Midland Independent School District

Human Capital Management

Benefits & Risk Management

615 W. Missouri Avenue, Midland, Texas 79701

Office: (432) 240-1950 Fax: (432) 689-5869 |www.midlandisd.net

FMLA Packet: Employee's Family Member's Medical Condition

Employee: Please return completed FMLA application & Doctor's Certification forms to Central Office - Benefits Dept (STE 223)

Employee ID # _____

Employee Name: _____

Employee Address: _____

City State Zip: _____

Employee Phone # (_____) _____ - _____

Employee's Campus or Dept: _____

Employee's Job Title (Position): _____

Employee's Supervisor: _____

Campus Secretary: _____

Anticipated Start Date of Leave: _____/_____/_____

Anticipated Return to Work Date: _____/_____/_____

Employee Signature: _____ Date: ____/____/____

Supervisor Signature: _____ Date: ____/____/____

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Doctor Certification: Employee's Family Member's Serious Health Condition

(Family and Medical Leave Act)

Employee: Take this form to your doctor. Once completed, please return to Central Office Benefits Dept

EMPLOYEE INSTRUCTIONS: 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. 29 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.

Employee Name: _____
First Middle Last

Notice of family member for whom you will provide care: _____
First Middle Last

Relationship of family member to you: _____

If family member is your son or daughter, date of birth: _____

Describe the care you will provide to your family member and esimtate the amount of leave needed to provide care:

_____

_____

_____

_____ _____

Employee Signature **Date**

To be completed by your family member's doctor (Health Care Provider):

Healthcare Provider Instructions: 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 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.

Please be sure to sign the form on the last page.

GINA NONDISCLOSURE NOTICE: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Doctor/Provider's Name: _____

Business Address: _____

Type of Practice/Medical Specialty: _____

Telephone Number: _____ Fax Number: _____

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Doctor Certification (Con't)

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?

   ❑ Yes ❑ No If yes, provide dates of admission: _____

   Was medication, other than over-the-counter medication, prescribed? ❑ Yes ❑ No

2. Is the medical condition pregnancy? ❑ Yes ❑ No If yes, expected delivery date: _____/_____/_____

3. What is the **DIAGNOSIS** (include symptoms or any regimen of continuing treatment such as the use of specialized equipment)

_____

_____

Part B: AMOUNT OF CARE NEEDED. When answering, 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 due to his/her medical condition, including any time for treatment and recovery? ❑ Yes ❑ No

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

   Beginning: _____/_____/_____ **Ending:** _____/_____/_____

   During this time, will the patient need care: ❑ Yes ❑ No

   If yes, explain care needed by the patient & why it's medically necessary?

_____

_____

_____

_____

_____

_____

Signature of Doctor/ Health Care Provider **Date**

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PLEASE READ

What is (FMLA)?

- FMLA is a federal law, which provides employees up to 12 wks of job-protected leave for qualified family and medical related reasons.
- FMLA does not provide additional leave (or days) which you can draw from & use.
- To qualify for FMLA you must have been employed with Midland ISD 12 months "**and**" worked 1,250 hours during the 12 month period preceding your FMLA qualifying event. Eligible employees are entitled up to 12 wks of FMLA per year.
- District policy requires you to use your own vacation, sick, compensatory time, temporary disability leave, & workers' compensation while you are on FMLA leave.
- Insurance & Benefits: Your health insurance / deductions will continue and remain the same as long as you have days to draw from AND you're receiving a paycheck. If you don't know how many days you have available, please call Payroll Dept (240-1943) for your balance. When you have run out of days & you are no longer receiving a paycheck, YOU will be responsible for your portion of your health premium / optional benefits and our dept will be mailing you an invoice for the amount you owe. Please be advised your health insurance & optional benefits will be cancelled if you don't pay by the deadline indicated on your invoice. If your insurance is cancelled, Blue Cross Blue Shield (BCBS) will mail you a COBRA packet within two weeks of cancellation, and you will have the option to continue your coverage, however you will have to pay BCBS directly.
- Upon returning to work: You must provide a "Fitness-for-Duty" certification (medical release) from your doctor allowing you to return to work full duty (no restrictions). **You must provide a copy to the Benefits office as well as your supervisor/principal**.

Contact Information

Insurance & Optional Benefits Questions: Amanda Jacquez 240-1952/ Dawn Martin 240-1953

**Deadline to add your newborn to your plan is one month from the birth date. Please bring a copy of your baby's social security card (if available) to Benefits Dept (STE 223)

Blue Cross Blue Shield: Customer Service (800) 521-2227

Disability questions: The Hartford Customer Service: 1-866-278-2655

*If you have a disability policy with Hartford, you can access the information by visiting: www.mybenefitshub.com/midlamdisd.

Payroll Department: (432) 240-1943.

*For Payroll questions or amount of sick/vacation days available.

For a more in-depth explanation on FMLA & TDL, please visit MISD district Policy:

http://pol.tasb.org/Policy/Download/886?filename=DEC(LOCAL).pdf