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

MIDDLE TOWNSHIP BOARD OF EDUCATION
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: _____

WAGE AND HOUR DIVISION
UNITED STATES DEPARTMENT OF LABOR

Fact Sheet #28: The Family and Medical Leave Act

Revised March 2025

The Family and Medical Leave Act (FMLA) provides job-protected leave from work for family and medical reasons. This fact sheet explains FMLA benefits and protections.

ABOUT THE FMLA

The FMLA provides eligible employees of covered employers with job-protected leave for qualifying family and medical reasons and requires continuation of their group health benefits under the same conditions as if they had not taken leave. FMLA leave may be unpaid or used at the same time as employer-provided paid leave. Employees must be restored to the same or virtually identical position when they return to work after FMLA leave.

Eligible employees: Employees are eligible if they work for a covered employer for at least 12 months, have at least 1,250 hours of service with the employer during the 12 months before their FMLA leave starts, and work at a location where the employer has at least 50 employees within 75 miles.

Covered employers: Covered employers under the FMLA include:

- Private-sector employers who employ 50 or more employees in 20 or more workweeks in either the current calendar year or previous calendar year,
- Public agencies (including Federal, State, and local government employers, regardless of the number of employees), and
- Local educational agencies (including public school boards, public elementary and secondary schools, and private elementary and secondary schools, regardless of the number of employees).

The FMLA protects leave for:

- The birth of a child or placement of a child with the employee for adoption or foster care,
- The care for a child, spouse, or parent who has a serious health condition,
- A serious health condition that makes the employee unable to work, and
- Reasons related to a family member's service in the military, including
    - Qualifying exigency leave - Leave for certain reasons related to a family member's foreign deployment, and
    - Military caregiver leave – leave when a family member is a current servicemember or recent veteran with a serious injury or illness.

Download "The Employee Guide to the Family and Medical Leave Act" for more information about the FMLA, including how to request FMLA leave.

USING FMLA LEAVE

Eligible employees may take:

- Up to 12 workweeks of leave in a 12-month period for any FMLA leave reason except military caregiver leave, and

- Up to 26 workweeks of military caregiver leave during a single 12-month period.

Examples:

- Sheila works 32 hours a week at a shoe store. When Sheila needs to take FMLA leave for 12 weeks, she may use up to 32 hours of FMLA leave a week for 12 weeks.
- Chester works 40 hours a week as an administrative assistant. When Chester needs to take FMLA leave for 12 weeks, he may use up to 40 hours of FMLA leave a week for 12 weeks.
- Kayden works 50 hours a week as a cook at a restaurant. When Kayden needs to take FMLA leave for 12 weeks, he may use up to 50 hours of FMLA leave a week for 12 weeks.

Intermittent or reduced schedule leave. Employees have the right to take FMLA leave all at once, or, when medically necessary, in separate blocks of time or by reducing the time they work each day or week. Intermittent or reduced schedule leave is also available for military family leave reasons. However, employees may use FMLA leave intermittently or on a reduced leave schedule for bonding with a newborn or newly placed child only if they and their employer agree.

Examples:

- Sheila has a daughter who serves in the Armed Forces and was seriously injured during deployment overseas. Sheila needs FMLA leave for one-half of her usual workweek (16 hours) over the next six months to assist with her daughter's care.
- Chester has a serious mental health condition that sometimes affects his ability to work. Occasionally, when Chester is unable to work because of his mental health, he takes FMLA leave, usually for one to three weeks at a time. Chester also takes FMLA leave every now and then for an hour or two when he has an appointment to see his doctor or attend therapy to treat his condition.
- Kayden, a cook, works Tuesday through Saturday. His father, Emile, has a serious health condition. Kayden and his wife, Maeve, take turns bringing Emile to dialysis during the week. Every other Friday evening Kayden uses five hours of FMLA leave to help his father. Even though his wife helps, Kayden also occasionally uses five hours of FMLA leave on other evenings to help his father.

Paid leave. FMLA is job-protected, unpaid leave. Employees may use employer provided paid leave at the same time that they take FMLA leave if the reason they are using FMLA leave is covered by the employer's paid leave policy. An employer may also require employees to use their paid leave during FMLA leave.

Examples:

- Sheila works for a shoe store that provides her with one week of paid vacation time every year. The store always requires employees to use their paid vacation time when they take time off from work for any reason, even if they are not taking a vacation. When Sheila takes 16 hours of FMLA leave because of her daughter's deployment with the Armed Forces to a foreign country, her employer pays her for her FMLA time off and deducts 16 hours from her one week of vacation time.
- When Chester needs FMLA leave for his own serious health condition, he uses paid sick leave that is part of his job benefits.
- The restaurant where Kayden works provides him paid sick leave that he can use for his own health needs but not for family care. Kayden also has other paid time off (PTO) that he uses when he takes leave to care for his father who has a serious health condition.

Requesting FMLA leave. Employees do not have to specifically ask for FMLA leave but do need to provide enough information so the employer is aware the leave may be covered by the FMLA. Employees must provide notice to their employer as soon as possible and practical that they will need to use FMLA leave. For example, if an employee knows that he or she has a procedure for a serious medical condition scheduled in three weeks, the employee needs to provide notice to the employer as soon as the procedure is scheduled. Employers may ask for information from the health care provider before approving FMLA leave and must allow 15 calendar days to provide the information. In some circumstances, such as when the employee's health care provider is not able to complete the certification information timely, employees must be allowed additional time.

