



Office of Human Capital

Chicago Public Schools HC Employee Services 320 N. Elizabeth Street First Floor Chicago, IL 60607 GSR# 38

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MEDICAL AND FAMILY LEAVE OF ABSENCE FACTS

What family and medical leaves of absence are available to employees of the Board of Education?

The Board's Family and Medical Leave Act policy entitles eligible employees to leaves of absence for:

- Their own serious illness.
- The serious illness of a child, spouse or parent.
- The birth, adoption, or foster care placement of a child and the care of a child within the first 12 months.
- The qualifying exigency relating to a spouse, son, daughter or parent in the military who is notified of an impending call/order of active duty.
- The serious injury or illness of a covered family member in the military.
- The Board's Supplemental Family and Medical Leave policy entitles certain categories of eligible employees to additional leaves of absence for the same reasons.
- Additional or supplemental leaves of absence run concurrently with FMLA leaves. In order to take an additional or supplemental leave, you must qualify for FMLA.
- To determine whether you may be entitled to a supplemental or additional leave of absence, go to the Supplemental and Family Medical Leave Policy at <http://policy.cps.k12.il.us/documents/513.3.pdf>.

What does the FMLA guarantee?

- 12 weeks of unpaid leave.
- No loss of seniority or benefits.
- Return to the same or an equivalent position.

Who is eligible to apply for a leave under the FMLA and the Rules of the Board of Education?

- Any employee who has been employed for 12 months and who has worked 1,250 hours in the preceding 12 months.

Who must apply for a personal or family medical leave of absence?

- Any employee who is absent for more than 10 consecutive days due to personal illness or the serious illness of a family member.
- Employees on workers' compensation or assault leave.
- Any employee who is absent for more than 10 consecutive days due to the serious illness or injury of a military family member or for a qualifying exigency caused by a call to active duty for a military family member.

Must I use accrued sick and vacation time while I am on leave?

- Employees must use accrued sick and vacation time while on FMLA.

How may I apply for a family or medical leave of absence?

- Complete the attached FMLA Application form and have your health care provider complete the accompanying Department of Labor Certification of Health Care Provider for Family Member's Serious Health Condition.
- Mail, fax or hand-deliver your completed application to Employee Services at the address listed on the top of the page.

How may I return to work at the end of my leave?

- Report to Employee Services in person to complete the Medical Reinstatement to Work form and obtain a return to work letter.



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FMLA APPLICATION for a Family Member's Serious Health Condition

Please Check One:

- Tenured Teacher
- PAT
- TAT
- PSRP
- Educational Support Personnel*
- Other*

Please Check One:

- Original Leave Request (FMLA)
- Extension Request (Supplemental Leave)*

Title: Last Name: MI: First Name:

Home Address: City: State: Zip Code:

Home Phone Number: Email Address:

Employee ID Number: Last Four Numbers of Social Security Number:

School Name: Work Address: Cluster: Area:

Work Phone: Work Fax: Position Title: Position Number:

Supervisor's Name: Supervisor's Phone Number:

Have you taken any leave of absence in the last 12 months? Yes No

If yes, what type of leave and for how long?

Requested Date to Begin Leave: Requested Date to End Leave:

If you are requesting a leave to care for a family member, please provide the following information:

Patient's Name: Relationship to Employee:

If request is for care of a child, please state the date of birth: My Spouse is a CPS employee

I understand that pursuant to the Family Medical Leave Act (29 USC 2601 *et seq.*), if I return from my leave within twelve work weeks I have the right to return to the same or equivalent position (see CPS FMLA Policy). ***If I request and receive a leave or an extension of this leave of absence that is more than or beyond the twelve weeks, I understand that I may not have a right to return to the same or an equivalent position.*** I also understand that if I fail to report for duty, or to request an extension of this leave of absence before the expiration of my approved leave, my failure may be considered as abandonment of my position and could result in termination of my employment.

Employee's Signature: _____ Date:

**Educational Support Personnel may not be entitled to an extension of a leave of absence beyond the twelve weeks to which they are entitled to under FMLA.*

You must personally report to Employee Services to complete the Reinstatement to Work form and obtain a return to work letter, prior to returning to your position.

All information about this leave is confidential. All inquiries about medical information related to your medical or family leave will be made by Human Capital personnel in Employee Services who may contact your health care provider with your permission.

Leaves will be processed pursuant to applicable Board rules and policies and applicable collective bargaining agreement provisions.

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

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division



OMB Control Number: 1215-0181
Expires: 12/31/2011

SECTION I: For Completion by the EMPLOYER

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

Employer name and contact: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your family member or his/her medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a covered family member with a serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Your name: _____
First Middle Last

Name of family member for whom you will provide care: _____
First Middle Last

Relationship of family member to you: _____

If family member is your son or daughter, date of birth: _____

Describe care you will provide to your family member and estimate leave needed to provide care:

Employee Signature _____ Date _____

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the patient needs leave. Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____) _____ Fax: (_____) _____

PART A. MEDICAL FACTS

1. Approximate date condition commenced: _____

Probable duration of condition: _____

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
 No Yes. If so, dates of admission: _____

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

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

Will the patient need to have treatment visits at least twice per year due to the condition? No Yes

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

2. Is the medical condition pregnancy? No Yes. If so, expected delivery date: _____

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care.

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? No Yes.

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

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

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

5. Will the patient require follow-up treatments, including any time for recovery? No Yes.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

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

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? No Yes.

Estimate the hours the patient needs care on an intermittent basis, if any:

_____ hour(s) per day; _____ days per week from _____ through _____

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

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ___ No ___ Yes.

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: ___ times per ___ week(s) ___ month(s)

Duration: ___ hours or ___ day(s) per episode

Does the patient need care during these flare-ups? ___ No ___ Yes.

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

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER

Signature of Health Care Provider

Date

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

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

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