

BOARD PROCEDURE

Descriptive Code: GBRIC

FAMILY AND MEDICAL LEAVE

Date: June 26, 2007

An employee of the Columbia County Board of Education who needs to request a family or medical leave of absence must:

1. Complete and submit a “Family and Medical Leave (**FMLA**) Request Form” (**Attachment 1**) to the principal or immediate supervisor at least 30 days prior to the date the leave is requested to begin. In case of emergency, the request must be completed as soon as possible, but no later than five days after the leave begins.
2. Attach the FMLA Request Form to the appropriate documentation required to support the request for leave:
 - (a) in cases of illness/disability of employee or eligible family member, the **two-page** "Certification of Physician or Practitioner Form" (**Attachment 2**),
 - (b) in cases of adoption or foster care placement, a copy of the adoption papers or foster care placement papers,
 - (c) in cases of first year care of a child, a copy of birth certificate.
3. Provide written notification of desire to return to work at the conclusion of the specified period of disability. This notice must include a doctor's statement clearing the individual to resume all job responsibilities. Whenever a leave of absence is 60 days or less, notification should be submitted to the immediate supervisor; for extended leave exceeding sixty days, notification should be submitted to the Human Resources **Department**.
4. If an extension to the specified period of disability is needed, the employee must submit a request on the “Extended Leave Request” form (**Attachment 3**). This document must be **submitted** to the Human Resources Department. Extensions may not extend past one calendar year from the date leave begins.

Upon receipt of a leave request, the principal or supervisor will:

1. Sign and recommend approval of the leave request and forward to Human Resources.
2. Contact the Human Resources Department to recommend a substitute employee to fill the temporary vacancy if necessary. The substitute employee must be an approved substitute; whenever possible a certified teacher substitute must be recommended for a short-term assignment when a teacher is absent ten or more consecutive days.

(see next page)

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3. Submit a Personnel/Payroll Change form on or before the first day of leave for the employee.
4. Enter the employee's absence and approved substitute in the employee attendance VIPS System on a daily basis.
5. Submit a Personnel/Payroll Change form with the doctor's statement clearing the employee to resume duties to Human Resources upon return to work. Employees out due to personal illness must provide the doctor's note prior to being allowed to return to work.

The Human Resources **Department** will:

1. Provide written notification to the employee of the decision of the Board of Education regarding the requested leave.
2. Provide written confirmation of employment assignment or change in employment status upon conclusion of the specified period of disability.

The principal or department head must inform an employee requesting leave under the Family and Medical Leave policy of the required timeline and forms necessary to apply for leave. Employees should not be allowed to begin leave without the proper documentation submitted 30 days in advance. In emergency cases, the leave request documents **MUST** be submitted as soon as possible after the first day of leave, but within five days unless unusual circumstances exist. In such cases, the employee should be informed in writing of the need for the documents to be submitted within the required time frame.

ADOPTED: 05/10/88

REVISED: 08/01/93, 8/7/00, 4/9/2007

Columbia County Board of Education

FAMILY AND MEDICAL LEAVE REQUEST FORM
DUE 30 DAYS BEFORE LEAVE BEGINS
COLUMBIA COUNTY SCHOOL SYSTEM

ATTACHMENT 1

DIRECTIONS: Employees of the Columbia County Board of Education **MUST** complete this request form and submit to the Human Resources Department at least 30 days before the anticipated date of family and medical leave, except in cases of emergency. In emergencies, the employee must submit all required documents no later than five (5) days from the first day of leave. The supporting documentation as described below is **ESSENTIAL** before requests for leave will be approved and granted. Check the appropriate category of leave, complete the required information in the spaces provided and attach all required documentation.

NAME: _____ SS#: _____

SCHOOL/DEPARTMENT: _____ POSITION: _____

DATE FORM COMPLETED: _____ DATE EMPLOYED BY SYSTEM: _____

SIGNATURE OF EMPLOYEE REQUESTING LEAVE: _____

Is spouse employed by the Columbia County Board of Education? ___ Yes ___ No

If yes, name of spouse _____

Birth of Child

Date leave anticipated to begin: _____ Anticipated date of delivery: _____

Expected date of return to work: _____ Length of leave requested: ___ weeks ___ days

REQUIRED DOCUMENTATION: "Certification of Physician or Practitioner" form verifying first date of disability, anticipated delivery date, and date expected to be able to return to work.

***If an employee elects to take additional time beyond the medical disability period for bonding or first year care of the child, such time must be leave without pay.

First Year Care of a Child

Placement for Adoption of Child

Placement for Foster Care of Child

Name of Child: _____ Relationship to Employee: _____

Date of leave requested to begin: _____ Anticipated date of return to work: _____

Length of leave requested: ___ weeks ___ days

REQUIRED DOCUMENTATION: Copy of official birth certificate of child; if adoption, copy of adoption papers; if foster child placement, copy of foster care placement records.

Serious Health Condition of Employee

Nature of Illness/Disabling Medical Condition: _____

Date condition commenced: _____ Date leave requested to begin: _____

Probable date of return to work: _____ Length of leave requested: ___ weeks ___ days

Request Intermittent Leave? ___ Yes ___ No If yes, describe: _____

Request Reduced Schedule Leave? ___ Yes ___ No If yes, describe: _____

REQUIRED DOCUMENTATION: "Certification of Physician or Practitioner" form must be completed in entirety by physician or health care provider and attached to this request.

