The Family and Medical Leave Act (FMLA)

February 2016

What is FMLA?

- The Family & Medical Leave Act (FMLA) makes available to eligible employees up to **12 weeks** or **60 work days** of unpaid, job-protected leave each year for FMLA-qualifying events.

What is FMLA For?

- Birth and care of an employee's newborn child
- Placement of a child for adoption or foster care
- Care of a spouse, child or parent suffering a serious health condition
- The employee's own serious health condition
- A qualifying exigency arising from the employee's spouse, son or daughter, or parent on active military duty

Who is Eligible?

- To be eligible for FMLA leave, employees must have been employed by M-DCPS for at least 12 months and have worked a minimum of 1,250 hours during the 12-month period immediately preceding the leave.
- Contact Ms. Prado at the Leave Office to know if an employee meets the service hours requirement.

What Does FMLA Do for Employees?

- Their job is protected when they are absent from work on FMLA leave and they maintain their health insurance.
  - That means that no negative employment actions (e.g., warning, suspension, termination) will be taken against you because of such absences.
- FMLA **does not** protect an employee from disciplinary action not related to your FMLA absences.

Is FMLA leave paid or unpaid?

- While FMLA leave is unpaid by definition, M-DCPS allows employees to continue pay by using Short-Term Disability, if eligible, and/or accrued sick and/or vacation leave during FMLA absences.
  - The use of vacation time for FMLA-related absences is at the discretion of the authorizing administrator.

- Unless you are receiving Short-Term Disability benefits, all paid leave must be used prior to going on Leave Without Pay (LWOP).

Intermittent Leave Under the Family and Medical Leave Act (FMLA)

Intermittent Leave Under the FMLA

- FMLA allows for “intermittent” leave
  - Absences may be in increments of 15 minutes to days for scheduled treatment, doctor’s visits or flare ups
- FMLA also allows for a reduced work schedule if necessitated by a FMLA-qualifying condition.
- Absences due to intermittent FMLA leave or a reduced work schedule will be tracked along with other FMLA leave.

Intermittent Leave Under the Family and Medical Leave Act (FMLA)

SITE SUPERVISORS

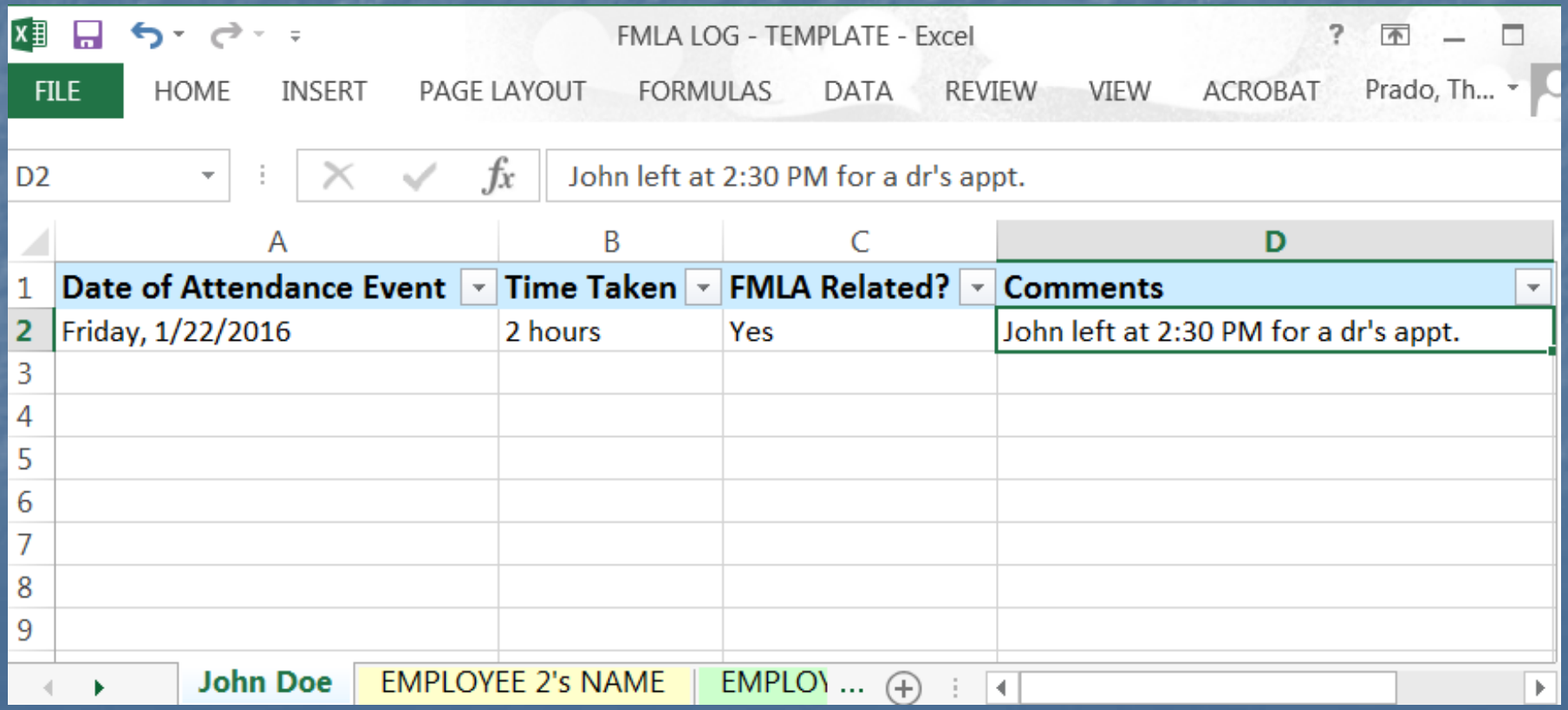
What are my FMLA responsibilities as a supervisor?

