Family and Medical Leave Request

Matanuska-Susitna Borough School District

FAMILY MEMBER'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 family member or his/her 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 to care for a covered family member with a 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. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R § 825.305.

Employee Name:

_____ _____ _____
First Middle Last

Name of family member for whom you will provide care:

_____ _____ _____
First Middle Last

Relationship of family member to you:

_____

If family member is your son or daughter, date of birth: _____

Describe care you will provide to your family member and estimate leave needed to provide care:

_____

_____

_____

_____ _____
Employee Signature Date

SECTION II: FOR COMPLETION BY THE HEALTH CARE PROVIDER

Instructions to the Health Care Provider: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. 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 patient needs leave. Page 4 provides space for additional information, should you need it. Please be sure to sign the form on the last page of your section (page 4).

Health Care Provider's name: _____

Business Address: _____

Telephone: ( ) _____ Fax: ( ) _____

Part A: Medical Facts

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

   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. 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 CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ☐ Yes ☐ No

   Estimate the beginning and ending dates for the period of incapacity: _____

   During this time, will the patient need care? ☐ Yes ☐ No

   Explain the care needed by the patient and why such care is medically necessary:

   _____

   _____

   _____

   _____

   _____

5. Will the patient require follow-up treatments, including any time for recovery? ☐ 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:

   _____

   Explain the care needed by the patient and why such care is medically necessary:

   _____

   _____

   _____

   _____

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? ☐ Yes ☐ No

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

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

   Explain the care needed by the patient, and why such care is medically necessary:

   _____

   _____

   _____

   _____

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal, daily activities? ☐ Yes ☐ No

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)

Duration: _____ hours or _____ day(s) per episode

Does the patient need care during these flare-ups? ☐ Yes ☐ No

Explain the care needed by the patient and why such care is medically necessary:

_____

_____

_____

_____

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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Matanuska-Susitna Borough School District

SECTION III: EMPLOYEE COMPLETION 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 5) 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: FAMILY MEMBER'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.