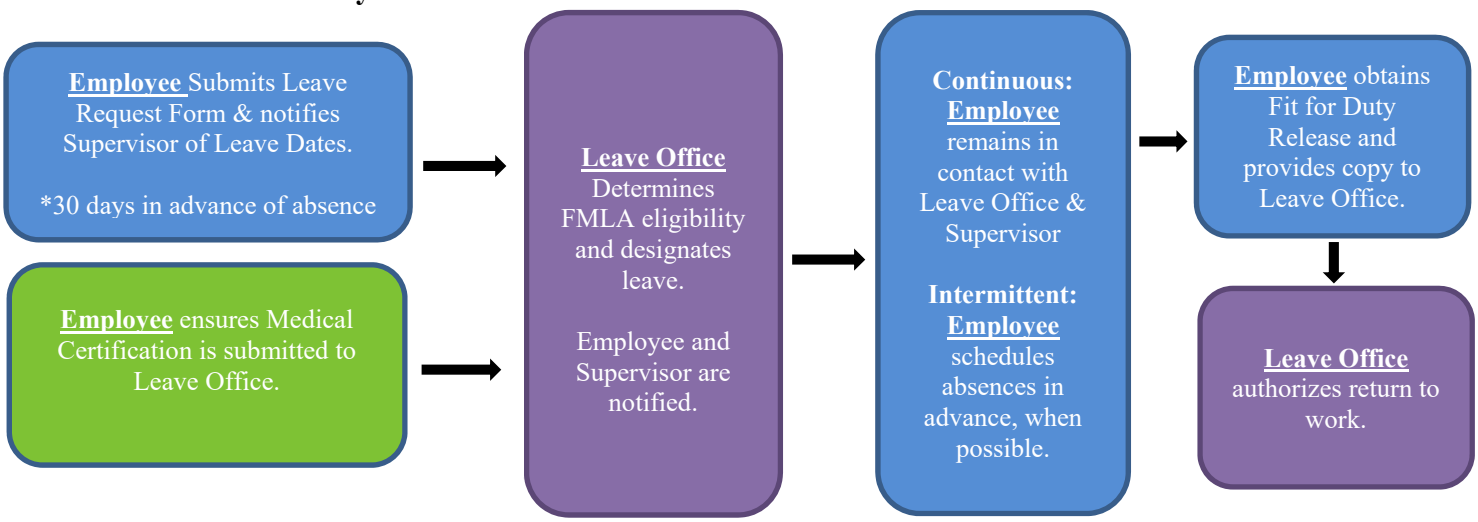
2. Return the completed and signed forms to the Leave Office. Faxes and emails are accepted. **DOCUMENTS MUST BE SUBMITTED 30 DAYS PRIOR TO SCHEDULED LEAVE AND WITHIN 15 DAYS OF UNFORESEEN events.**

3. For personal illness/injury, to receive compensation employee must file a short term disability claim. Call (877) 932-7287.

4. **Before returning to work, the employee must furnish the Leave Office with a signed release from the Health Care Provider, certifying that the employee is fit for duty. The employee may also want to make sure their TimeKeeper is aware of his/her return.**

5. **Section II (Office Use Only)** – This section will be completed by the Leave Office. A copy of the form will be provided to you and your Supervisor/Principal outlining details of your Leave.

Leave Process Summary:



PLEASE NOTE: HEALTH INSURANCE and LEAVE – Your insurance benefits are affected based on the type of approved leave. During Leave with Pay, your eligibility and premium deductions will continue. If your check is reduced, and benefits cannot be fully deducted, you must make payment directly to the Benefits Office. Failure to pay will result in termination of coverage. During Leave Without Pay-FMLA Approved, you are eligible to continue your benefits, BUT you must pay your portion of premiums directly to the Benefits Office. If Leave Without Pay-Non-FMLA, you are not eligible for benefits and all existing coverages will cease at the end of the month in which your leave without pay begins.

