Red River Parish School Board

P.O. Box 1369
Coushatta, LA 71019
Phone 318-932-4081 Fax 318-271-1396

Leave Request Procedures

1. Complete Leave Application form.
2. All supporting documents for leave request **MUST** be attached to the leave application:
   a. Leave With Pay (Employee Medical Treatment Certification, Government Orders)
      i. Extended Medical Leave
      ii. Sabbatical Medical Leave
      iii. Professional/ Cultural Improvement
      iv. Military Leave
   b. Leave With-Out Pay (Employee Medical Treatment Certification)
      i. Maternity Leave
      ii. Family Medical Leave
3. Failure to provide all necessary document will lead to denial of leave request.
4. Request for Leave Application Form **MUST** have principal or supervisor signature before submitting to Human Resources.
5. Return application and EMTC form to Human Resources Department via scan/email **OR** fax.
6. Human Resources will provide a copy of the completed and approved or denied Request for Leave form to the principal.

Request for Leave is administered under RRPSB policy GBRIB, GBRIC, and GBRIBA.

RED RIVER PARISH SCHOOL BOARD

LEAVE APPLICATION

SECTION I – TO BE COMPLETED BY THE EMPLOYEE **DATE: ______________**

EMPLOYEE'S NAME	TELEPHONE	CAMPUS
______________________________	______________________________	______________________________
POSITION	EXPERIENCE	SOCIAL SECURITY
______________________________	______________________________	______________________________

☐ Initial Application ☐ Amendment to LOA that began on ____________

A leave of absence is normally leave without pay or pay of 65% of daily rate. Refer to Red River CAPS for complete details of policies.

REASON FOR LEAVE OF ABSENCE:

Proper documentation must be submitted with this form

LEAVE WITH PAY (Physician Certificate/ (Government Orders needed)

___ Extended Medical Leave (GBRIB 65% of salary)

___ Sabbatical Medical Leave (GBRIB 65% of salary)

___ Professional/ Cultural Improvement (Sabbatical Leave GRIB 65% of salary)

___ Military Leave (GRID 100% of salary)

LEAVE WITH-OUT PAY (Physician Certificate needed)

___ Maternity Leave (GRIC 0% of salary)

___ Family Medical Leave (GBRIBA 0% of salary)

___ Leave Without Pay

Requested start date: ________________

Anticipated return date: ________________

Physician Certification Attached ____ Yes ____ No

EMPLOYEE'S SIGNATURE:	DATE:	TELEPHONE:

SECTION II – TO BE COMPLETED BY CENTRAL OFFICE

APPROVAL/ DENIAL OF LEAVE REQUEST

☐ Your request for ____________________ leave is approved and Begins on ______________ (MM/DD/YYYY) and ends on ______________ (MM/DD/YYYY)

☐ Request denied (see attached for explanation of denial)

PRINCIPAL/ SUPERVISOR SIGNATURE
(I recommend approval with proper documentation for leave of absence)

NAME (PRINT)

SIGNATURE	DATE

BUSINESS MANAGER SIGNATURE

NAME (PRINT)

SIGNATURE	DATE

SUPERINTENDENT SIGNATURE

NAME (PRINT)

SIGNATURE	DATE

RED RIVER PARISH SCHOOLS
EMPLOYEE MEDICAL TREATMENT CERTIFICATION
Phone: 318-271-3150 Fax: 318-271-1396

PURPOSE of FORM: In accordance with state law, school employees may use leave for medical necessity. The statue defines a "medical necessity" as the result of a catastrophic illness or injury, which means a life threatening, chronic, or incapacitating condition. The below-named employee has requested a leave of absence for his/her health condition which may qualify as a protected leave. This medical certification form will provide the Red River Parish School Board with information needed to determine if the employee's requested leave is for a qualifying reason. Section II must be fully completed by a licensed physician.

INSTRUCTIONS to EMPLOYEE: You are required to submit a timely, complete, and sufficient medical certification to support your request for leave due to your own or immediate family member serious health condition. Failure to provide a complete and sufficient medical certification may result in a delay or denial of your leave request.

This form may be presented along with the leave request or (3) days after the employee returns to service. The Superintendent reserves the right to question the validity of the medical certification after the (3) day period. You may return this form in person, by e-mail (neason@rrbulldogs.com), or by fax (318-271-1396).

SECTION I: To be completed by Employee

EMPLOYEE'S NAME	DOB
POSITION	SIGNATURE OF EMPLOYEE

SECTION II – To be completed by PHYSICIAN

INSTRUCTIONS to the PHYSICIAN: Your patient (our employee) has requested leave. Please answer, fully and completely, all applicable parts.
Be sure to sign and date the form on page 2.

