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.**
***THE FEDERAL GOVERNMENT (FMLA) AND THE STATE OF NEW JERSEY (FLA) REQUIRE THAT LEAVES MUST BE REQUESTED AT LEAST 30 DAYS IN ADVANCE.**
***LEAVE PAPERWORK SHOULD BE SUBMITTED TO THE BUSINESS OFFICE AS FAR IN ADVANCE AS POSSIBLE.**

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 Form must be filled out in its entirety by the treating physician. Please inform your doctor that incomplete forms will be returned, which may delay your approval.

3. The Middle Township Board of Education uses a 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: Must use all sick time in bank.
    - Transportation: Must use all 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 and Ch 44, 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 clearing you to work with no limitations if you anticipate returning earlier than your original cert date.

7. You must fill in page 1 of your request form and submit that as well as the Cert of Health Care Provider to your Principal or 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. This can also be checked by you, on Board Docs for the District.

9. If you are out on leave for the birth of a baby or adoption of a child, please be aware your new bundle(s) must be added to your insurance policy WITHIN 30 DAYS OF THE EVENT! Please contact Anna Striluik to do so at x3119 or Striluka@middletwp.k12.nj.us.

Please feel free to contact me with any questions; I know it's very confusing! Just allow me some time to return your calls/emails. I will get back to you asap!

Mary Kate Garry

Payroll Supervisor

PH: 609.465.1800 x3116

Fax: 609.465.7058

Email: garrym@middletwp.k12.nj.us

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216 S. Main Street
Cape May Court House, NJ 08210

LEAVE OF ABSENCE REQUEST FORM

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. 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 ___/___/___

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

7. 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:

[ ] Has been recommended for Board of Education approval.

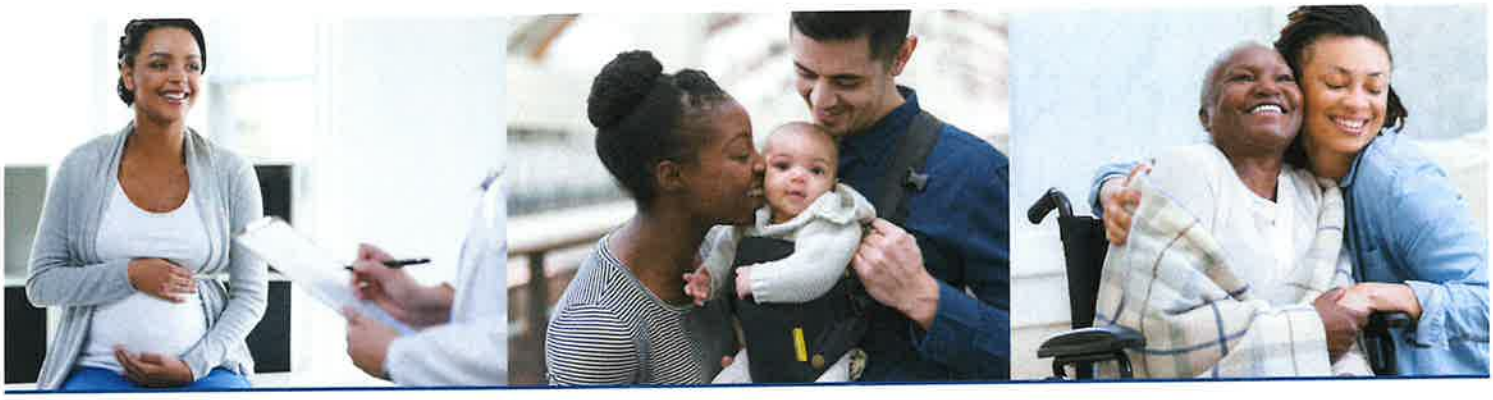
[ ] Has been rejected:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Date: _____