- Approve Intermittent Leave Under the FMLA
  - Check with the Leave Office to ensure employee's eligibility for intermittent leave
- Notify employees concerning their eligibility status and rights and responsibilities
- Tracking FMLA-related absences

Address absences from the beginning!

Tracking of FMLA Absences

- The location must keep a detailed record of the FMLA-related absences
  - The employer has the right to inquire about the nature of the absence



Why is tracking important?

- Keeping a good record of the FMLA-related absences will help minimize disruption
- The only way to address the possible abuse of intermittent leave by an employee is by having DOCUMENTATION

FM-7380 Forms the Parameters

- The employee is the initiator of the request
- They have 15 calendar days to provide the documentation
- Write down everything they say about the reasons they were late, left early, or were absent.
- You cannot make the employee take more time than they are requesting.
- Do not contact the healthcare provider. Leave that to the Leave Office.
- The form is valid for up to six months or until medical condition ceases to exist

FM-7380

MIAMI-DADE COUNTY PUBLIC SCHOOLS

INTERMITTENT LEAVE REQUEST MEDICAL CERTIFICATION

UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

For Completion by the EMPLOYEE: *(SUBMIT TO WORKSITE ADMINISTRATOR)*

_____ EMPLOYEE NAME (PRINT) _____ EMPLOYEE NUMBER

☐ **FOR ILLNESS OF EMPLOYEE OR** ☐ **FOR ILLNESS OF FAMILY MEMBER** _____ Family Member Name

If request is for illness of family member indicate the relationship _____ and age _____ if it is for a son or daughter **(must be accompanied by FM-7497).**

I hereby authorize Miami-Dade County Public School's healthcare representative to contact my healthcare provider for purposes of verification, clarification and/or authentication of the information on this form.

I certify, under the penalty of perjury and disciplinary action, including, but not limited to termination of employment, that the foregoing information is true and correct. I also understand that my or my healthcare representative's failure to cooperate in the verification of the foregoing information may result in denial of the FMLA request. I further understand that I may not take leave without approval and that said unapproved leave may constitute abandonment of my employment and may result in disciplinary action, including, but not limited to termination of employment.

The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support your request for FMLA. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. Time taken as part of the intermittent leave request constitutes designation of your FMLA entitlement.