Contact the Leave office with any questions and/or concerns at:

Email: leaveoffice@austinisd.org **Phone Number:** (512) 414-2297 **Fax Number:** (512) 414-9976

AISD LEAVE REQUEST FORM

Leave is designated in accordance with Board Policy, DEC(LOCAL). All AISD employees are subject to District policies, and, under Board Policy BF (Local), the Board may adopt policies at any time of the year. If an employee's leave is scheduled to begin after the Board adopts policy changes, the leave will be subject to the new policy changes.

SECTION I: TO BE COMPLETED BY EMPLOYEE

Name: _____ Employee ID: _____

Location/School: _____ Position: _____

Home Address: _____ City: _____ Zip: _____

Home/Cell Phone: _____ Personal Email: _____

Preferred Contact Method: ☐ **Phone** ☐ **Personal Email** **Preferred Language:** ☐ **English** ☐ **Spanish**

Beginning Date of Absence: _____ Anticipated Return to Work Date: _____

If you are requesting leave for your own medical condition, please indicate how you would like to use your available leave:

☐ Use ALL ☐ Use only during STD Waiting Period **AND** Parenting Leave

DISTRICT ASSUMES ALL LEAVE WILL BE USED, IF A SELECTION IS NOT MADE. CHANGES CANNOT BE MADE AFTER LEAVE IS PROCESSED.

Employee Signature: _____ Date: _____

SECTION II: TO BE COMPLETED BY BENEFITS OFFICE

NOTE: The following information is subject to change based on the certification of the Health Care Provider and/or other circumstances.

☐ **REQUEST APPROVED:** _____

☐ **REQUEST NOT APPROVED:** _____

Eligible for FMLA:	
☐ **YES**	☐ **NO**

DATES ON FAMILY MEDICAL LEAVE (FMLA): From _____ Through _____

INTERMITTENT: ☐ YES ☐ NO **FMLA EXHAUSTION DATE:** _____

Health Insurance: Your benefits terminate at the end of the month when your FMLA exhausts and/or when your leave enters an unpaid status. Call our office with questions at (512) 414-2297.

AISD Years of Service (at the end of prior school year): _____ Leave Balance as of: _____

Available Leave Days:

Accrued Leave _____ SLB (if applicable) _____ Extended Leave _____ Parenting Leave _____

DATES ON LEAVE WITH FULL PAY: From _____ Through _____

DATES ON LEAVE WITH **PARTIAL PAY**: From _____ Through _____

DATES ON LEAVE **WITHOUT PAY**: From _____ Through _____

ANTICIPATED RETURN TO WORK DATE: _____ ☐ UPDATE: _____

A FIT FOR DUTY RELEASE WILL BE REQUIRED PRIOR TO RETURNING TO WORK: ☐ YES ☐ NO ☐ ON FILE

Leave Office Signature: _____ Date: _____

AUSTIN INDEPENDENT SCHOOL DISTRICT
CERTIFICATION OF MEDICAL CONDITION BY LICENSED HEALTH CARE PROVIDER
(Includes Pregnancy Related Health Conditions)
Submit this form via Fax: (512) 414-9976 or Email: leaveoffice@austinisd.org.

TO BE COMPLETED BY EMPLOYEE

Employee Name: _____ Employee ID: E_____ DOB _____

Leave is requested for: (Please check one):

☐ Self **OR** Employee's: ☐ Spouse ☐ Dependent Child (DOB _____) ☐ Parent

TO BE COMPLETED BY 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. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b). **Please be sure to sign the form on the last page.**

Patient Name (Please Print): _____

For Pregnancy:
Estimated Delivery Date:_____ Post-Partum Recovery: ☐ 6 Wks. (Reg. Delivery) ☐ 8 Wks. (C-Section)

Other Medical Conditions: Describe 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):

_____

_____

Requested Dates of Absence: *Dates are **required** and may be amended with a new statement from the Health Care Provider as needed.

