



Office of Human Capital

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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 Employee'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 with medical certification from your health care provider indicating that you are able to resume work. (For those employees returning from a child rearing leave, an original birth certificate or a set of child's footprints from the hospital is required to reinstate. If you are returning to work less than six weeks after giving birth, a doctor's release is also required.)



Office of Human Capital

FMLA APPLICATION for Employee's Own 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 under FMLA.*

An employee seeking to return to work from an illness leave occasioned by the employee's own serious health condition that made the employee unable to perform the employee's job, must personally report to Employee Services with a medical certification from the employee's health care provider which states the employee is able to resume work. (29CFR 825.310)

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
Employee'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
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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 due to a serious health condition to submit a medical certification issued by the employee's health care provider. 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 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: _____

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions: _____

Check if job description is attached: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your 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 due to your own 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. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: _____
First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. 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 employee is seeking leave. 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: _____

Mark below as applicable:

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:

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

Was medication, other than over-the-counter medication, prescribed? 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. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition: No Yes.

If so, identify the job functions the employee is unable to perform:

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

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? No Yes.

If so, estimate the beginning and ending dates for the period of incapacity: _____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? No Yes.

If so, are the treatments or the reduced number of hours of work medically necessary?
 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:

Estimate the part-time or reduced work schedule the employee needs, if any:

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

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? No Yes.

Is it medically necessary for the employee to be absent from work during the flare-ups?
 No Yes. If so, explain:

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

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.
