Family or Medical Leave Request

Conroe Independent School District ***Based on Policy DEC (Local)***

Please type or print

Employee's name _____ Position _____

Employee Identification # (EIN) _____ Date(s) of leave requested _____

Campus/Department _____ Anticipated return date _____

Reason for Leave:

☐ birth of your child or the placement of a child with you for adoption or foster care

☐ a serious health condition that makes you unable to perform the essential functions of your job

☐ a serious health condition affecting your ☐ *spouse* ☐ *child* ☐ *parent* for which you are needed to provide care.

☐ because of the qualifying exigency arising out of the fact that your ☐ *spouse* ☐ *child* ☐ *parent* is on active duty or status in support of a contingency operation as a member of the National Guard or Reserves.

☐ because you are the ☐ *spouse* ☐ *child* ☐ *parent* ☐ *next of kin* of a covered service-member with a serious injury or illness.

Note: *To be eligible, an employee must have worked for Conroe ISD for at least 12 months and have worked at least 1,250 hours in the 12 months immediately preceding the need for leave.*

I have read and understand district policies DEC (Legal) and DEC (Local), Compensation and Benefits: Leaves of Absences. I understand that this leave must be taken concurrently with any other leave to which I am entitled under Board policy. I understand that I must make arrangements with the district Payroll Office to pay for my share of the health insurance benefits. I understand that failure to make timely payments may result in loss of coverage. I also understand that as long as I qualify for FMLA the district will continue to pay my health insurance benefits at the same level and under the same conditions that coverage would have been provided if I had continued in my job.

Employee Signature _____ Date _____

Administrator Acknowledgement

_____ _____

Principal/Supervisor *Date forwarded to Human Resources Department*

Human Resources Department

☐ Approved FMLA hours _____

☐ Not Approved

Signature: _____ Date: _____

Certification of Health Care Provider for Family Member's Serious Health Condition

SECTION I: _____

For completion by the EMPLOYEE

Instructions for the Employee: Please complete Section I before giving this form to your family member or his/her medical provider.

Your name *(PRINT first, middle, last)* _____

Name of family member for whom you will provide care *(PRINT 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 II: _____

For completion by the HEALTH CARE PROVIDER

Instructions for 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. The next page provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's name *(Print)* _____

Provider's business address _____

Type of practice/medical specialty _____ Telephone (_____) _____ Fax (_____) _____

PART A: MEDICAL FACTS

1. Approximate date condition commenced _____ Probable duration of condition _____

   Was 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)

   _____

   _____

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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 _____

   _____

Continued on reverse side

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

Estimate treatment schedule, if any, including 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 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 _____

_____

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_____ _____

Health Care Provider signature *Date*

Additional writing space

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