# FAMILY AND MEDICAL LEAVE POLICY

This is the Family and Medical Leave Policy of Jefferson School District (the "District"). The District is dedicated to providing eligible employees with unpaid leave periods as required under federal and Wisconsin law. In general, family and medical leave is available to eligible employees for the birth or placement for adoption or foster care of a child, or for the serious health condition of an employee or an employee's covered family member. Employees may also be eligible for leave to care for an ill or injured service member, or to address certain situations relating to a covered service member's active duty or call to active duty.

Under the federal law, employees are eligible for up to 12 work weeks of unpaid leave for the reasons set forth in this Policy. The classification of an absence from work as Family and/or Medical Leave qualified leave will be determined by the District based on the information received from the employee or from other sources, without regard to the employee's request. In instances associated with caring for an injured qualifying military member as outlined below, employees may be eligible for a total of 26 weeks of leave (which includes the 12 weeks allowed for other FMLA-qualifying leaves) in a single 12-month period. These entitlements under federal law will run concurrently with any Wisconsin FMLA leave available to an employee, to the extent permitted by law.

Wisconsin law allows for up to 6 weeks of unpaid leave on the birth or placement of a child for adoption, up to 2 weeks for the serious health condition of the employee and up to 2 weeks for the serious health condition of the employee's child, spouse, domestic partner or parent (or the parent of your spouse or domestic partner). Employees will be allowed federal and/or Wisconsin leave based on their eligibility.

Further, where permitted by law, Wisconsin and/or federal Family and Medical Leave available to an employee shall run concurrently with any other leave available through the District, i.e., worker's compensation leave and other state leave entitlements. Employees will only be granted the leave for which they are eligible. Leave entitlements under this Policy will be administered on a calendar-year basis.

Family and Medical Leave is intended to afford an employee the opportunity to be absent from work to care for the employee's serious health condition or for a qualifying family member for reasons recognized under the law. In the event an employee uses the period of leave to work for another employer or engage in other work/activities during the excused period not otherwise permitted by the law, the employee may be subject to discipline, up to and including termination from employment. False leave requests will subject employees to discipline as well.

Taking leave under this Policy will not be used against an employee in any employment decision, including in the determination of raises or discipline. However, no greater right to employment or benefits will result to an employee than if no FMLA leave had been taken.

## I. Eligibility for Family and Medical Leave

The District provides unpaid leave from employment at eligible worksites as required under the federal and Wisconsin Family and Medical Leave laws. Employees who have been employed by the District for 12 months or more and who have worked at least 1,250 hours in the 12 months before the beginning of the requested leave may be entitled to unpaid federal family and/or medical leave. For Wisconsin FMLA eligibility, the employee must have been paid by the District for at least 1,000 hours of work in the 12 months preceding the beginning of leave and also have been employed for at least 52 consecutive weeks. The District will determine an employee's eligibility for, and availability of, FMLA leave based upon the 12 months immediately before the date the requested leave is to begin.

There may be instances in which the District provides leave to employees who are not employed at a covered worksite. The District may do so voluntarily as a benefit to those employees. The District reserves the right, in its sole discretion, to discontinue at any time providing leave to those employees who are not eligible employees under the federal law. Providing such leave does not constitute an agreement by the District that it will subject itself to the jurisdiction of federal courts or administrative agencies with regard to such leave.

Employees must notify the District of their intention to take a planned or foreseeable leave at least 30 calendar days in writing before any proposed period of leave is to begin. The District reserves the right to deny or delay the start of any requested leave until appropriate notice is given. In the event of an unplanned or unforeseeable need for leave, notice of the need for leave must be provided to the District as soon as possible but no later than 2 business days after the leave begins. If the employee does not timely notify the District of the need for leave, the leave request may be delayed or denied. The leave available to employees shall not exceed that permitted under federal and applicable state law.

## II. Type and Amount of Leave Available

Employees are generally entitled to a total of 12 work weeks of unpaid leave during a calendar year, regardless of the number of events giving rise to the leave entitlement, for any one or combination of the following reasons:

### A. Birth or Placement of a Child

An employee may take unpaid leave on the birth or placement for adoption or foster care (if eligible for leave under the federal law) of a son or daughter. While continuous leave may be taken up to one year following the birth or placement, leave may begin no earlier than 16 weeks before the birth or placement, subject to any limitations on intermittent leave. Leave must be taken all at once, except as otherwise required by state law or this Policy.

### B. Medical Leave

Eligible employees may use available unpaid medical leave for their own serious health condition or to care for a child, spouse, or parent with a serious health condition. Wisconsin FMLA also allows an eligible employee up to two (2) weeks of leave to care for his/her domestic partner and the parent of a domestic partner. A "serious health condition" will generally occur when: (1) the individual receives inpatient care at a hospital, hospice or nursing home; or (2) experiences a period during which an eligible individual is incapable of work or certain activities of daily living and receives outpatient care which requires a schedule of continuing treatment by a health care provider. To meet the definition of a serious health condition, the condition must generally exist for more than 3 calendar days, unless the condition is chronic and/or long term, and which requires at least 2 visits to a health care provider within a 30-day period after commencement or 1 visit to a health care provider which results in a regimen of continuing treatment.

If an employee suffers a work-related injury/illness that qualifies as a serious health condition, federal leave provided under this Policy will be considered as taken along with the worker's compensation leave. If an employee suffers a work-related illness or injury, FMLA leave available

under Wisconsin law will not run concurrently with the worker's compensation leave. If the injury/illness is determined not to be work related, however, the FMLA leave available under the employee's Wisconsin leave entitlement will run concurrently with the period of absence.