_____ through _____
Beginning Date of Employee's Absence* **Anticipated** Date Employee Will Return to Work *

Frequency of Absences (Please select one):

☐ Continuous (time off all at once)

☐ Intermittent (time off only when needed). 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 (Example: 1 episode/visit every 3 months lasting 1-2 days):

_____ Times per _____ Week(s) **OR** _____ Month(s), Lasting _____ Day(s) _____

HEALTH CARE PROVIDER INFORMATION

Provider Name and Medical Specialty: _____

Address: _____

City: _____ State:_____ Zip: _____ Telephone: (_____) _____ - _____

Signature of Health Care Provider: _____ Date: _____

EMPLOYEE RIGHTS
UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION

LEAVE ENTITLEMENTS

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

BENEFITS & PROTECTIONS

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

ELIGIBILITY REQUIREMENTS

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

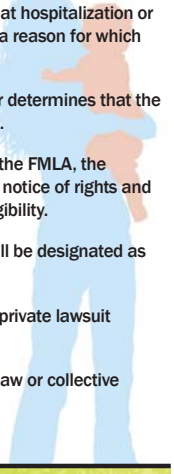
*Special "hours of service" requirements apply to airline flight crew employees.

REQUESTING LEAVE

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.



EMPLOYER RESPONSIBILITIES

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

ENFORCEMENT

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division

WH1420 REV 04/16

EMPLOYEE RIGHTS

PAID SICK LEAVE AND EXPANDED FAMILY AND MEDICAL LEAVE UNDER THE FAMILIES FIRST CORONAVIRUS RESPONSE ACT

The **Families First Coronavirus Response Act (FFCRA or Act)** requires certain employers to provide their employees with paid sick leave and expanded family and medical leave for specified reasons related to COVID-19. These provisions will apply from April 1, 2020 through December 31, 2020.

▸ PAID LEAVE ENTITLEMENTS

Generally, employers covered under the Act must provide employees:

Up to two weeks (80 hours, or a part-time employee's two-week equivalent) of paid sick leave based on the higher of their regular rate of pay, or the applicable state or Federal minimum wage, paid at:

- 100% for qualifying reasons #1-3 below, up to $511 daily and $5,110 total;
- ⅔ for qualifying reasons #4 and 6 below, up to $200 daily and $2,000 total; and
- Up to 12 weeks of paid sick leave and expanded family and medical leave paid at ⅔ for qualifying reason #5 below for up to $200 daily and $12,000 total.

A part-time employee is eligible for leave for the number of hours that the employee is normally scheduled to work over that period.

▸ ELIGIBLE EMPLOYEES

In general, employees of private sector employers with fewer than 500 employees, and certain public sector employers, are eligible for up to two weeks of fully or partially paid sick leave for COVID-19 related reasons (see below). *Employees who have been employed for at least 30 days* prior to their leave request may be eligible for up to an additional 10 weeks of partially paid expanded family and medical leave for reason #5 below.

▸ QUALIFYING REASONS FOR LEAVE RELATED TO COVID-19

An employee is entitled to take leave related to COVID-19 if the employee is unable to work, including unable to **telework**, because the employee:

1. is subject to a Federal, State, or local quarantine or isolation order related to COVID-19;
2. has been advised by a health care provider to self-quarantine related to COVID-19;
3. is experiencing COVID-19 symptoms and is seeking a medical diagnosis;
4. is caring for an individual subject to an order described in (1) or self-quarantine as described in (2);
5. is caring for his or her child whose school or place of care is closed (or child care provider is unavailable) due to COVID-19 related reasons; or
6. is experiencing any other substantially-similar condition specified by the U.S. Department of Health and Human Services.

▸ ENFORCEMENT

The U.S. Department of Labor's Wage and Hour Division (WHD) has the authority to investigate and enforce compliance with the FFCRA. Employers may not discharge, discipline, or otherwise discriminate against any employee who lawfully takes paid sick leave or expanded family and medical leave under the FFCRA, files a complaint, or institutes a proceeding under or related to this Act. Employers in violation of the provisions of the FFCRA will be subject to penalties and enforcement by WHD.

WAGE AND HOUR DIVISION
UNITED STATES DEPARTMENT OF LABOR

For additional information or to file a complaint:
1-866-487-9243
TTY: 1-877-889-5627
dol.gov/agencies/whd

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