_____ EMPLOYEE SIGNATURE _____ DATE

For Completion by the Healthcare Provider: _____ **Patient Name**

Diagnosis

- **Diagnosis** _____ **ICD CODE:** _____
- Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery?
  Yes _____ No _____
- Recommended intermittent leave of absence dates are from _____ **Date (be specific)** to _____ **Date (be specific)**

Date Range

- Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions?
  Yes _____ No _____
- Is it medically necessary for the employee to be absent from work during the flare-ups?
  Yes _____ No _____
- 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

PROVIDER'S COMMENTS: _____

DR's Info.

_____ Physician's Name Printed _____ Physician's Signature _____ Date

_____ Specialty _____ Phone Number

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Important Facts to Remember

- Display the FMLA poster
- Be consistent and equal
- A medical note does not need to be provided for every absence
- Check the Certification Form to prevent abuse
- Encourage employees to schedule their appointments outside of the work day

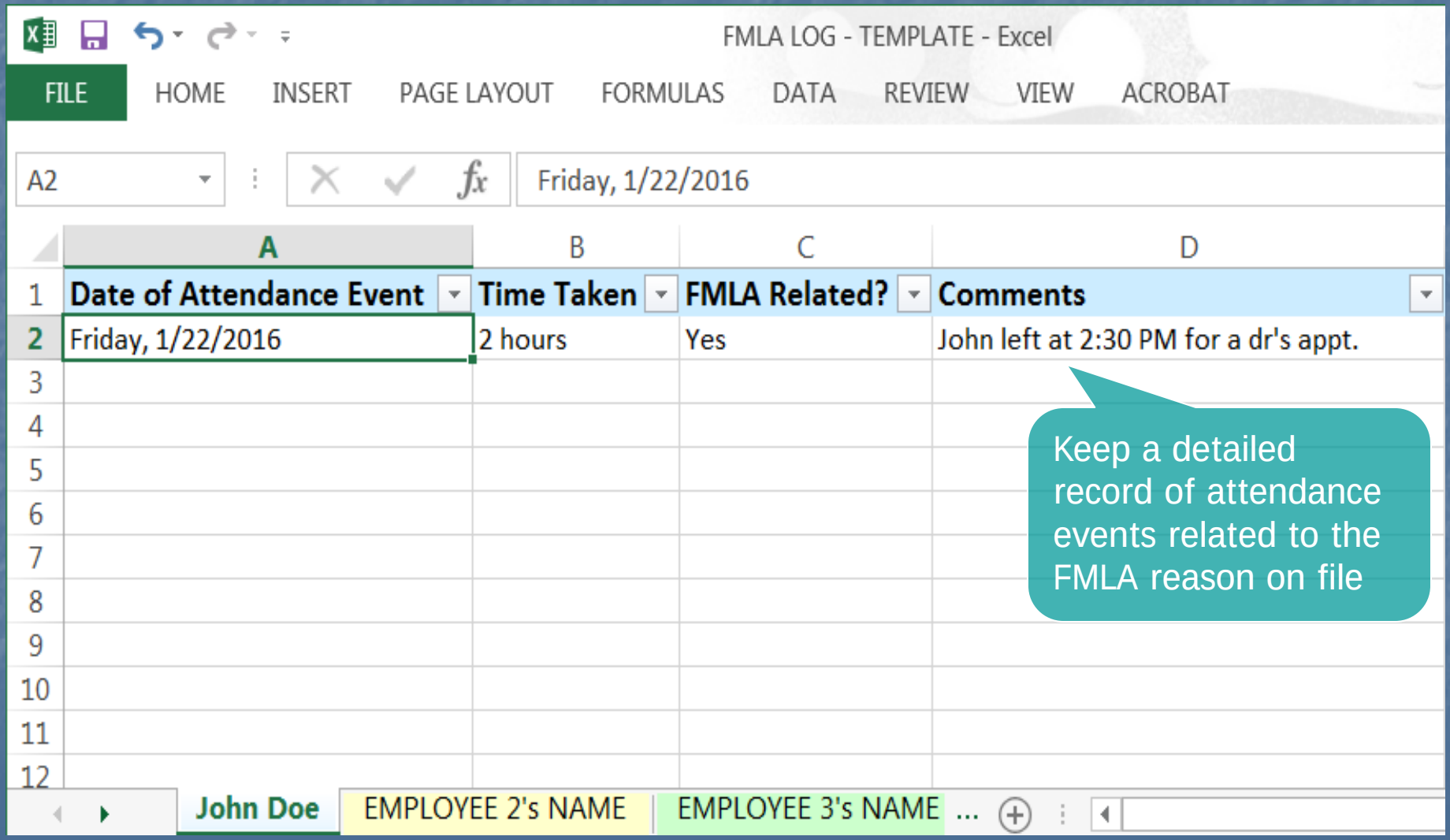
Be cautious before denying a leave request for illness or having a conference about tardiness. Contact the Leave Office for assistance with any intermittent leave issues.

