MIDDLE TOWNSHIIP BOARD OF EDUCATION
216 S. Main Street
Cape May Court House, NJ 08210

LEAVE OF ABSENCE REQUEST FORM INSTRUCTIONS

ALL LEAVES MUST BE REQUESTED FROM AND GRANTED BY THE BOARD OF EDUCATION FOR AN ABSENCE OVER 5 CONSECUTIVE DAYS.

1. Notification to your principal or supervisor is not a request for leave. The process requires that the required forms are submitted to School Business Administrator/Board Secretary so that Board of Education approval can be obtained. Please call Mary Kate Garry as soon as you know of an impending leave to schedule an appointment to review the necessary paperwork.

2. If you are requesting a medical leave for yourself or a seriously ill spouse, child, parent or dependent, the appropriate Certification of Health Care Provider (4 pages) must be completed in its entirety by the treating physician. Please inform your doctor that incomplete forms will be returned, which may delay your approval. Ideally, the Certification of Health Care Provider should be attached to your Request Form so that the dates that you are requesting can be verified. If not, please have your doctor's office fax the form to 465-7058.

3. The Middle Township Board of Education uses a rolling 12 month period measured backwards from the date you wish your FMLA to begin to determine eligibility.

4. The requirement for you to use your paid time off is at the discretion of the District and is as follows:

   - **Certified Staff** – May only use paid time off for themselves and will be required to use all sick time in their bank.
   - **Transportation** - Must use all their personal time in their bank.
   - **Support Staff** – Must use all sick time in their bank.

5. You have the right to maintain your health benefits while out on FMLA. With the implementation of Ch 78 Pension and Health Reform Law the employee's responsibility

for their calculated percentage of health coverage will STILL BE DUE while on an unpaid leave. This may be paid back to the District upon your return from leave for a period not to exceed the length of the leave.

6. You have the right to return to your job at the end of your FMLA leave, you are **required** to furnish a new doctor's note if you anticipate returning earlier than your original date.

7. You must fill in page 1 of the request form and submit pages 1 and 2, along with a completed Certification of Health Care Provider (4 pages) to your Principal/Supervisor for approval and signature.

8. Once all paperwork is received in the Board Admin office, your request will be reviewed and placed on the agenda of the next Board meeting. If you do not hear from me stating that your leave has been denied, you are to take this as notification that your FMLA leave request has been approved by our office.

9. Please remember different groups under CNA enjoy different benefits per your contract (certified staff, support staff, transportation, etc...). Certified staff members may only use their sick days for their own illnesses.

10. If you are out on leave to have a baby, please be aware your new bundle(s) must be added to your insurance policy **within 30 days**!! Please contact Dawn Aftanis to do so at x3116 or aftanisd@middletwp.k12.nj.us.

Both the Federal and State leave of absences acts require your notification to the employer at least 30 days in advance (when applicable).

Please feel free to contact me with any questions; I know it's very confusing!

Mary Kate Garry, Payroll Supervisor

Ph: 609.465.1800 x 3116 ~ Fax: 609.465.7058 ~ Email: garrym@middletwp.k12.nj.us

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

The New Jersey **Family Leave Act**

Employees who are covered by the New Jersey Family Leave Act (N.J.S.A.34:11B-1, et seq.) and related regulations (N.J.A.C. § 13:14-1.1., et seq.) are entitled to take up to 12 weeks of family leave in a 24-month period without losing their jobs. With some exceptions, employers must provide this type of leave when the following conditions are met:

- The EMPLOYER has at least 50 employees or is a government entity (regardless of the number of employees).
- The EMPLOYEE has worked for that employer for at least one year, and has worked at least 1,000 hours for that employer during the 12 months immediately prior to taking the leave.
- The LEAVE OF ABSENCE is being taken in connection with the birth or adoption of a child, or because of a serious health condition of a child, parent, step-parent, parent-in-law, spouse or civil union partner. (The New Jersey Family Leave Act **does not** provide leave for the employee's own health condition.)

Leave granted by the Family Leave Act is separate from any rights granted under the Temporary Disability Benefits Law or the Family Leave Insurance Law. Employees may be eligible for additional leave under the federal Family and Medical Leave Act.

The employee must give the employer notice 30 days before taking Family Leave, except when emergent circumstances require the employee to begin Family Leave sooner. In emergent circumstances, the employee should give the employer as much notice as possible.

To ensure that the employee meets the eligibility requirements, the employer may require the employee to provide a certification from a health care provider regarding the family member's serious health condition, the date of a newborn's birth or the date of placement for adoption.