Serious Health Condition of Family Member Which Necessitates Care by Employee

Name of Family Member: _____ Relation to Employee: _____

Nature of Illness/Disabling Medical Condition: _____

Date condition commenced: _____ Date leave requested to begin: _____

Probable date of return to work: _____ Length of leave requested: ___ weeks ___ days

Request Intermittent Leave? ___ Yes ___ No If yes, describe: _____

Request Reduced Schedule Leave? ___ Yes ___ No If yes, describe: _____

REQUIRED DOCUMENTATION: "Certification of Physician or Practitioner" form must be completed in entirety by physician or health care provider and attached to this request.

TO BE COMPLETED BY PRINCIPAL OR SUPERVISOR

I recommend that this request for family and medical leave be approved. _____
Date Signature of Principal/Supervisor

HUMAN RESOURCES DEPARTMENT USE ONLY

Approved by Director of Human Resources: _____ Date Received: _____

Date of Official Board of Education Approval: _____ Leave Designated as FMLA Leave? ___ Yes ___ No

Human Resources Department
4781 Hereford Farm Road
Evans, Georgia 30809
(706) 541-2723 x 5143-Fax (706) 855-2518
www.cboe.net

CERTIFICATION OF PHYSICIAN OR PRACTITIONER FORM
(Family and Medical Leave Act of 1993)

- 1. Employee's Name:
2. Patient's Name (If Other than Employee): Relationship to Employee:
3. Diagnosis:
4. Date condition commenced: 5. Probable duration of condition:
Beginning date of disability: "Anticipated" ending date of disability: (Unknown, Indefinite, Etc., is NOT ACCEPTABLE)

NOTE: If leave is related to birth of child, indicate date after birth that the employee can be released to return to work since elective bonding leave must be without pay. Date employee on leave due to birth of child is released to work:

- 6. Regimen of treatment to be prescribed (Indicate number of visits, general nature and duration of treatment, including referral to other provider of health services. Include schedule of visits or treatment if it is 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.):
a. By Physician or Practitioner:
b. By another provider of health services, if referred by a Physician or Practitioner:

PLEASE COMPLETE THIS SECTION ONLY FOR CERTIFICATION RELATED TO MEDICAL CONDITION/TREATMENT OF THE EMPLOYEE.

Check YES or NO in the spaces below, as appropriate:

YES NO

- 7. Is inpatient hospitalization of the employee required?
8. Is employee able to perform work of any kind? (If "No", skip to item 9.) If "Yes", please specify:
9. Is employee able to perform the functions of employee's position? (Answer after discussing with the employee the essential functions of the employee's position.)

PLEASE COMPLETE THIS SECTION ONLY FOR CERTIFICATION RELATING TO CARE FOR THE EMPLOYEE'S SERIOUSLY-ILL FAMILY MEMBER.

YES NO

- 10. ___ ___ Is hospitalization of the family member (patient) required?
- 11. ___ ___ Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation?
- 12. ___ ___ After review of the employee's signed statement (See Item 14 below), is the employee's presence necessary or would it be beneficial for the care of the patient? (This may include psychological comfort.)
- 13. Estimate the period of time care is needed or the employee's presence would be beneficial:

ITEM 14 IS TO BE COMPLETED BY THE EMPLOYEE NEEDING FAMILY LEAVE.

- 14. When Family Leave is needed to care for a seriously-ill family member, the employee shall state the care he or she will provide and an estimate of the time period during which this care will be provided, including a schedule if leave is to be taken intermittently or on a reduced leave schedule:

Employee Signature: _____

Date: _____

15. Signature of Physician or Practitioner: _____

Printed Name of Physician or Practitioner: _____

Street Address

City/St/Zip

Phone Number

Fax Number

16. Date: _____

17. Type of Practice (Field of Specialization, if any): _____





Extended Leave Request
(Family and Medical Leave Policy)

Employee's Name: School/Department:

Patient's Name
(If Other than Employee): Relationship to Employee:

I am requesting extended leave under Policy GBRIC, Family and Medical Leave, due to a serious health condition as documented by my physician below. I understand and accept the terms of employment:

- 1. Due to my absence extending more than the allowable 60 days, I understand that my position will be filled.
2. I will be offered the next available equivalent position as determined by the Board of Education upon receipt of written my request to return accompanied by my physician statement clearing me to resume all duties.
3. My employment will be terminated if I am unable to return within one calendar year.

Employee's Signature: Date:

Principal/Supervisor Signature: Date:

To be completed by physician or practitioner

Diagnosis:

Date condition commenced: Probable duration of extended leave:

Beginning date of extended leave: "Anticipated" ending date of extended disability:
(Unknown, Indefinite, Etc., NOT ACCEPTABLE)

Signature of Physician or Practitioner:

Printed Name of Physician or Practitioner:

Street Address City/St/Zip

Phone Number Fax Number

Date:

Type of Practice (Field of Specialization, if any):

Return this form to:
Columbia County School System
ATTN: Human Resources Department
4781 Hereford Farm Road
Evans, GA 30809
(706) 541-2723 ext. 5143-Phone
(706) 855-2518-Fax