LICENSED EMPLOYEE FAMILY AND MEDICAL LEAVE NOTICE TO EMPLOYEES

YOUR RIGHTS UNDER THE FAMILY AND MEDICAL LEAVE ACT OF 1993

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

1 • For incapacity due to pregnancy, prenatal medical care or child birth;
2 • To care for the employee's child after birth, or placement for adoption or foster care;
3 • To care for the employee's spouse, son or daughter, or parent, who has a serious health condition; or
4 • For a serious health condition that makes the employee unable to perform the employee's job.

MILITARY FAMILY LEAVE ENTITLEMENTS

Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies.

Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

BENEFITS AND PROTECTION

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

JOB ELIGIBILITY REQUIREMENTS

Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

DEFINITION OF SERIOUS HEALTH CONDITION

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

USE OF LEAVE

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule

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when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

NOTE: **FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.**

If you have access to the Internet visit FLMA's website: http://www.dol.gov/esa/whd/fmla.

To locate your nearest Wage-Hour Office, phone our toll-free information at 1-866-487-9243 or to the Web site at: http://www.wagehour.dol.gov.

For a listing of records that must be kept by employers to comply with FMLA visit the U.S. Dept. of Labor's website:
http://www.dol.gov/dol/allcfr/ESA/Title_29/Part_825/29CFR825.500.htm

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LICENSED EMPLOYEE FAMILY AND MEDICAL LEAVE REQUEST FORM

Date:_____

I, _____, request family and medical leave for the following reason:

(check all that apply)

____ for the birth of my child;
____ for the placement of a child for adoption or foster care;
____ to care for my child who has a serious health condition;
____ to care for my parent who has a serious health condition;
____ to care for my spouse who has a serious health condition; or
____ because I am seriously ill and unable to perform the essential functions of my position.
___ because of a qualifying exigency arising out of the fact that my
___spouse;
___ son or daughter;
___parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves.
___ because I am the
___ spouse;
___ son or daughter;
___ parent;
___ next of kin of a covered service member with a serious injury or illness.

I acknowledge my obligation to provide medical certification of my serious health condition or that of a family member in order to be eligible for family and medical leave within 15 days of the request for certification.

I acknowledge receipt of information regarding my obligations under the family and medical leave policy of the school district.

I request that my family and medical leave begin on _____ and I request leave as follows: (check one)

____ continuous
I anticipate that I will be able to return to work on _____.

____ intermittent leave for the:
____ birth of my child or adoption or foster care placement subject to agreement by the district;
____ serious health condition of myself, parent, or child when medically necessary;
____ because of a qualifying exigency arising out of the fact that my
___spouse;
___ son or daughter;
___parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves.
___ because I am the
___ spouse;
___ son or daughter;
___ parent;
___ next of kin of a covered service member with a serious injury or illness.

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Details of the needed intermittent leave:

_____

_____

_____

I anticipate returning to work at my regular schedule on _____.

____ reduced work schedule for the:

____ birth of my child or adoption or foster care placement subject to agreement by the district;

____ serious health condition of myself, parent, or child when medically necessary;

____ because of a qualifying exigency arising out of the fact that my

___spouse;

___ son or daughter;

___parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves.

____ because I am the

___ spouse;

___ son or daughter;

___ parent;

___next of kin of a covered service member with a serious injury or illness.

Details of needed reduction in work schedule as follows:

_____

_____

_____

I anticipate returning to work at my regular schedule on _____.

I realize I may be moved to an alternative position during the period of the family and medical intermittent or reduced work schedule leave. I also realize that with foreseeable intermittent or reduced work schedule leave, subject to the requirements of my health care provider, I may be required to schedule the leave to minimize interruptions to school district operations.

While on family and medical leave, I agree to pay my regular contributions to employer sponsored benefit plans. My contributions will be deducted from moneys owed me during the leave period. If no monies are owed me, I will reimburse the school district by personal check or cash for my contributions. I understand that I may be dropped from the employer-sponsored benefit plans for failure to pay my contribution.

I agree to reimburse the school district for any payment of my contributions with deductions from future monies owed to me or the school district may seek reimbursement of payments of my contributions in court.

I acknowledge that the above information is true to the best of my knowledge.

Signed _____

Date _____