Intermittent Leave Under the Family and Medical Leave Act (FMLA)

SITE SUPERVISORS

Samples

Attendance Log Sample



Sample Memos

- **Approval**

M E M O R A N D U M Date: _____

TO:

FROM:

SUBJECT: INTERMITTENT LEAVE REQUEST MEDICAL CERTIFICATION UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

I am in receipt of your *Intermittent Leave Request Medical Certification* form dated _____. In order to exercise your rights under the Family and Medical Leave Act (FMLA), you must follow all established attendance procedures and convey to this administrator your need to be absent, arrive late or leave early because of an event covered by your *Intermittent Leave Medical Certification* form.

Failure to follow the attendance policy or to provide sufficient information for this administrator to know that your absence may be covered by the FMLA may result in the delay or denial of FMLA designation of your future absences.

Attached is also a copy of the Employee Rights and Responsibilities under FMLA poster.

I am in receipt of this memorandum.

_____ _____
Employee Signature Date

CC:

- **Missing Information**

M E M O R A N D U M Date: _____

TO:

FROM:

SUBJECT: INTERMITTENT LEAVE REQUEST MEDICAL CERTIFICATION UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

I am in receipt of your *Intermittent Leave Request Medical Certification* form dated November 23rd, 2015. The form was received missing the following information:

- Specific recommended intermittent leave of absence dates
- ***Frequency*** of flare-ups or treatment which may require time off from work
- ***Duration*** (how long) of flare-ups or treatment for which you may need time off from work

In order to exercise your rights under the Family and Medical Leave Act (FMLA), please provide an updated form that includes the aforementioned within 10 calendar days from the date of this memo. Attached is a copy of the Employee Rights and Responsibilities under FMLA poster.

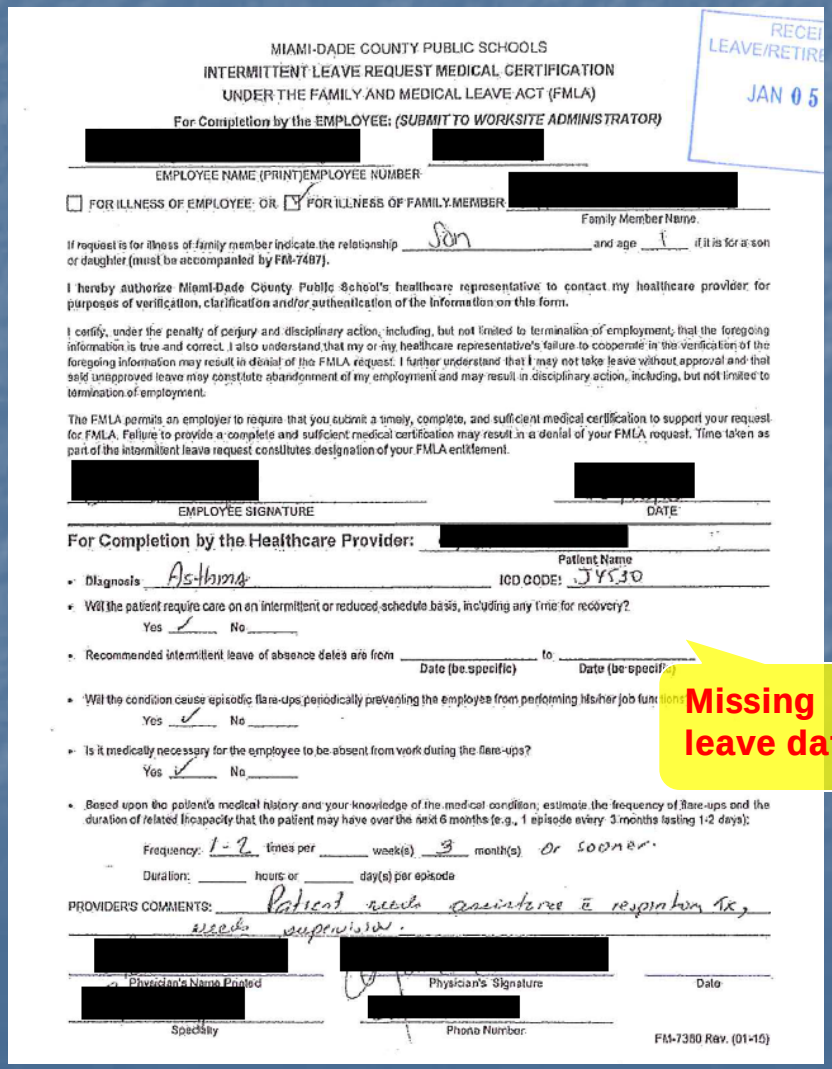
I am in receipt of this memorandum.