C. Leave for Qualifying Exigencies.

Under federal law, eligible employees may take leave for certain qualifying situations when a son, daughter, parent or spouse who is a member of a reserve or regular component of the Armed Forces is deployed to a foreign country. Family members of certain retired members of the Regular Armed Forces and retired Reserve who are ordered to active duty may also be eligible for this type of leave entitlement.

Qualifying exigencies may be taken for the following reasons:

- Leave to address any issue arising from being called to active duty less than 7 days before the deployment date;
- Leave to attend military events and related activities involving an eligible individual;
- Leave to arrange for child care and school activities;
- Leave to make or update financial or legal documents;
- Leave to attend certain counseling sessions;
- Leave for rest and recuperation with the covered service member while on leave (limited to 5 work days per instance);
- Leave for post-deployment activities; or
- Leave for other events arising from service if the District agrees that the event qualifies as an exigency.

The District may require verification of the service member's status and impending leave.

D. Illness or Injury of Service Members (Military Caregiver Leave)

An employee who is a spouse, child, parent or "next of kin" of a member of the Armed Forces of the United States ("covered service member") may be entitled to leave to provide care for such covered service member who has incurred a serious illness or injury in the line of duty while on active duty. An eligible family member may also take leave to care for a covered service member whose pre-existing serious illness or injury was aggravated in the line of duty while on active duty. The illness or injury must make the service member medically unfit to perform the duties of their office, grade, or rank, not other employment.

Military Caregiver Leave is also available to eligible family members of veterans who are undergoing medical treatment, recuperation, or therapy, for a serious injury or illness, provided that the veteran was a member of the Armed Forces, National Guard or Reserve at some time during the 5-year period before the medical treatment, recuperation, or therapy that requires the leave.

This is a one-time period of leave. This type of leave, combined with other FMLA-qualifying leave, may not exceed 26 weeks in a single 12-month period.

Leave taken under this Policy will count toward the leave to which an employee may be entitled under both the federal and applicable state law.

## III. Intermittent and Reduced Schedule Leave

When requesting intermittent or reduced schedule leave for planned medical treatment, the employee must work with his/her direct supervisor and make a reasonable effort to schedule the leave so as not to unduly disrupt the operations of the department. An employee shall advise his/her direct supervisor, upon request, of the reasons why the intermittent or reduced schedule leave is needed and of the schedule (or anticipated schedule) of treatment/absence. The employee and the direct supervisor shall attempt to work out a schedule which meets the needs of the District without unduly disrupting the department's operations, subject to the approval of the employee's treating health care provider.

If leave is taken intermittently or on a reduced schedule for the medical care or treatment, the District may transfer the employee temporarily to an alternative position for which s/he is qualified. In the alternative position, the employee will receive the same pay and benefits s/he was entitled to in the original position. When an employee is allowed to take leave in less than one-week increments, s/he will receive reduced compensation consistent with the hours actually worked, unless paid leave is used for the otherwise unpaid time, in accordance with the requirements of the paid leave policy.

Intermittent or reduced schedule leave is available on the birth or placement of a child for adoption or foster care. This leave opportunity is only available during the 16 week period before the scheduled due date and after the actual birth or placement. Intermittent or reduced schedule leave is not available outside the period described under this paragraph.

Employees seeking intermittent or reduced schedule leave may be required to provide proof of the need for leave from time to time, when requested by the District. The District will not accept "annual certifications" in the absence of a request for leave.

## IV. Substitution of Paid Leave

Employees may use, or may be required to use (to the extent permitted by law), accrued paid leave during a period of unpaid FMLA leave. This paid leave includes vacation time. Paid leave is only available for substitution for unpaid periods of leave if the employee has accrued a current right to the benefit. To accrue a right to a benefit, the employee must meet all eligibility requirements needed to receive the benefit, as defined under the terms of the benefit policy, and have a present right to the benefit. Contingent or discretionary benefits or paid leave is not accrued leave for purposes of substitution. Paid time used will not be available later for use by the employee. Extensions of leave will not be permitted except as required by law.

## V. Medical Certification

Employees who wish to take a medical leave of absence for a serious health condition, whether for his/her own or that of an eligible family member, must provide the District with a Health Care Provider Certification completed by the treating health care provider. Certification will also be required for leave to care for an ill or injured service member. This document must be returned to the Human Resources Department within 15

calendar days after the District requests the information. Failure to provide this documentation on a timely basis may result in the delay or denial of leave. The District may grant an extension of time to return the Health Care Provider Certification, if the extension is requested before the Certification's original due date.

In the event the Certification is incomplete or contains insufficient information with which to evaluate a leave request, the District may request a Clarification of the Certification from the health care provider. Any requested Clarification must be completed and returned to the District within 7 calendar days after the request, unless the District agrees to an extended response date. If the documentation is still incomplete, the District may contact the health care provider to obtain the required information.

After receiving the Health Care Provider Certification, the district may require that the employee see a health care provider of the District's choice in order to verify the information provided. The District will pay the cost of this second opinion examination. If the results of the second examination differ from the original certification, the District may require a third examination, again at its expense, by a mutually agreed upon health care provider. Both the District and the employee are obligated to cooperate in selecting a suitable health care provider. The results of this third examination will be final and binding on the employee and the District in determining whether a serious health condition exists.

When an employee takes leave because of his or her serious health condition, or that of an eligible family member, the District may require the employee to submit additional certifications periodically during the leave. The District may request recertifications of the Health Care Provider Certification, where permitted by law, every 30 calendar days (or if longer, the stated duration of the leave) or more often if: (1) the facts and circumstances do not appear to support the original Certification; or (2) the District has information which casts doubt on the employee's stated reason for leave. In such a case, a recertification of the serious health condition may be requested at an earlier point in time. The District will provide notice to the employee of any recertifications which may be required. The failure to provide a recertification may result in the delay or denial of leave.