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

Signature: _____



5 Things You Should Know About Job-Protected Family Leave

1. **Under the New Jersey Family Leave Act (NJFLA)**, if you work for a state or local government agency, or a company or organization with 30 or more employees worldwide, and you have been employed by the company for at least 1 year (and have worked at least 1,000 hours in the past 12 months), you generally can take up to 12 weeks of job-protected leave during any 24-month period:
   - To care for or bond with a child, as long as the leave begins within 1 year of the child's birth or placement for adoption or foster care;
   - To care for a family member, or someone who is the equivalent of family, with a serious health condition (including a diagnosis of COVID-19), or who has been isolated or quarantined because of suspected exposure to a communicable disease (including COVID-19) during a state of emergency; or
   - To provide required care or treatment for a child during a state of emergency if their school or place of care is closed by order of a public official due to an epidemic of a communicable disease (including COVID-19) or other public health emergency.
2. **You can take a consecutive block of up to 12 weeks** of leave or you can take leave on an intermittent or reduced schedule.
3. **NJFLA leave is not the same as the Federal Family Medical Leave Act (FMLA)**, so you will not use up NJFLA leave while taking leave for your own serious medical condition under the FMLA. In some situations, you therefore may be entitled to take up to 12 weeks of FMLA leave for your own condition and 12 weeks of NJFLA leave to care for a family member, in a single 12-month period.
4. **If you are pregnant or just had a baby, you can take up to 12 weeks** for pregnancy and recovery from childbirth under the FMLA, and you can then take an additional 12 weeks of NJFLA leave to bond with or care for your baby after your doctor certifies you are fit to return to work or you have exhausted your FMLA leave (whichever is earlier). Any parent may take leave under the NJFLA to bond with or care for a newborn or a child just placed for adoption or foster care.
5. **When you return to work, you are generally entitled to return to the same position** you held before leave, and your employer may not retaliate against you because you took or attempted to take leave under the NJFLA.

To find out more or to file a complaint, go to **NJCivilRights.gov** or call **973-648-2700**

NJ Office of the Attorney General
NJCivilRights.gov
DIVISION ON CIVIL RIGHTS

5.13.20

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

U.S. Department of Labor
Wage and Hour Division

WAGE AND HOUR DIVISION

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

OMB Control Number: 1235-0003
Expires: 6/30/2026

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave to care for a family member with a serious health condition to submit a medical certification issued by the family member's health care provider. 29 U.S.C. §§ 2613, 2614(c)(3); 29 C.F.R. § 825.305. The employer must give the employee **at least 15 calendar days** to provide the certification. If the employee fails to provide complete and sufficient medical certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

SECTION I - EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, this form asks the health care provider for the information necessary for a complete and sufficient medical certification, which is set out at 29 C.F.R. § 825.306. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308.** Additionally, you **may not** request a certification for FMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care.

Employers must generally maintain records and documents relating to medical information, medical certifications, recertifications, or medical histories of employees or 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.

(1) Employee name: _____
First Middle Last

(2) Employer name: _____ Date: _____ (mm/dd/yyyy)
(List date certification requested)

(3) The medical certification must be returned by _____ (mm/dd/yyyy)
(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee's diligent, good faith efforts.)

SECTION II - EMPLOYEE

Please complete and sign Section II before providing this form to your family member or your family member's health care provider. The FMLA allows an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of your family member. If requested by your employer, your response is required to obtain or retain the benefit of the FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). **You are responsible for making sure the medical certification is provided to your employer within the time frame requested, which must be at least 15 calendar days.** 29 C.F.R. §§ 825.305-825.306. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA leave request. 29 C.F.R. § 825.313.

(1) Name of the family member for whom you will provide care: _____

(2) Select the relationship of the family member to you. The family member is your:

☐ Spouse ☐ Parent ☐ Child, under age 18

☐ Child, age 18 or older and incapable of self-care because of a mental or physical disability

Spouse means a husband or wife as defined or recognized in the state where the individual was married, including in a common law marriage or same-sex marriage. The terms "child" and "parent" include in loco parentis relationships in which a person assumes the obligations of a parent to a child. An employee may take FMLA leave to care for an individual who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave to care for a child for whom the employee has assumed the obligations of a parent. No legal or biological relationship is necessary.

Employee Name: _____

(3) Briefly describe the care you will provide to your family member: **(Check all that apply)**

☐ Assistance with basic medical, hygienic, nutritional, or safety needs ☐ Transportation

☐ Physical Care ☐ Psychological Comfort ☐ Other: _____

(4) Give your **best estimate** of the amount of leave needed to provide the care described:

_____

(5) If a **reduced work schedule** is necessary to provide the care described, give your **best estimate** of the reduced schedule you are able to work. From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy), I am able to work

_____ (hours per day) _____ (days per week)

Employee Signature _____ **Date** _____ (mm/dd/yyyy)

SECTION III - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form below. A family member of your patient has requested leave under the FMLA to care for your patient. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a family member with a serious health condition. For FMLA purposes, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves inpatient care or continuing treatment by a health care provider. For more information about the definitions of a serious health condition under the FMLA, see the chart at the end of the form.