FMLA LEAVE BENEFITS AND PROTECTIONS

Job protection. Employees who use FMLA leave have the right to go back to work at their same job or to an equivalent job that has the same pay, benefits, and other terms and conditions of employment at the end of their FMLA leave. Violations of an employee's FMLA rights may include changing the number of shifts assigned to the employee, moving the employee to a location outside of his or her normal commuting area, or denying the employee a bonus for which the employee qualified before taking FMLA leave.

An employer cannot threaten, discriminate against, punish, suspend, or fire an employee because he or she requested or used FMLA leave. Violations of an employee's FMLA rights may include actions such as writing up the employee for missing work when using FMLA leave, denying a promotion because the employee has used FMLA leave, or assessing negative attendance points for FMLA leave use.

Group health plan benefits. Employers are required to continue group health insurance coverage for an employee on FMLA leave under the same terms and conditions as if the employee had not taken leave. For example, if family member coverage is provided to an employee, family member coverage must be maintained during the employee's FMLA leave.

SPECIAL FMLA RULES FOR SOME WORKERS

FMLA Leave and Teachers. Special rules apply to employees of elementary schools, secondary schools, and school boards. Generally, these rules apply when an employee needs intermittent leave or leave near the end of a school term.

FMLA Eligibility for Flight Crews. Airline flight crew employees have special hours of service eligibility requirements. For more information about the special rules for flight crew employees, see Fact Sheet #28J.

FMLA Eligibility for Servicemembers under the Uniformed Services Employment and Reemployment Rights Act (USERRA)

Returning servicemembers are entitled to receive all rights and benefits of employment that they would have obtained if they had been continuously employed. Any period of absence from work due to USERRA-covered service counts toward an employee's months and hours of service requirements for FMLA leave eligibility.

ADDITIONAL PROTECTIONS

State Laws

Some States have their own family and medical leave laws. Nothing in the FMLA prevents employees from receiving protections under othe laws. Workers have the right to benefit from all the laws that apply.

Protection from Retaliation

FMLA is a federal worker protection law. Employers are prohibited from interfering with, restraining, or denying the exercise of, or the attempt to exercise, any FMLA right. Any violations of the FMLA or the FMLA regulations constitute interfering with, restraining, or denying the exercise of rights provided by the FMLA. For more information about prohibited employer retaliation under the FMLA, see Fact Sheet #77B and Field Assistance Bulletin 2022-2.

Enforcement

The Wage and Hour Division is responsible for administering and enforcing the FMLA for most employees. If you believe that your rights under the FMLA have been violated, you may file a complaint with the Wage and Hour Division or file a private lawsuit against your employer in court. State employees may be subject to certain limitations in pursuit of direct lawsuits regarding leave for their own serious health conditions. Most Federal and certain congressional employees are also covered by the law but are subject to the jurisdiction of the U.S. Office of Personnel Management or Congress.

Where to Obtain Additional Information

For additional information, visit our Wage and Hour Division Website: http://www.dol.gov/agencies/whd and/or call our toll-free information and helpline, available 8 a.m. to 5 p.m. in your time zone, 1-866-4USWAGE (1-866-487-9243).

This publication is for general information and is not to be considered in the same light as official statements of position contained in the regulations.

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way. This document is intended only to provide clarity to the public regarding existing requirements under the law or agency policies.

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Certification of Health Care Provider for Employee'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 protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee'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 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.)

(4) Employee's job title: _____ Job description ☐ is / ☐ is not attached.

Employee's regular work schedule: _____

Statement of the employee's essential job functions:

_____

(The essential functions of the employee's position are determined with reference to the position the employee held at the time the employee notified the employer of the need for leave or the leave started, whichever is earlier.)

SECTION II - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form. Your patient has requested leave under the FMLA. 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 due to the serious health condition of the employee. 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 on page 4.

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.

Employee Name: _____

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

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

(3) 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.

Employee Name: _____

(4) 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 FMLA coverage.

(5) 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): _____

_____

(6) 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)

_____

(7) Due to the condition, it is medically necessary for the employee to work a **reduced schedule**.

Provide your **best estimate** of the reduced schedule the employee is able to work. From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy) the employee is able to work: (e.g., 5 hours/day, up to 25 hours a week)

_____

(8) 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.

(9) Due to the condition, it (☐ was / ☐ is / ☐ will be) medically necessary for the employee to be absent from work 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.

Employee Name: _____

PART C: Essential Job Functions

If provided, the information in Section I question #4 may be used to answer this question. If the employer fails to provide a statement of the employee's essential functions or a job description, answer these questions based upon the employee's own description of the essential job functions. An employee who must be absent from work to receive medical treatment(s), such as scheduled medical visits, for a serious health condition is considered to be **not able** to perform the essential job functions of the position during the absence for treatment(s).

(10) Due to the condition, the employee (☐ was not able / ☐ is not able / ☐ will not be able) to perform **one or more** of the essential job function(s). Identify at least one essential job function the employee is not able to perform:

_____

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.

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