## VI. Benefits During Family and Medical Leave

During an approved family or medical leave, the District will make available to the employee, the same insurance benefits which are available to employees who are not on leave. It is the employee's responsibility to continue to contribute his/her portion of any employee-paid premium during leave. If the employee is paid during the leave period, the premium will be deducted from pay. If the leave is unpaid, the employee is responsible for arranging with the Human Resources Department payment of the employee's share of the premium during the period of unpaid leave. The failure to make timely premium payments may result in the loss of benefits.

If an employee fails to return from FMLA leave and is terminated from employment, the District will deduct any unpaid premium amounts due at such time from the employee's final paycheck, where permitted by law. If an employee chooses not to return to employment from an FMLA leave, the employee will be required to reimburse the District for any premiums it paid on the employee's behalf during the period of leave.

Employees on FMLA will not lose any accrued seniority or benefits due to taking FMLA leave; however, additional seniority and benefits will not accrue during the period of unpaid leave. However, no new benefits or greater right to employment will accrue to an employee during an unpaid period of leave, except as required by a collective bargaining agreement covering the employee.

During the FMLA leave period, the District will continue to pay the other benefits available for the employee which is normally paid for by the District during active employment. Benefits for which employee payment is required during active employment may be continued by the employee paying all required premiums as requested by the Human Resources Department. Failure to make timely payment will result in the immediate discontinuation of the benefit for the employee and all covered individuals.

## VII. Returning From Family and Medical Leave

Employees returning from Family or Medical Leave should, where possible, give the District at least 2 weeks, but not less than 2 work days, written notice of their intent to return to work. Any employee who returns from Family or Medical Leave within 12 weeks, or the lesser amount of leave that was available to that employee, will be reinstated to the same or an equivalent position with equivalent benefits, pay and other terms and conditions of employment. However, the District cannot guarantee reinstatement to employees whose leave extends beyond the FMLA protected leave period, except to the extent necessary to comply with applicable state or federal laws and District policy. An employee will not have any greater right to employment than s/he would have had if FMLA leave had not been taken.

If an employee is on leave for more than 3 work days because of his/her own serious health condition, the employee must provide a return-to-work certificate to the District before returning to work. The return-to-work certificate must be completed by the treating health care provider. It includes the treating health care provider's opinion regarding the ability of the employee to perform his/her job duties and must identify any work restrictions. If an employee fails to provide a return-to-work certificate by the end of any medical leave, the employee may not be eligible for reinstatement. Please contact the Human Resources Department for a return-to-work certification form.

## VIII. Failure to Meet Policy Requirements

If an employee does not meet the requirements of this Policy for Family and Medical Leave, the request for leave may be delayed or denied. Any period of absence not covered by this Policy will be administered under the District's Attendance Policy.

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If you have any questions regarding the operation or interpretation of this Policy, please contact the Director of Business Services.

ADOPTED: April 25, 2005
REVISED: December, 2009
May 24, 2010
REVIEW DATE: May 21, 2012

LEGAL REFS.: 26 U.S.C. § 2601, *et. seq*., Section 103.10, Wis. Stats.

CROSS REFS.: Jefferson Education Association Master Agreement
Jefferson Support Staff Federation Master Agreement

# JEFFERSON SCHOOL DISTRICT REQUEST FOR LEAVE OF ABSENCE

Employee Name: _____ Date of Hire: _____ (☐ Full-Time ☐ Part-Time)

Date Leave Requested to Begin: _____ Date to Return to Work: _____

## TYPE OF LEAVE REQUEST

☐ Medical Leave for employee*

☐ Medical Leave for immediate family member or domestic partner* (Please see attached certification of domestic partnership)

☐ Parental Leave for birth or placement for adoption or foster care*

☐ Servicemember Leave* (Please attach orders)

☐ Worker's Compensation*

☐ Personal (needs other than listed above)

☐ Uniformed Service Leave (Please attach orders)

☐ Leave for a "Qualifying Exigency" relating to active duty* (Please attach orders)

* A leave request for any of these reasons may qualify you for family and/or medical leave. For leave for a domestic partner, please complete and forward with this Request the Certification of Domestic Partnership.

Reason for Requesting Leave: _____

For leave to care for an immediate family member with a medical condition or an ill or injured servicemember, please indicate the following:

➔ full name of person to be cared for ☐ parent, ☐ spouse, ☐ child: _____

➔ if the person is your child, the age of the child: _____

➔ the care to be provided (please be specific): _____

_____

For "qualifying exigency" leave, please indicate the situation the employee is needed to address (i.e., arrange for childcare, attend pre-deployment briefings, etc.) _____

## AMOUNT OF LEAVE

I request that the leave be granted for the following period of time:

| Beginning date: | Ending date: |
|---|---|

I further request that the leave be granted for the following reduced or intermittent leave schedule:

I would like to substitute the following paid leave time during my family or medical leave:

☐ Sick Days_____ number of days ☐ JEA Personal Days _____ number of days

How will Employee pay for missed Benefit Deductions while on an unpaid Leave of Absence?

☐ Discontinue Coverage ☐ I will make monthly benefit payments by check to Jefferson School District

## EMPLOYEE CERTIFICATION AND SIGNATURE

I hereby certify that the information given above is true and correct to the best of my knowledge. I understand that misrepresentation of the reason for leave or any of the facts supporting the need for leave will result in denial of the leave and disciplinary action up to and including discharge.

Employee Signature: _____ Date:

## FOR EMPLOYER USE ONLY

Type Of Leave: ☐ FMLA ☐ Non-FMLA ☐ Workers Compensation ☐ Other Leave approved? ☐ Yes ☐ No

The following paid leave will be substituted:

Remarks:

Signature:

| Title: | Date: |
|---|---|

*5/24/10*

SCHOOL DISTRICT OF JEFFERSON
GUIDELINES FOR IMPLEMENTATION

Reference Code: GBGA-E(2)

# M E M O R A N D U M

To:

From: Human Resources Department

Date:

Re: Family and Medical Leave Information - RESPONSE REQUIRED

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You have requested an absence from employment with Jefferson School District. Based upon the information you have provided, it appears that your leave request may qualify for classification as an absence under the District's Family and Medical Leave Policy, which covers the federal and state law, as applicable.

