

Human Resource Services

Application for FMLA/CFRA

Family Member's Serious Health Condition

Date:
The Family and Medical Leave Act and California Family Rights Act ("FMLA/CFRA" require covered employers to provide up to 12 weeks of unpaid, job-protected leave to "eligible" employees for certain family and medical reasons.
<u>Eligibility</u>
Employees are eligible if they have worked for a covered employer for at least one year and for 1,250 hours over the previous 12 months, and if there are at least 50 employees within 75 miles.
Job Benefits
Employers are required to maintain coverage, except life insurance and accidental death and dismemberment benefits, for employees on leave under a group health plan on the same basis as if they had continued regular employment during the leave period. The employer and employee contribution responsibilities for maintaining continued health coverage remain unchanged during the leave period.
I hereby apply for a Family Leave for the period beginning at the beginning of the day on and terminating at the close of the day on
Reason for Taking the Family Leave:
☐ To care for my child(ren) after birth, or placement for adoption or foster care.
☐ To care for my spouse, son, daughter, or parent who has a serious health condition.
Type of Leave Requested:
Consecutive weeks. (Up to 12 weeks, but not less than two weeks.)
Intermittent or reduced schedule (please explain and specify number of days a week and/or hours

Advance Notice and Medical Certification:

a day or week):

- ➤ The employee must provide 30 days advance notice when the leave is "foreseeable." If you do not notify the District in advance for foreseeable leave, the District may delay your leave as necessary to make appropriate arrangements for your temporary replacement. Such delay will not postpone your leave for more than 30 days from date of your request.
- ➤ Medical certification to support a request for leave because of a serious health condition is required, Form WH-380-F attached. You must provide a medical certificate at the time you request leave if your leave is to care for a qualifying family member.

Certification of Health Care Provider must be attached.

Advance Notice and Medical Certification (continued)

The District may require an employee requesting intermittent or reduced leave as a result of planned medical treatment, to transfer to an alternate position which has equivalent pay and benefits and accommodates recurring periods of leave better than the employee's regular position.

Restoration Rights

Agenda Date:

Hold Position:

Recommended By:

You will be reemployed in the same, comparable, or equivalent position upon return from full leave.	
By my signature, I attest that I have read and understand the above.	

Name (Print or Type)	Signature		
Social Security Number	Mailing Address		
Гelephone	City	State	Zip Code
	School Site/Department	Posi	ition
	Grade and/or Subjects Tau	ght	
Leave of absence granted in accordance with ab	bove:		
Chief Human Resources Officer or Designee Human Resource Services	_	Dat	e
(Do not write in this	space. For office use only.)		
Eligibility Certified By:			
Medical Certification Form WH-380-F Verified	d∙ 		

Certification of Health Care Provider must be attached.

Position Number:

Transfer to Unassigned:

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

U.S. Department of Labor Wage and Hour Division



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

OMB Control Number: 1235-0003 Expires: 8/31/2021

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, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

and in accordance with 29 C.F.	.R. § 1635.9, if the Genetic I	niormation No	ndiscrimination Act	applies.
Employer name and contact: _				
SECTION II: For Completion INSTRUCTIONS to the EMI member or his/her medical procomplete, and sufficient medical member with a serious health or retain the benefit of FMLA prosufficient medical certification must give you at least 15 calen	PLOYEE: Please complete vider. The FMLA permits a al certification to support a recondition. If requested by you tections. 29 U.S.C. §§ 2613 may result in a denial of yo	n employer to request for FMI our employer, y 8, 2614(c)(3). If ur FMLA reque	require that you substant LA leave to care for your response is required as least. 29 C.F.R. § 825	mit a timely, a covered family tired to obtain or complete and .313. Your employer
Your name: First	Middle	Last		
Name of family member for we Relationship of family member is your s		First	Middle	Last
Describe care you will provide	to your family member and	estimate leave	needed to provide c	are:
Employee Signature		Date		
Page 1	CONTINUED ON	NEXT PAGE	Form	WH-380-F Revised May 2015

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. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e). 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: ()
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? NoYes. If so, dates of admission:
Date(s) you treated the patient for condition:
Was medication, other than over-the-counter medication, prescribed?NoYes.
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)? NoYes. If so, state the nature of such treatments and expected duration of treatment:
2. Is the medical condition pregnancy?NoYes. 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):

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:

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

7. Will the condition cause episodic flare-ups peri activities?NoYes.	iodically preventing the patient from participating in normal daily
	our knowledge of the medical condition, estimate the frequency of that the patient may have over the next 6 months (e.g., 1 episode
Frequency: times per week(s)	month(s)
Duration: hours or day(s) per episod	de
Does the patient need care during these flare-up	os? No Yes.
Explain the care needed by the patient, and why	y such care is medically necessary:
	
ADDITIONAL INFORMATION: IDENTIFY Q	UESTION NUMBER WITH YOUR ADDITIONAL ANSWER.
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Signature of Health Care Provider	Date
MENGRAL WILLIAM VALUE INVINCE	Dail

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.**