For more information visit **www.NJCivilRights.gov**.
To report a violation, please contact one of the regional offices below:

Northern Regional Office
31 Clinton Street
Newark, NJ 07102
Phone: (973) 648-2700
Fax: (973) 648-4405

Central Regional Office
140 East Front Street
P.O. Box 090
Trenton, NJ 08625-0090
Phone: (609) 292-4605
Fax: (609) 984-3812

Southern Regional Office
5 Executive Campus
Suite 107
Cherry Hill, NJ 08034
Phone: (856) 486-4080
Fax: (856) 486-2255

South Shore Regional Office
1325 Boardwalk
Tennessee Ave. & Boardwalk
Atlantic City, NJ 08401
Phone: (609) 441-3100
Fax: (609) 441-3578

DIVISION ON CIVIL RIGHTS

State regulations require all employers covered by the New Jersey Family Leave Act to display this official poster in places easily visible to all employees. N.J.A.C. 13:8-2.2.

rev.9.6.16

MIDDLE TOWNSHIP BOARD OF EDUCATION
216 S. Main Street
Cape May Court House, NJ 08210

LEAVE OF ABSENCE REQUEST FORM

you

Step I - Employee Request

1. **Employee's Name**

   _____

2. **Employee's Work Location**

   _____

3. **Employee's Job Title**

   _____

4. **Type of Leave Requested:**

   ( )* **Maternity/Paternity (FMLA/FLA)**
   ( )* **Medical/Sick Leave (Employee) (FMLA)**
   ( )* **Seriously Ill Spouse, Child, Parent or Dependent (FMLA/FLA)**
   ( ) **Adoption/Foster Child Placement (Attach documentation) (FMLA/FLA)**
   ( ) **Military (Attach orders)**
   ( ) **Personal (A detailed explanation must be attached)**

   * **Appropriate Certification of Health Care Provider must be provided**

5. **Is this an initial request ( ) or an extension ( )? (Check one)**

6. **If this is a request for an extension, complete the following:**

   a. **When did your initial leave begin? ___/___/___.**
   b. **When does your initial leave end? ___/___/___.**

7. **Have you had a Leave of Absence in the past 24 months? ( ) Yes ( ) No**
   If yes, give the beginning and ending date of each leave of absence:
   Start date ___/___/___ End date ___/___/___
   Start date ___/___/___ End date ___/___/___

8. **On what date do you want your leave or extension to begin? ___/___/___**

9. **On what date do you expect to return to work? ___/___/___**

Comments:_____
_____
_____
_____

I have been given information on my rights under the Family and Medical Leave Act and NJ Family Leave Act. _____
Signature of Employee

Attachments:
FMLA
FLA
Certification of Health Care Provider (2) - For Employee or For Family Member

Step 2 - Supervisor's Review

Recommended Approval: **Recommended Rejection:**

Reason for Rejection:

Name of Supervisor: _____ **Date:** _____

Certification of Health Care Provider attached, if applicable _____

Signature: _____

Step 3 - Personnel Review

Your request:

[ ] Cannot be approved without your doctor's certification. Please provide as soon as possible.

[ ] Has been recommended for Board of Education approval.

[ ] Has been rejected:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Date: _____

Name: Diane S. Fox **Title:** School Business Administrator/Board Secretary

Signature: _____

your

Dr.

Mary Kate Garry
Fax: 609-465-7058
Ph: 609-465-1800 x 3116

Certification of Health Care Provider for Family Member's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

U.S. Wage and Hour Division

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.

OMB Control Number: 1235-0003
Expires: 5/31/2018

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: Middle Township Board of Education

Mary Kate Garry (609) 465-1800 x 3116 Fax: (609) 465-7058

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II 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.

Your 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

CONTINUED ON NEXT PAGE

Dr.

SECTION III: 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. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e). Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

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?
   ___No ___Yes. If so, dates of admission: _____

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

   Was medication, other than over-the-counter medication, prescribed? ___No ___Yes.

   Will the patient need to have treatment visits at least twice per year due to the condition? ___No ____ Yes

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
   ____ No ____Yes. If so, state the nature of such treatments and expected duration of treatment:

   _____

   _____

2. Is the medical condition pregnancy? ___No ___Yes. 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):

_____

_____

_____

_____

CONTINUED ON NEXT PAGE

Dr.

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? ___No ___Yes.

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

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

   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? ___No ___Yes.

   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? __ No __ Yes.

   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:

   _____

   _____

   _____

   _____

CONTINUED ON NEXT PAGE

Dr.

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ____No ____Yes.

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? ____ No ____ Yes.

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

_____

_____

_____

_____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Health Care Provider **Date**

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210.
DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.