To confirm that your absence from work is FMLA eligible, we are enclosing the following information which is to be completed and returned to the Human Resources Department:

- Request for Leave of Absence (To be completed by you)
- Certification of Domestic Partnership (To be completed by you)
- Health Care Provider Certification (To be completed by doctor)

Also enclosed are the School District of Jefferson's Family and Medical Leave Policy and a Notice of Rights and Responsibilities which should be retained by you for future reference.

The Request for Leave of Absence must be returned to the District at least 15 calendar days before your leave is to begin, if the reason for your leave is foreseeable. If the need for leave is unforeseen, the Request for Leave must be returned as soon as possible after you have knowledge of the need for leave, but in no event later than 2 working days after the commencement of your leave.

If your leave is due to your own serious health condition or that of a qualified individual, you must also provide the District with a completed Health Care Provider Certification. THE HEALTH CARE PROVIDER CERTIFICATION MUST BE COMPLETED BY THE TREATING PHYSICIAN. This document must be returned to the District within 15 calendar days of the date of this memorandum. If additional time is required, please contact the Human Resources Department before the expiration of the 15-day period for an extension of time to respond.

If the above information is not received within the time periods stated, as required under the District's FMLA Policy, your time away from work may not be classified as protected leave. Instead, the time may be classified as an absence and subject to the employment policies of the District.

For further information, please see the FMLA Policy or contact the Human Resources Department.

*5/24/10*

# M E M O R A N D U M

To:

From: Human Resources Department

Date:

Re: Family and Medical Leave Information - RESPONSE REQUIRED

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- Health Care Provider Certification (To be completed by doctor)

Also enclosed are the School District of Jefferson's Family and Medical Leave Policy and a Notice of Rights and Responsibilities which should be retained by you for future reference.

The Request for Leave of Absence must be returned to the District at least 15 calendar days before your leave is to begin, if the reason for your leave is foreseeable. If the need for leave is unforeseen, the Request for Leave must be returned as soon as possible after you have knowledge of the need for leave, but in no event later than 2 working days after the commencement of your leave.

If your leave is due to your own serious health condition or that of a qualified individual, you must also provide the District with a completed Health Care Provider Certification. THE HEALTH CARE PROVIDER CERTIFICATION MUST BE COMPLETED BY THE TREATING PHYSICIAN. This document must be returned to the District within 15 calendar days of the date of this memorandum. If additional time is required, please contact the Human Resources Department before the expiration of the 15-day period for an extension of time to respond.

If the above information is not received within the time periods stated, as required under the District's FMLA Policy, your time away from work may not be classified as protected leave. Instead, the time may be classified as an absence and subject to the employment policies of the District.

For further information, please see the FMLA Policy or contact the Human Resources Department.

*5/24/10*

# JEFFERSON SCHOOL DISTRICT
# NOTICE OF RIGHTS AND RESPONSIBILITIES
# WHEN TAKING FAMILY AND MEDICAL LEAVE

## KEEP FOR YOUR RECORDS

Jefferson School District has received your request for family and medical leave. The following information concerns your rights and obligations under the family and medical leave law and will explain the consequences of your failure to meet these obligations. Please read the information carefully, and if you have any questions, please contact the Human Resources Department.

1. Leave Entitlement. The actual amount of time you spend on family and/or medical leave will be subtracted from your 12 workweeks (26 workweeks if you are caring for a qualifying person in the military) of unpaid leave entitlement under federal law. Unpaid leave entitlement under Wisconsin law is 2 workweeks for your serious health condition; 2 workweeks for the serious health condition of a child, spouse, domestic partner or parent (including your parent in-laws or the partner(s) of a domestic partner); and 6 workweeks on the birth or adoption of a child with the employee. These leave rights will run concurrently. Leave rights are administered on a calendar-year basis. To be eligible for leave, you must request leave not fewer than 30 days in writing before your leave is to begin, unless, due to the circumstances, a shorter notice is necessary. However, notice must be given not later than 2 workdays after leave begins. Leave may be taken on an intermittent or reduced leave schedule basis for a serious health condition, after attempting to coordinate the period of absence with the District. In the event of a birth, adoption or foster care placement, intermittent leave will be permitted only during the 16-week period before and after the birth or placement.

2. Medical Certification. If your leave request is based on your own serious health condition or the serious health condition of a qualifying person (as defined under the FMLA Policy), you must provide the District with a medical certification prepared by your health care provider. The medical certification must be provided to the District within 15 calendar days of notice to you from the District of the need to provide such information, unless the District agrees to an extension of time. If the information in the Certification is incomplete or insufficient, the District may request a clarification of the Certification from your health care provider. This certification document must be completed and returned to the District within 7 calendar days unless the District agrees to extend the response time. In the event questions continue to exist, your health care provider may be contacted for clarification of the request. If you fail to provide a timely Certification, your leave request, or your continuation of leave, may be denied. If your leave request is denied, your absences will be classified under the District's attendance policy.

3. Additional Certifications. If the District has any doubts about the accuracy of your initial medical certification, you must submit to another examination, at the District's expense, by a health care provider selected by the District. If the second opinion differs from the initial certification, a third opinion, from a mutually agreed upon health care provider, may be required. The third opinion is final and binding.

4. Recertification. You must provide the District, to the extent required by law, with recertifications on a periodic basis that your serious health condition prevents you from performing your job functions or that you are needed to care for a family member with a serious health condition.