NOTE: DO NOT DISCLOSE THE EMPLOYEE'S UNDERLYING DIAGNOSIS WITHOUT HIS/HER CONSENT.

PROVIDER'S NAME

BUSINESS ADDRESS

TELEPHONE	FAX

PART A: MEDICAL FACTS

(1) Approximate date condition began: ___________________	Probable duration of condition: From: ___________________ To: ___________________
(2) Date of Most Recent Visit & Illness/ Injury treated:	(3) Date of Last Recent Visit & Illness/ Injury treated:

(4) Patient's current diagnosis:

(5) What medication(s) have you prescribed to relative to the patient's diagnosis?

(6)When did you first prescribe such medication (s) (or similar medications) for this patient?

(7) How long do you expect the patient to require such medication(s)?

(8) Do such medications interfere with the ability of the patient to perform his/ her duties? If so, please explain:

(9) Is the employee able to perform work with no limitations? ☐ Yes ☐ No

If no, what are the recommended limitations?

(10) Does the employee's condition qualify as one of the types of serious health conditions described?
Page 3 describes what is meant by a "serious health condition" under the FMLA. ☐ **Yes** ☐ **No**

If yes, which type of serious health condition listed on Page 3 applies:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

PART B: AMOUNT OF LEAVE NEEDED

(11) Will the employee 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: FROM TO

Answer questions 12 and/or 13 only if the employee requires leave on an intermittent or reduced schedule basis.

(12) Will it be medically necessary for the employee to leave work intermittently or work a reduced schedule as a result of the medical condition (other than for episodic flare-ups which are addressed in question #6 below)? ☐ Yes ☐ No

If the employee needs reduced schedule leave, estimate the part-time or reduced work schedule the employee needs:

Employee should work no more than:

_______ Hours per Day _______ Days Per Week From: ____________________ through: ____________________

If the employee needs intermittent leave, estimate the frequency of need for intermittent leave and the duration of incapacity (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

(13) Will the medical condition cause episodic flare-ups that will make it medically necessary for the employee to leave work intermittently or work a reduced schedule? ☐ Yes ☐ No

If yes, based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups, the likely duration of incapacity that the patient may have as a result, and the period during which the flare-ups may occur (e.g., 1 episode every 3 months lasting 1-2 days during the specified period):

Frequency: ____Times per _____week(s) ____month(s) | Duration: _______ Hours or _______ Day(s) per episode

Flare-ups may occur from: ___________________ through: ___________________

Part C: SIGNATURE

SIGNATURE OF HEALTH CARE PROVIDER	DATE

Serious Health Conditions

A "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves one of the following:

1. Inpatient Care

Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

2. Incapacity of More Than 3 Consecutive Days Plus Continuing Treatment by a Health Care Provider

A period of incapacity of more than three consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:

(a) Treatment two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; OR

(b) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider (e.g., a course of prescription medication, or therapy requiring special equipment, to resolve or alleviate the health condition). Note: This does not include taking over-the-counter medications or activities that can be initiated without a visit to a health care provider (e.g., bed rest, exercise, drinking fluids).

3. Pregnancy

A period of incapacity due to pregnancy, childbirth, or related medical conditions. This includes severe morning sickness and prenatal care.

4. Chronic Conditions Requiring Treatment

A chronic condition which:

(a) Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;

(b) Continues over an extended period of time (including recurring episodes of a single underlying condition); and

(c) May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

5. Permanent/Long-Term Conditions Requiring Supervision

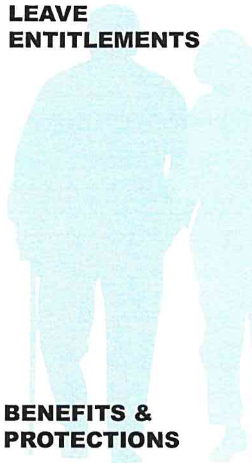
A period of incapacity that is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

6. Multiple Treatments (Non-Chronic Conditions)

Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.) severe arthritis (physical therapy), or kidney disease (dialysis).

EMPLOYEE RIGHTS
UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION



LEAVE ENTITLEMENTS

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within one year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

BENEFITS & PROTECTIONS

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

ELIGIBILITY REQUIREMENTS

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

REQUESTING LEAVE

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

EMPLOYER RESPONSIBILITIES

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

ENFORCEMENT

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division