_____ _____
Employee Signature Date

CC:

Sample Forms

X Incorrect



MIAMI-DADE COUNTY PUBLIC SCHOOLS
INTERMITTENT LEAVE REQUEST MEDICAL CERTIFICATION
UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

RECEI
LEAVE/RETIRE
JAN 05

For Completion by the EMPLOYEE: *(SUBMIT TO WORKSITE ADMINISTRATOR)*

[redacted] [redacted]
EMPLOYEE NAME (PRINT) EMPLOYEE NUMBER

☐ FOR ILLNESS OF EMPLOYEE OR ☑ FOR ILLNESS OF FAMILY MEMBER [redacted]
Family Member Name

If request is for illness of family member indicate the relationship Son and age 1 if it is for a son or daughter (must be accompanied by FM-7497).

I hereby authorize Miami-Dade County Public School's healthcare representative to contact my healthcare provider for purposes of verification, clarification and/or authentication of the information on this form.

I certify, under the penalty of perjury and disciplinary action, including, but not limited to termination of employment, that the foregoing information is true and correct. I also understand that my or my healthcare representative's failure to cooperate in the verification of the foregoing information may result in denial of the FMLA request. I further understand that I may not take leave without approval and that said unapproved leave may constitute abandonment of my employment and may result in disciplinary action, including, but not limited to termination of employment.

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[redacted] [redacted]
EMPLOYEE SIGNATURE DATE

For Completion by the Healthcare Provider: [redacted]
Patient Name

- Diagnosis Asthma ICD CODE: J45.30
- Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery?
  Yes ✓ No
- Recommended intermittent leave of absence dates are from _____ to _____
  Date (be specific) Date (be specific)
- Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions?
  Yes ✓ No
- Is it medically necessary for the employee to be absent from work during the flare-ups?
  Yes ✓ No
- 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: 1-2 times per _____ week(s) 3 month(s) or sooner.
  Duration: _____ hours or _____ day(s) per episode

PROVIDER'S COMMENTS: Patient needs assistance ☐ respiratory Tx, needs supervision.

