



Family and Medical Leave Request

FAMILY MEMBER'S SERIOUS HEALTH CONDITION

Employer: Mat-Su Borough School District

Contact: Payroll Department

Phone: 907-761-4095

Fax: 907-761-4084

SECTION I: FOR COMPLETION BY THE EMPLOYEE

Instructions to the Employee: Please complete Section I before giving this form to your family member or his/her medical provider. The FMLA permits an employer to require that you submit a timely, complete and sufficient medical certification to support a request for FMLA leave to care for a covered family member with a 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 to your employer. 29 C.F.R. § 825.305.

Employee Name:

First

Middle

Last

Name 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 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 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 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. Page 4 provides space for additional information, should you need it. Please be sure to sign the form on the last page of your section (page 4).

Health Care Provider's name: _____

Business Address: _____

Telephone: () _____ Fax: () _____

PART A: MEDICAL FACTS (SECTION II CONTINUED...)

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? ☐ Yes ☐ No.

If so, dates of admission: _____

Date(s) you treated the patient for condition: _____

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

Will the patient need to have treatment visits at least twice per year due to the condition?
☐ Yes ☐ No

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? ☐ Yes ☐ No

If so, state the nature of such treatments and expected duration of treatment:

2. Is the medical condition pregnancy? ☐ Yes ☐ No. 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):

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? ☐ Yes ☐ No

Estimate the beginning and ending dates for the period of incapacity: _____

During this time, will the patient need care? ☐ Yes ☐ No

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? ☐ Yes ☐ No

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? ☐ Yes ☐ No

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:

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal, daily activities? ☐ 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 _____ days(s) per episode

Does the patient need care during these flare-ups? ☐ Yes ☐ No

Explain the care needed by the patient and why such care is medically necessary:

ADDITIONAL INFORMATION: Identify question number with your additional answer.

Name of Health Care Provider (printed)

Signature of Health Care Provider

Date



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SECTION III: EMPLOYEE COMPLETION DIRECTIONS AND SUPERVISOR APPROVAL

In accordance with federal and state mandated law, the Matanuska-Susitna Borough School District has instituted the ability for eligible employee's to request and take Family and Medical Leave. All documentation related to the employee's medical condition will be kept confidential and maintained in the employee's medical records file. The District may require additional information in order to process this request. If you have questions, contact Payroll.

Employee - Please bring completed form to the Payroll Department: After all information is filled out by you (employee), the physician (with signature), and this page (page 5) is signed by your supervisor/principal, bring this packet to Payroll for approval of leave request.

EMPLOYEE NAME: _____ **EMPLOYEE ID:** _____

Reason for Family/Medical Leave Request: FAMILY MEMBER'S SERIOUS HEALTH CONDITION

1. Begin and End Dates of Leave Request: Must be completed in order for request to be considered. (the employee shall have the responsibility to notify their Supervisor and the Payroll Department in the event any dates needed for Family Leave change.)

Begin Date: _____ End Date: _____

2. An intermittent or Reduced Leave Schedule may be requested for the serious illness of the employee or immediate family member, if medically necessary.

3. Employees must utilize all of their paid leave prior to leave without pay. Please indicate the categories of leave you plan to use while on Family and Medical Leave.

_____ Sick Leave _____ Floating Holidays _____ Leave Without Pay
_____ Personal Days _____ Sick Leave Bank

Address while on leave: _____

Phone number on leave: _____

Employee Signature

Date

Principal/Supervisor Signature

Date

Supervisory signature indicates knowledge of request. Official approval of request will come from the Payroll Department.