5. Intent to Return to Work. For leaves that are longer than one month for the serious health condition of yourself or a covered person, you should provide with a periodic report on your status and intent to return to

work at least 2 weeks before your return to work, but in no event no later than 2 business days before your desired return to work.

6. Return to Work. If you are on medical leave because of your own serious health condition and it is for more than 3 consecutive workdays, you may be required to provide the District with a return-to-work release, signed by your health care provider, which addresses your ability to perform the essential duties of your job, before you can return to work. If you fail to provide the District with a return-to-work release, your reinstatement may be denied until the required certification is provided.

7. Substitution. You may have the option of using certain types of paid leave, i.e., short-term disability or vacation, for unpaid family and/or medical leave pursuant to the District's Policy. The District may require you to use your accrued paid leave for any unpaid leave period. When paid leave is used for your unpaid leave, the paid leave will not be available to you later. These leaves will run concurrently, provided you meet any applicable requirements of the leave policy, which are outlined in the summary previously provided to you. If you do not meet the requirements for taking paid leave, you remain entitled to take unpaid FMLA leave. Leave required for a work-related injury may run concurrently with your point of coverage under worker's compensation benefits.

8. Maintenance of Health Insurance Coverage. Your health insurance coverage and other District provided benefits will continue in full effect during your leave, if the required premium contribution is made. If you elect to use paid leave, or if the District requires the use of paid leave, your share of premiums will be paid through the District's normal payroll deduction method. Otherwise, you must pay the required contribution on a monthly basis during the period of unpaid leave, as requested by the District. If payment is not made timely, your group health insurance may be cancelled.

9. Employment Protection. Upon returning to work from family or medical leave, you will be reinstated to the position you held prior to leave or, if your position is no longer available, to an equivalent position with equivalent pay, benefits, and other terms and conditions of employment, unless your employment would otherwise have ceased. You will have no greater right to employment with the District at the end of your leave than you would have had if you had not taken leave.

10. Recovery of Premiums. If you fail to return to work after your family or medical leave, you may be liable to the District for any health coverage premiums paid during your leave.

11. Designation of Leave. Once the District receives any requested information, we will inform you whether your leave will be designated as FMLA leave. If you do not provide the District with the required information within the time specified, your absence will be classified as other than family and/or medical leave.

12. Fitness for Duty. If leave is for your serious health condition, you may be required to present a fitness-for-duty certification to be restored to employment, unless you are directed in writing not to provide such information. If such certification is not timely received, your return to work may be delayed until a certification is provided. A list of the essential functions of your position is attached to your Health Care Provider Certification.

If you have any questions, please do not hesitate to contact the Human Resources Department.

*5/24/10*

# JEFFERSON SCHOOL DISTRICT
# FAMILY AND MEDICAL LEAVE REQUEST
# HEALTH CARE PROVIDER CERTIFICATION

NOTE TO HEALTH CARE PROVIDER: Please avoid use of the terms "lifetime," "unknown," or "indeterminate," when responding to questions relating to the frequency or duration of a condition or its treatment. Such terms may not be sufficient to determine FMLA coverage.

Employee Requesting Leave: _____

I, _____, confirm that _____
(Name of Health Care Provider or Christian Science Practitioner) (Patient's Name)

is under my care for an illness or injury, impairment or physical or mental condition involving (check the appropriate box):

- □ Inpatient care in a hospital, hospice or residential medical facility; and/or
- □ Any period of absence which:
  - renders the person incapable of performing work, school attendance, or other regular activities; and
  - involves continuing treatment or supervision by a health care provider;
- □ Continuing treatment by (or under the supervision of) a health care provider for a chronic or long-term health condition that is incurable or so serious that it may result in a period of incapacity;
- □ Any period of absence which renders a service person who is a family member unable to perform the duties of his/her rank;
- □ A period of absence during which a covered veteran service member who is a family member is undergoing medical treatment, recuperation or therapy for a qualifying serious illness or injury;
- □ Prenatal care; or
- □ None of the above.

In addition, my understanding is that the patient is one of the following (check the appropriate box):

- □ An employee of the District;
- □ The spouse of an employee;
- □ The son or daughter of an employee;
- □ The domestic partner of an employee;
- □ A covered service member who has incurred or aggravated a serious illness or injury in the line of duty and is the son, daughter, spouse or next of kin of the employee;
- □ The parent (including a parent in law and parent of domestic partner) of an employee; or
- □ None of the above.

Accordingly, I confirm that:

1. My area of medical practice is: _____.

2. The health condition commenced on _____, 20____ and has a probable duration through _____, 20____.

3. The patient was first seen by me relative to, and treated for, this health condition on _____. In addition, I have provided care to the patient on the following date(s) (list all dates of treatment or supervision):

_____

_____

4. The patient's condition has manifested itself for the dates of absence in question in the following manner (specifically describe including impact on ability to work, attend school or perform activities of daily living):

_____

_____

5. If the individual is a service member who has incurred a serious illness or injury in the line of duty, please specify how the patient's condition has manifested itself (specifically describe impact on ability to perform the duties of his/her rank):

_____

_____

Please describe the origin of the service member's illness or injury:

_____

_____

6. I will be providing care to the patient on the following dates (list all dates of treatment or supervision):

_____

_____

7. The patient was treated on an ☐ inpatient ☐ outpatient basis (check as applicable).

8. Was medication, other than over-the-counter medication, prescribed? □ Yes □ No

If Yes, please describe impact on patient:

_____

_____

9. Describe other relevant medical facts, including symptoms, diagnosis, or any regimen of continuing treatment.

_____

_____

10. Was the procedure/treatment scheduled in advance or on an emergency basis? If scheduled in advance, please indicate how many days in advance the treatment was scheduled.

