Family and Medical Leave Request

Matanuska-Susitna Borough School District

EMPLOYEE'S SERIOUS HEALTH CONDITION

Employer: Mat-Su Borough School District
Contact: Human Resources Department phone: 907-746-9242 fax: 907-761-4088

SECTION I: FOR COMPLETION BY THE EMPLOYEE

Instructions to the Employee: Please complete Section I before giving this form to your medical provider. The 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. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825-305(b).

Employee Name:

_____ _____ _____
First Middle Last

Employee Job Title: _____

Regular Work Schedule: _____

Please bring the MSBSD Job Description for your position to your health care provider for evaluation during your appointment.

SECTION II: FOR COMPLETION BY THE 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. Please be sure to sign the form on the last page of Section II (page 3).

Health Care Provider's name: _____

Type of practice/ Medical Specialty: _____

Business Address: _____

Telephone: ( ) _____ Fax: ( ) _____

Part A: Medical Facts *(section II continued…)*

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

   Mark below as applicable:
   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ☐ Yes ☐ No.

   If so, dates of admission: _____

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

   Was medication, other than over-the-counter medication prescribed? ☐ Yes ☐ No

   Will the patient need to have treatment visits at least twice per year due to the condition? ☐ Yes ☐ No

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? ☐ Yes ☐ No

   If so, state the nature of such treatments and expected duration of treatment:

   _____

   _____

2. Is the medical condition pregnancy? ☐ Yes ☐ No. If so, expected delivery date: _____

3. Use the information provided by the employee in their job description from their employer to answer this question. If no job description is available, answer these questions based upon the employee's own description of his/her job functions.

   Is the employee unable to perform any of his/her job functions due to the condition? ☐ Yes ☐ No

   If so, identify the job functions the employee is unable to perform:

   _____

   _____

4. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

_____

_____

_____

_____

_____

Part B: AMOUNT OF LEAVE NEEDED

5. 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 so, estimate the beginning and ending dates for the period of incapacity: _____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ☐ Yes ☐ No

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   _____

   Estimate the hours the patient needs care on an intermittent basis, if any:

   _____ hour(s) per day; _____ days per week from _____ through_____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ☐ Yes ☐ No

   Is it medically necessary for the employee to be absent from work during the flare-ups?
   ☐ Yes ☐ No If so, explain:

   _____

   _____

   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 (e.g., 1 episode every 3 months lasting 1-2 days):

   Frequency: _____ times per _____ week(s) _____ month(s)

ADDITIONAL INFORMATION: Identify question number with your additional answer.

_____

_____

_____

_____

_____
Name of Health Care Provider (printed)

_____ _____
Signature of Health Care Provider Date

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SECTION III: EMPLOYEE COMPLETION DIRECTIONS AND SUPERVISOR APPROVAL

In accordance with federal and state mandated law, the Matanuska-Susitna Borough School District has instituted the ability for eligible employee's to request and take Family and Medical Leave. All documentation related to the employee's medical condition will be kept confidential and maintained in the employee's medical records file. The District may require additional information in order to process this request. If you have questions, contact Human Resources.

Employee - Please bring completed form to Human Resources Department: After all information is filled out by you (employee), the physician (with signature), and this page (page 4) is signed by your supervisor/principal, bring this packet to Human Resources for approval of leave request.

EMPLOYEE'S NAME: _____ **DATE:** _____

Reason for Family/Medical Leave Request: EMPLOYEE'S SERIOUS HEALTH CONDITION

1. Begin and End Dates of Leave Request: Must be completed in order for request to be considered. (the employee shall have the responsibility to notify their Supervisor and the Human Resources Department in the event any dates needed for Family Leave change.)

Begin Date: _____ End Date: _____

2. An intermittent or Reduced Leave Schedule may be requested for the serious illness of the employee or immediate family member, if medically necessary.

3. CEA and MSPA members must utilize all of their paid leave prior to leave without pay. MSEA and MLMA members may utilize their paid leave prior to leave without pay. Please indicate the categories of leave you plan to use while on Family and Medical Leave.

_____ Sick Leave _____ Annual Leave Days _____ Floating Holidays

_____ Personal Days _____ Sick Leave Bank _____ Leave Without Pay

Address While on Leave: _____

_____

_____

Phone number on leave: _____

_____ _____

Employee Signature Date

_____ _____

Principal/Supervisor Signature Date

Supervisory signature indicates knowledge of request. Official approval of request will come from the Human Resources Department.