[redacted] [redacted] _____
Physician's Name Printed Physician's Signature Date

[redacted] [redacted]
Specialty Phone Number

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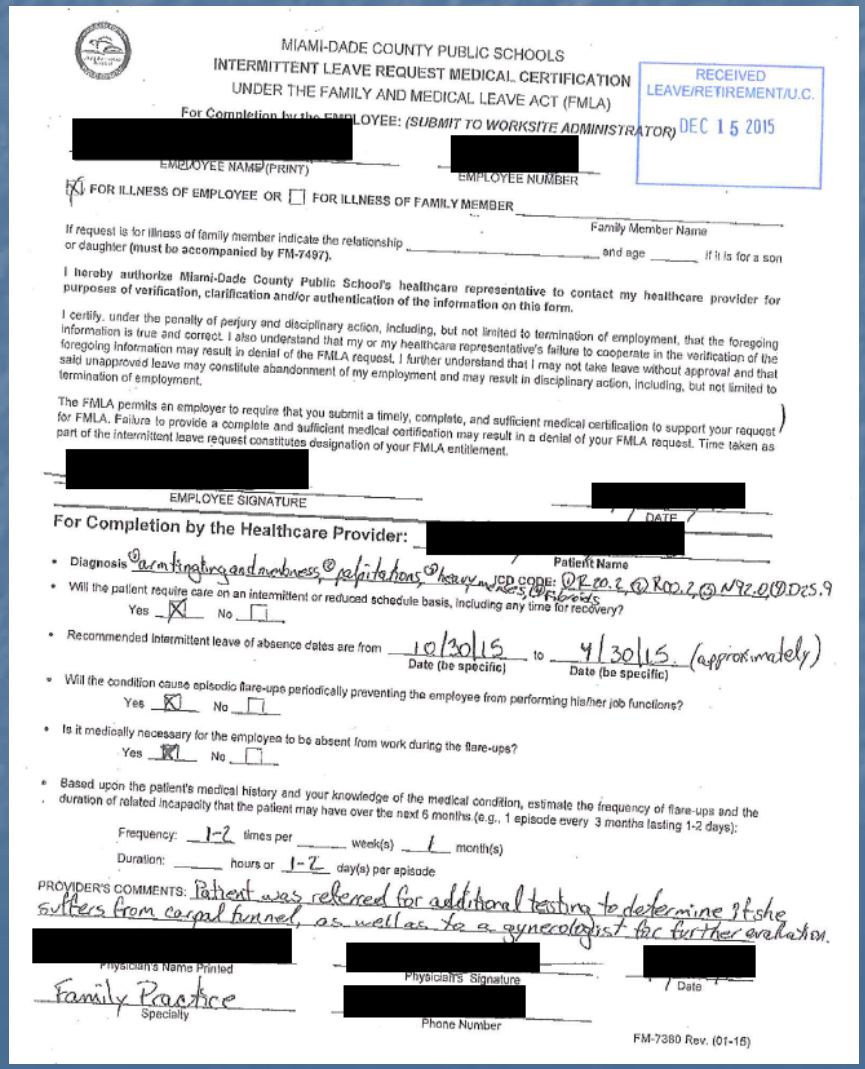
Missing leave dates

✓ Correct



MIAMI-DADE COUNTY PUBLIC SCHOOLS
INTERMITTENT LEAVE REQUEST MEDICAL CERTIFICATION
UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

RECEIVED
LEAVE/RETIREMENT/U.C.
DEC 15 2015

For Completion by the EMPLOYEE: *(SUBMIT TO WORKSITE ADMINISTRATOR)*

[redacted] [redacted]
EMPLOYEE NAME (PRINT) EMPLOYEE NUMBER

☒ FOR ILLNESS OF EMPLOYEE OR ☐ FOR ILLNESS OF FAMILY MEMBER _____
Family Member Name

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[redacted] [redacted]
EMPLOYEE SIGNATURE DATE

For Completion by the Healthcare Provider: [redacted]
Patient Name

- Diagnosis ① vomiting and weakness ② palpitations ③ heavy ... ④ JCD CODE: ① R10.2 ② R00.2 ③ N92.0 ④ D25.9
- Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery?
  Yes ☒ No ☐
- Recommended intermittent leave of absence dates are from 10/30/15 to 4/30/15 (approximately)
  Date (be specific) Date (be specific)
- Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions?
  Yes ☒ No ☐
- Is it medically necessary for the employee to be absent from work during the flare-ups?
  Yes ☒ No ☐
- 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: 1-2 times per _____ week(s) 1 month(s)
  Duration: _____ hours or 1-2 day(s) per episode

PROVIDER'S COMMENTS: Patient was referred for additional testing to determine if she suffers from carpal tunnel, as well as to a gynecologist for further evaluation.

[redacted] [redacted] [redacted]
Physician's Name Printed Physician's Signature Date

Family Practice [redacted]
Specialty Phone Number

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Contact Information for Questions About FMLA

If you receive an Intermittent Leave Request Form call Mrs. Baluja or Ms. Prado for Immediate Assistance at (305) 995-7090