Scheduled in advance □ Emergency Basis □

Date scheduled: _____

Comments, if any: _____

If the patient is an employee: the health condition must render the employee unable to perform the functions of his or her position which means the employee is unable to work at all or is unable to perform the essential functions of the position.

1. Is the employee able to perform the following employment functions during the period over which the absence from work occurred/is occurring:

| Yes | No | |
|---|---|---|
| □ | □ | Standing for 30 minutes or less |
| □ | □ | Standing for more than 30 minutes but less than 2 hours (with or without breaks) |
| □ | □ | Standing for more than 2 hours (with or without breaks) |
| □ | □ | Sitting for 30 minutes or less |
| □ | □ | Sitting (with or without breaks) for more than 30 minutes but less than 2 hours |
| □ | □ | Sitting (with or without breaks) of 2 hours or more |
| □ | □ | Walking short distances (20 yards) |
| □ | □ | Arm movement (if limited please note below) |
| □ | □ | Lifting less than 20 pounds |
| □ | □ | Lifting 20 or more pounds |
| □ | □ | Speaking |

2. Is the employee limited to working 40 or fewer hours per week (exclusive of breaks and other time off of active work?)

☐ Yes ☐ No

3. If the employee requires intermittent (leave taken in separate blocks of time) or reduced leave (leave that reduces the employee's hours per workweek or workday) which is medically necessary, please describe why the intermittent or reduced leave is medically necessary.

_____

_____

_____

Please identify the dates on which treatment/care is to be provided: _____

How long will the employee need to be absent for each appointment? _____

_____

If the patient is the spouse, domestic partner, son, daughter or parent of the employee: the health condition of such individual must require that the employee is needed to care for such individual. A health condition for such individual must be such that affects an individual's ability to engage in normal daily activities.

1. The employee will be needed to care for the spouse, parent, domestic partner, son or daughter on the following dates:

   _____

   (Please indicate which portion of such days will be required for care, i.e., hours needed for care):

   _____

2. What is the date of birth of the child? _____

3. Is the patient incapable of performing certain activities of daily living without assistance from the employee? If so, please indicate which of the following may not be performed by the patient because of the patient's condition (check as appropriate):

   | | | | |
   |---|---|---|---|
   | □ | Personal grooming | □ | Personal hygiene |
   | □ | Bathing | □ | Dressing |
   | □ | Eating | □ | Cooking & cleaning |
   | □ | Shopping | □ | Using a telephone |
   | □ | Other (please specify) _____ | | |

4. Describe care to be provided by the employee:_____

   _____

5. If the employee requires intermittent (leave taken in blocks of time) or reduced leave (leave that reduces the employee's hours per workweek or workday) to care for the employee's spouse, domestic partner, parent, son or daughter, please describe why it is medically necessary:

   _____

   _____

   _____

   Please identify the treatment schedule (dates and times): _____

   _____

Dated this _____ day of _____, 20___.

_____ _____
Signature of Health Care Provider/ Telephone Number
Christian Science Practitioner

_____ _____
Address City/State

Important Note: Certain states have enacted anti-fraud provisions making it a crime to provide false information to obtain for oneself or another employee benefit from an employer. Specifically, Wis. Stat. Section 943.395 prohibits anyone from knowingly providing false or fraudulent information in the presentation of a claim, or any proof in support of such claim to be paid under any contract or certificate of insurance; or prepares, makes or subscribes to a false or fraudulent account, certificate, affidavit, proof of loss or other document or writing with knowledge that the same may be represented or used in support of a claim for payment under a policy of insurance; or presents or causes to be presented a false or fraudulent claim or benefit application or any false or fraudulent proof in support of such a claim or benefit application or false or fraudulent information which would affect a future claim or benefit application to be paid under any employee benefit program created by Chapter 40; or makes any misrepresentation in or with reference to any application for membership or documentary or other proof for the purpose of obtaining membership or in or noninsurance from any fraternal subject to Chapter 600-646 from himself, or herself or any other person.

# AUTHORIZATION FOR THE DISCLOSURE OF HEALTH INFORMATION

PATIENT INFORMATION

_____
Name of Patient/Previous Name

DISCLOSURE OF HEALTH INFORMATION TO:

Jefferson School District
206 S. Taft Avenue
Jefferson, WI 53549-1453

PATIENT AUTHORIZES DISCLOSURES BY:

_____
Name of Treating Health Care Provider

_____
Phone Number and Fax Number of Treating Health Care Provider

INFORMATION TO BE DISCLOSED: *Check all of the following that apply:*

Medical Records: __X__ Treatment Records: __X__ Diagnostic Records: __X__ Other: Phone contact and other medical information as requested.

DISCLOSURES REQUIRING SPECIAL CONSENT: *In compliance with State and Federal Statues which require special permission to disclose otherwise privileged information, I am authorizing that the following information also be disclosed. Check all that apply:*

_____ HIV/AIDS ____Mental/Behavioral Health Conditions _____ Drug/Alcohol Abuse Treatment

PURPOSE FOR DISCLOSURE: *Please provide specific purpose for disclosure or check applicable category.*

_____ Disability Determination _____ Workers Compensation
_____ Continued Medical Leave _____ Other – Employment Related Evaluation/Leave Request

I hereby authorize my current physician(s) or medically related facilities to release any records, knowledge or information concerning any evaluation or treatment provided to me regarding my current medical condition since my employment with the Jefferson School District for up to five (5) years ago.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

I understand that I have a right to inspect or receive a copy of the health information I have authorized to be used or disclosed by this authorization form. I understand that if I agree to sign this authorization, I must be provided with a copy. I understand that I am under no obligation to sign this form. I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) listed above have already made in reference to this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

_____ _____
Signature of Patient Date

Expiration Date: This authorization will expire within 90 days of the date of my signature or on the following date or event (please specify): _____

COMPANY: Jefferson School District, 206 S. Taft Avenue, Jefferson, WI 53549-1453

*5/24/10*

# M E M O R A N D U M

TO:

FROM: Human Resources Department

DATE:

RE: Family and Medical Leave Eligibility

---

Eligibility: This is to inform you that you are:

☐ Eligible for FMLA leave for the period of leave you requested on _____, 20___. If the leave is for your own or a covered family member's serious health condition, please have the Health Care Provider Certification form previously forwarded to you completed by the treating health care provider and returned to the Human Resources Department within 15 calendar days of the date of our initial request to you. If leave is for a domestic partner, please complete the Certification of Domestic Partnership and return it to the Human Resources Department. Additional time may be allowed if a request for an extension of time to respond is made to the Human Resources Department before the expiration of the response period. If sufficient information is not provided in a timely manner, your leave may be denied.

