



# Talent Office

Chicago Public Schools Employee Services • 125 S. Clark Street • 2<sup>nd</sup> Floor • Chicago, IL 60603 • GSR# 125  
Telephone: 773.553.1142 Fax: 773.553.2821 • Email: [EmployeeServices@cps.k12.il.us](mailto:EmployeeServices@cps.k12.il.us)

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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 for Serious Injury or Illness of Covered Servicemember for Military Family Leave.
- 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.



# Talent Office

## FMLA APPLICATION for the Serious Injury or Illness of a Covered Service Member for Military Family Leave

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:  Apt:

City:  State:  Zip Code:  Home Phone Number:

Employee ID Number:  Email Address:

School Name:  Work Address:

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:

I understand that pursuant to the Family Medical Leave Act (29 USC 2601 *et seq.*), if I return from my leave within twenty-six 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 twenty-six 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 twenty-six weeks to which they are entitled 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 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 for Serious Injury or  
Illness of Covered Servicemember--  
for Military Family Leave (Family and  
Medical Leave Act)

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



O:MB Control Number:1215-0181  
Expires: 12/31/20

**Notice to the EMPLOYER** INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides an employer may require an employee seeking FMLA leave due to a serious injury or illness of a covered servicemember to submit a certification providing sufficient facts to support the request for leave. 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. § 825.310. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees or employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

**SECTION I: For Completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the Employee Is Requesting Leave** INSTRUCTIONS to the EMPLOYEE or COVERED

**SERVICEMEMBER:** Please complete Section I before having Section II completed. The FMLA permits an employer to require that an employee submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a serious injury or illness of a covered servicemember. If requested by the employer, your response is required to obtain or retain the benefit of FMLA-protected leave. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to do so may result in a denial of an employee's FMLA request. 29 C.F.R. § 825.310(f). The employer must give an employee at least 15 calendar days to return this form to the employer.

**SECTION II: For Completion by a UNITED STATES DEPARTMENT OF DEFENSE ("DOD") HEALTH CARE PROVIDER or a HEALTH CARE PROVIDER who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider** INSTRUCTIONS

to the HEALTH CARE PROVIDER: The employee listed on Page 2 has requested leave under the FMLA to care for a family member who is a member of the Regular Armed Forces, the National Guard, or the Reserves who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list for a serious injury or illness. For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty that may render the servicemember medically unfit to perform the duties of his or her office, grade, rank, or rating.

A complete and sufficient certification to support a request for FMLA leave due to a covered servicemember's serious injury or illness includes written documentation confirming that the covered servicemember's injury or illness was incurred in the line of duty on active duty and that the covered servicemember is undergoing treatment for such injury or illness by a health care provider listed above. 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.

**Certification for Serious Injury or Illness  
of Covered Servicemember - - for  
Military Family Leave (Family and  
Medical Leave Act)**

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



**SECTION I: For Completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the Employee Is Requesting Leave:** (This section must be completed first before any of the below sections can be completed by a health care provider.)

**Part A: EMPLOYEE INFORMATION**

Name and Address of Employer (this is the employer of the employee requesting leave to care for covered servicemember):

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Name of Employee Requesting Leave to Care for Covered Servicemember:

\_\_\_\_\_  
First Middle Last

Name of Covered Servicemember (for whom employee is requesting leave to care):

\_\_\_\_\_  
First Middle Last

Relationship of Employee to Covered Servicemember Requesting Leave to Care:

Spouse  Parent  Son  Daughter  Next of Kin

**Part B: COVERED SERVICEMEMBER INFORMATION**

(1) Is the Covered Servicemember a Current Member of the Regular Armed Forces, the National Guard or Reserves?  Yes  No

If yes, please provide the covered servicemember's military branch, rank and unit currently assigned to:

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Is the covered servicemember assigned to a military medical treatment facility as an outpatient or to a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients (such as a medical hold or warrior transition unit)?  Yes  No If yes, please provide the name of the medical treatment facility or unit:

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(2) Is the Covered Servicemember on the Temporary Disability Retired List (TDRL)? Yes  No

**Part C: CARE TO BE PROVIDED TO THE COVERED SERVICEMEMBER**

Describe the Care to Be Provided to the Covered Servicemember and an Estimate of the Leave Needed to Provide the Care:

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**SECTION II: For Completion by a United States Department of Defense ("DOD") Health Care Provider or a Health Care Provider who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider.** If you are unable to make certain of the military-related determinations contained below in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator). (Please ensure that Section I above has been completed before completing this section.) Please be sure to sign the form on the last page.

**Part A: HEALTHCARE PROVIDER INFORMATION**

Health Care Provider's Name and Business Address:

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Type of Practice/Medical **Specialty:** -----

Please state whether you are either: (1) a DOD health care provider; (2) a VA health care provider; (3) a DOD TRICARE network authorized private health care provider; or (4) a DOD non-network TRICARE authorized private health care provider: -----

Telephone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_ Email: \_\_\_\_\_

**PART B: MEDICAL STATUS**

(1) Covered Servicemember's medical condition is classified as (Check One of the Appropriate Boxes):

(VSI) Very Seriously Til/Injured-Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

(SI) Seriously Til/Injured-Illness/injury is of such severity that there is cause for immediate concern, but there is no imminent danger to life. Family members are requested at bedside. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

OTHER Illiinjured-a serious injury or illness that may render the servicemember medically unfit to perform the duties of the member's office, grade, rank, or rating.

NONE OF THE ABOVE (Note to Employee: If this box is checked, you may still be eligible to take leave to care for a covered family member with a "serious health condition" under § 825.113 of the FMLA. If such leave is requested, you may be required to complete DOL FORM WH-380 or an employer-provided form seeking the same information.)

(2) Was the condition for which the Covered Service member is being treated incurred in line of duty on active duty in the armed forces?  Yes  No

(3) Approximate date condition **commenced:** -----

(4) Probable duration of condition and/or need for care: \_\_\_\_\_

(5) Is the covered servicemember undergoing medical treatment, recuperation, or therapy?  Yes  No. If yes, please describe medical treatment, recuperation or therapy:

**PART C: COVERED SERVICEMEMBER'S NEED FOR CARE BY FAMILY MEMBER**

- (1) Will the covered servicemember need care for a single continuous period of time, including any time for treatment and recovery?  Yes  No  
If yes, estimate the beginning and ending dates for this period of time: \_\_\_\_\_
  
- (2) Will the covered servicemember require periodic follow-up treatment appointments?  
 Yes  No If yes, estimate the treatment **schedule**: -----
  
- (3) Is there a medical necessity for the covered servicemember to have periodic care for these follow-up treatment appointments?  Yes  No
  
- (4) Is there a medical necessity for the covered servicemember to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)?  Yes  No If yes, please estimate the frequency and duration of the periodic care:  
  
\_\_\_\_\_  
  
\_\_\_\_\_

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, in accordance with 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 AV, NW, Washington, DC 20210. DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION. RETURN IT TO THE PATIENT.