You also may, but are **not required** to, provide other appropriate medical facts including symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment. Please note that some state or local laws may not allow disclosure of private medical information about the patient's serious health condition, such as providing the diagnosis and/or course of treatment.

Health Care Provider's name: (Print) _____

Health Care Provider's business address: _____

Type of practice / Medical specialty: _____

Telephone: _____ Fax: _____ E-mail: _____

PART A: Medical Information

Limit your response to the medical condition for which the employee is seeking FMLA leave. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. **After completing Part A, complete Part B to provide information about the amount of leave needed.** Note: For FMLA purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. 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).

(1) Patient's Name: _____

(2) State the approximate date the condition started or will start: _____ (mm/dd/yyyy)

(3) Provide your **best estimate** of how long the condition lasted or will last: _____

(4) For FMLA to apply, care of the patient must be medically necessary. Briefly describe the type of care needed by the patient (e.g., assistance with basic medical, hygienic, nutritional, safety, transportation needs, physical care, or psychological comfort).

_____

Employee Name: _____

(5) Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

☐ **Inpatient Care**: The patient (☐ has been / ☐ is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): _____

☐ **Incapacity plus Treatment**: (e.g. outpatient surgery, strep throat)

Due to the condition, the patient (☐ has been / ☐ is expected to be) incapacitated for more than three consecutive, full calendar days from: _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy).

The patient (☐ was / ☐ will be) seen on the following date(s): _____

_____

The condition (☐ has / ☐ has not) also resulted in a course of continuing treatment under the supervision of a health care provider (e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment)

☐ **Pregnancy**: The condition is pregnancy. List the expected delivery date: _____ (mm/dd/yyyy).

☐ **Chronic Conditions**: (e.g. asthma, migraine headaches) Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

☐ **Permanent or Long Term Conditions**: (e.g. Alzheimer's, terminal stages of cancer) Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

☐ **Conditions requiring Multiple Treatments**: (e.g. chemotherapy treatments, restorative surgery) Due to the condition, it is medically necessary for the patient to receive multiple treatments.

☐ **None of the above**: If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed. Go to page 4 to sign and date the form.

(6) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. (e.g., use of nebulizer, dialysis)

_____

PART B: Amount of Leave Needed

For the medical condition(s) checked in Part A, complete all that apply. 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 if the benefits and protections of the FMLA apply.

(7) Due to the condition, the patient (☐ had / ☐ will have) **planned medical treatment(s)** (scheduled medical visits) (e.g. psychotherapy, prenatal appointments) on the following date(s): _____

_____

(8) Due to the condition, the patient (☐ was / ☐ will be) **referred to other health care provider(s)** for evaluation or treatment(s).

State the nature of such treatments: (e.g. cardiologist, physical therapy) _____

Provide your **best estimate** of the beginning date _____ (mm/dd/yyyy) and end date _____ (mm/dd/yyyy). for the treatment(s).

Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery (e.g. 3 days/week)

_____

Employee Name: _____

(9) Due to the condition, the patient (☐ was / ☐ will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.

Provide your **best estimate** of the beginning date _____ (mm/dd/yyyy) and end date _____ (mm/dd/yyyy). for the period of incapacity.

(10) Due to the condition, it (☐ was / ☐ is / ☐ will be) medically necessary for the employee to be absent from work to provide care for the patient on an **intermittent basis** (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, episodes of incapacity are estimated to occur _____ times per (☐ day ☐ week ☐ month) and are likely to last approximately _____ (☐ hours ☐ days) per episode.

Signature of Health Care Provider _____ Date: _____ (mm/dd/yyyy)

Definitions of a Serious Health Condition (See 29 C.F.R. §§ 825.113-.115)

Inpatient Care

- An overnight stay in a hospital, hospice, or residential medical care facility.
- Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.

Continuing Treatment by a Health Care Provider (any one or more of the following)

Incapacity Plus Treatment: A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either:

- o Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or,
- o At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.

Pregnancy: Any period of incapacity due to pregnancy or for prenatal care.

Chronic Conditions: Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.

Permanent or Long-term Conditions: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.

Conditions Requiring Multiple Treatments: Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.

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 15 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 Avenue, N.W., Washington, D.C. 20210.

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