Once the District has received all requested information, we will notify you whether your leave qualifies as FMLA leave.

☐ Ineligible for FMLA Leave from the District due to:

- ☐ Insufficient hours of work
- ☐ Insufficient period of employment
- ☐ Ineligible person
- ☐ Other: _____

_____

*5/24/10*

# JEFFERSON SCHOOL DISTRICT - ESTIMATED FUNCTIONAL CAPACITIES FORM

*To be completed prior to the employee's return to work.*

Health Care Provider: Please complete the following items based on your estimated clinical evaluation of _____ (Employee's Name). Any item that you do not believe you can answer can be marked N/A. (Any additional comments can be provided on a separate sheet.)

1. My area of medical practice is: _____.

2. The patient's condition had manifested itself in the following manner (specifically describe including impact on ability to work, attend school or perform activities of daily living):

_____

_____

3. Describe other relevant medical facts, including symptoms, diagnosis, or any regimen of continuing treatment.

_____

_____

4. In an 8 hour workday, the patient can: (Circle full capacity for each activity)

| | | | | | | | | | Continuously | With Rests |
|---|---|---|---|---|---|---|---|---|---|---|
| Sit | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 (hrs) | _____ | _____ |
| Stand | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 (hrs) | _____ | _____ |
| Walk | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 (hrs) | _____ | _____ |

| | NEVER | OCCASIONALLY (0% TO 33%) | FREQUENTLY (34% TO 66%) | CONTINUOUSLY (67% TO 100%) |
|---|---|---|---|---|
| Lift/Carry: | | | | |
| 10 lbs. | _____ | _____ | _____ | _____ |
| 11-20 lbs. | _____ | _____ | _____ | _____ |
| 21-50 lbs. | _____ | _____ | _____ | _____ |
| 51-100 lbs. | _____ | _____ | _____ | _____ |
| Push/Pull: | | | | |
| 10 lbs. | _____ | _____ | _____ | _____ |
| 11-20 lbs. | _____ | _____ | _____ | _____ |
| 21-50 lbs. | _____ | _____ | _____ | _____ |
| 51-100 lbs. | _____ | _____ | _____ | _____ |
| Bend: | _____ | _____ | _____ | _____ |
| Squat: | _____ | _____ | _____ | _____ |
| Crawl: | _____ | _____ | _____ | _____ |
| Climb: | _____ | _____ | _____ | _____ |
| Reach above shoulder level: | _____ | _____ | _____ | _____ |

5. Cognitive Job Duties: For each item listed below, using a scale of 1 to 5 (1 being the least complex; 5 the highest), circle the complexity level that you feel the patient can perform with his/her medication:

| | | | | | |
|---|---|---|---|---|---|
| Comprehend and follow instructions | 1 | 2 | 3 | 4 | 5 |
| Perform assigned tasks | 1 | 2 | 3 | 4 | 5 |
| Perform complex or varied tasks under time constraints (i.e., meet deadlines) | 1 | 2 | 3 | 4 | 5 |
| Make decisions | 1 | 2 | 3 | 4 | 5 |
| Relate to others (co-workers) | 1 | 2 | 3 | 4 | 5 |
| Relate to other (public) | 1 | 2 | 3 | 4 | 5 |
| Ability to communicate orally or written effectively | 1 | 2 | 3 | 4 | 5 |

6. Patient can use hands for repetitive actions such as:

| | Simple Grasping | Pushing & Pulling | Fine Manipulating |
|---|---|---|---|
| Right | ☐ yes ☐ no | ☐ yes ☐ no | ☐ yes ☐ no |
| Left | ☐ yes ☐ no | ☐ yes ☐ no | ☐ yes ☐ no |

Patient can use feet for repetitive movements as in operating foot controls:

| Right | Left | Both |
|---|---|---|
| ☐ yes ☐ no | ☐ yes ☐ no | ☐ yes ☐ no |

7. Current ability to work:

Can patient now work? _____
Part-time: (hrs/day) _____
Full-time: (yes) _____
Overtime limitation: ☐ yes ☐ no
Please explain: _____
_____
Disability Rating: _____ %

8. Please describe in detail all limitations on work for the employee and the expected duration of such restrictions:

_____

_____

Dated this _____ day of _____, 20___.

_____ _____
Signature of Health Care Provider/ Christian Science Practitioner — Telephone Number

_____ _____
Address — City/State

*5/24/10*

# M E M O R A N D U M

TO:

FROM: Human Resources Department

DATE:

RE: Family and Medical Leave Designation

---

Designation:

This is to inform you that your leave request has been:

☐ Approved – All leave taken for this reason will be designated as FMLA leave:

☐ Provided there is no deviation from your anticipated leave schedule, [_____hours/ _____days/_____weeks] will be counted against your FMLA entitlement. This will also count against your Wisconsin leave entitlement for:

☐ your serious health condition or

☐ your eligible family member's serious health condition.

☐ The following paid leave will be used and counted against your FMLA entitlement:

_____.

☐ You have requested to use paid leave during your FMLA leave. The requested leave of [_____] will be used. The leave will count against your leave entitlement unless we have notified you to the contrary.

☐ If the exact amount of leave is unknown or intermittent, you may request this information at least once every 30 days (if leave was taken in the 30-day period) during your FMLA leave as to how much leave you have used.

☐ You will be required to present a fitness-for-duty certificate to be restored to employment. If such certification is not timely received, your return to work may be delayed until certification is provided. A list of the essential functions of your position __is __ is not attached. If attached, the fitness-for-duty certification must address your ability to perform these functions.

* * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * *

☐ Denied - The District is not designating your leave as FMLA leave for the following reason:

_____

# CERTIFICATION OF DOMESTIC PARTNERSHIP
## Wisconsin Employees to Complete

Employee Information:

Name: _____

Address: _____

City/State: _____ Zip Code: _____

**********

Partner Name: _____ Social Security No.: _____

Daytime Phone No.: _____ Home Phone No.: _____

Address: _____

City/State: _____ Zip Code: _____

Declaration

We, the undersigned _____ and _____

[Print Employee's Name] [Print Partner's Name]

Declare that on _____ we agreed to live as domestic partners in a committed

[Insert Date]

relationship of mutual support and caring as defined in this document, and that we have so lived since that time. We further state that since that time we have held ourselves out publicly to be each other's sole domestic partner and intend to remain in such a committed relationship. To demonstrate our status as Domestic Partners, and as proof of benefit eligibility as established by my employer, we are willing to provide at least two of the following documents, two from Group A or one from Group A and one from Group B:

| Group A | Group B |
|---|---|
| Evidence of joint purchase and ownership of a home | Certified copy of a life insurance policy naming domestic partner as the beneficiary |
| Notarized copy of lease naming both domestic partners | Evidence that domestic partner is a beneficiary under subscriber's deferred compensation or retirement plan |
| Evidence of joint savings or joint checking account, that has been in effect for at least 6 months | Evidence of durable powers of attorney per § 243.07, 243.10, 155.05, and/or 155.10, Wis. Stats. |
| Title and registration of joint ownership of an automobile | Employee's last will and testament evidencing that domestic partner is a major recipient of estate proceeds |
| Evidence of joint use and liability for credit cards | Other documentary evidence which depicts significant joint financial interdependency between the Employee and Domestic Partner and which is acceptable to the Employer. |

The documents are attached to this Certification.

DOMESTIC PARTNERS are defined as two individuals who, together, each meet all of the following criteria:

1. Are 18 years of age or older.
2. Are competent to enter into a contract.
3. Are not legally married to, nor the domestic partner of, any other person.
4. Are not related by marriage.
5. Are not related by blood closer than permitted under marriage laws of the State of Wisconsin.
6. Have entered into the domestic partner relationship voluntarily, willingly and without reservation.
7. Have entered into a relationship which is the functional equivalent of a marriage, and which includes all of the following:
    a. living together as a couple;
    b. mutual support of each other;
    c. mutual caring and commitment to each other;
    d. mutual fidelity;
    e. mutual responsibility for each other's welfare; and
    f. joint responsibility for the necessities of life.
8. Have been living together as a couple for at least six (6) months.
9. Intend to continue the domestic partner relationship indefinitely, with the understanding that the relationship is terminable at the will of either partner.

## Change in Domestic Partner Status

We agree to notify the employee's employer by filing a Statement of Termination if there is any change in our status as domestic partners as attested to in this Certification. After termination of this relationship, we understand that a subsequent Certification of Domestic Partnership cannot be filed for at least 6 months.

## Acknowledgements

We understand that if the District suffers any loss due to any false statement contained in this Certification, it may bring a civil action against either or both of us to recover its losses, including reasonable attorney's fees. We have provided the information in this Certification for use by the District for the sole purpose of determining eligibility for Domestic Partner benefits under the Wisconsin Family and Medical Leave Law.

We affirm that the information in this Certification is true and complete to the best of our knowledge; we acknowledge and agree to the terms stated herein; and we understand that any misrepresentation may result in loss of benefits and/or termination of employment. We understand that we are subject to the same enrollment requirements as all other employees who are covered by, or apply for, the plan.

We have read and understand the provisions of this Certification of Domestic Partnership. We agree that the giving of false, inaccurate, or misleading information may result in unauthorized benefits, and may result in legal, financial, and other penalties as provided by law. We further understand that the District retains the right to verify, at any time, any and/or all of the information set forth herein. We have reviewed information we have provided herein and do hereby certify that it is true and correct to the best of our knowledge.

_____ _____
Employee Date

_____ _____
Partner Date

*5/24/10*

SCHOOL DISTRICT OF JEFFERSON
GUIDELINES FOR IMPLEMENTATION

Reference Code: GBGA-E(10)

# M E M O R A N D U M

TO:

FROM: Human Resources Department

DATE:

RE: Worker's Compensation Leave and Concurrent Running with Federal Family and Medical Leave

NO RESPONSE REQUIRED – KEEP FOR YOUR RECORDS

---

We have received notice that you will be absent from work as a result of an injury which you assert is work related. As required under federal law, your period of absence will be classified as leave under the federal Family and Medical Leave Law resulting in the concurrent running of your worker's compensation leave and your federal FMLA leave entitlement. Attached is the Notice of Rights of your entitlements under the FMLA.

In the event your period of absence is determined not to be the result of a work- related injury or illness, your period of leave will continue to be classified as leave under the federal Family and Medical Leave Law. This period may also be classified as leave under state law.

If you have any questions on your federal Family and Medical Leave law rights or obligations, please contact the Human Resources Department. Please note that periodic recertifications as to the continuation of your serious health condition may be required.

cc: Personnel File

*5/24/10*