SELMA CITY SCHOOLS

LEARNING, APPLYING, ACHIEVING & DEVELOPING MINDS FOR WORLD SUCCESS

Complete forms FMLA-1 through FMLA 4. Sign and return to Human Resources at the Central Office
(P. O. Box 350, 2194 Broad Street, Selma, Al 36702-0350)
(P) 334-874-1600 (F) 334-874-1604

When the need for leave is foreseeable, the employee must apply for leave 30 days in advance. If the need for leave is unforeseen, the employee must provide such notice within 1-2 business days or when the need for leave becomes known. If the employee does not advise the supervisor or the appropriate designee that the reason for his or her leave was covered by FMLA, he or she has **two business days** upon returning to work to inform such supervisor or appropriate designee; otherwise, the employee may not subsequently assert FMLA protections. Failure to request Family and Medical Leave in a timely manner could result in the delay of your request.

You are required to furnish medical certification for a serious health condition for yourself (including pregnancy) or a family member. For your own medical leave, the certification must include information that you are or will be unable to perform one or more of the essential functions of your job.

I understand this is **unpaid leave** once all paid sick and catastrophic leave has been exhausted. I understand that my health insurance coverage will be maintained under the group health plan for the duration of the 12 weeks (60 contract days) of FMLA Leave at the same level and under the same conditions coverage would have been provided if no leave had been taken. Should I fail to return to work, the Board may recover from me the cost of any benefit coverage premium that was paid by the Board during my FMLA leave period.

I understand that FMLA is a period of 12 weeks (60 contract days) and medical/birth adoption leave may be extended up to one full year, provided my leave has not ended and I have not been returned to payroll status. Requests for extensions/changes must be submitted to human resources in writing.

You are responsible for timely payment of your portion of premiums for health and other benefits you elect to continue during leave. If you are in a paid status during any part of your leave, usual deductions will be made from your paycheck. If you are in an **unpaid status,** you must make arrangements to pay your usual contributions/payments.

If the premiums for insurance become past due for 30 days or more and a 15 day written notification is issued, coverage will be cancelled and cannot be reinstate until you return to paid status. Contact PEEHIP at member.services@rsa-al.gov, call toll free at 877-517-0020 or call local at 334-517-7000.

My signature below authorizes the release of my Certification of Health Care Provider and any other information needed to administer this request for Family and Medical Leave to Selma City Schools Board of Education. I have read and understand my rights under FMLA Leave.

_____ _____

Employee Signature Date

PRINT SAVE RESET

SELMA CITY SCHOOLS

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FAMILY MEDICAL LEAVE ACT

CONFIDENTIAL INFORMATION RELEASE

I, _____, hereby give permission to the Division of Human Resources, Selma City Schools, to discuss my medical condition with:

Dr._____

_____

_____

Address: _____

City, State, Zip _____

Phone Number: _____

_____

Employee Signature

_____

Date

PLEASE RETURN via FAX, EMAIL or MAIL TO

Fax: 334-874-1604

marcy.sherfield@selmacityschools.org **janet.bradley@selmacityschools.org**

Selma City Schools-Human Resources Department, P. O. Box 350 Selma, Al 36702-0350

PRINT SAVE RESET

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FAMILY MEDICAL LEAVE ACT

CERTIFICATION OF PHYSICIAN OR PRACTITIONER

Employee Name: _____

*Patient's Name (if other than Employee): _____

*Relationship to Employee: _____

Diagnosis:

_____

_____

Dates of Absence from work for this condition: _____

Probable Duration/Return to work: _____

Treatment Prescribed:

_____

_____

Additional
Comments:_____

_____

_____

……

For certification **RELATING TO ILLNESS OF THE EMPLOYEE,** please complete the following:

1. Is in-patient hospitalization of the employee required? ◯ Yes ◯ No
2. Is employee able to perform work of any kind? ◯ Yes ◯ No
3. Is employee able to perform the functions of his/her job? ◯ Yes ◯ No

   (Answer after reviewing statement from employer of essential functions of employee's position, or after discussing with employee)

*For certification **RELATING TO CARE FOR THE EMPLOYEE'S SERIOUSLY ILL FAMILY MEMBER** (parent, child, etc.), please complete the following as they apply to the family member:

1. Is the employee's presence necessary/beneficial for the care of the patient? ◯Yes ◯No

2. Probable duration of the need for employee's presence: _____

……

_____ _____

Signature of Physician or Practitioner Date

_____ _____

(Type or Print Name of Physician) Address

Professional Organization: _____

TO BE COMPLETED BY THE EMPLOYEE REQUESTING FAMILY MEDICAL LEAVE

When Family Medical Leave is needed, please state the reason you will be absent and the estimated time period.

_____

_____

_____

_____ _____

Employee's Signature Date

PLEASE RETURN via FAX, EMAIL, or MAIL TO:

Fax: 334-874-1604

marcy.sherfield@selmacityschools.org janet.bradley@selmacityschools.org

Selma City Schools, Human Resources Department, P. O. Box 350 Selma, Al 36702-0350

PRINT Reset SAVE

Selma City Schools

Selma, Alabama

Family and Medical Leave Request Form

To: Superintendent

From: Name: _____ SSN: _____

Date: _____ School / Location _____

Subject: Family and Medical Leave

Eligibility: To be eligible for Family and Medical Leave an employee must have been employed with the Board for at least 12 months and have worked for at least 1,250 hours during the past 12 months.

Reasons: Family and Medical Leave may be requested only for the following reasons:

a) Birth of a child
b) Adoption or placement of a child
c) Care of a sick spouse, child, or parent
d) Serious health condition of an employee

I hereby request Family and Medical Leave from my official duties due to the following reason:

- ☐ Birth of Child
- ☐ Placement of Foster Cnild
- ☐ Serious Personal Health Condition
- ☐ Adoption of a Child
- ☐ Care of a Sick Spouse
- ☐ Care of a Sick Child
- ☐ Care of a Sick Parent

I have read the certification section of the policy and have forwarded a statement from a state licensed medical doctor to central office personnel – ☐ Yes ☐ No

The expected date on which I would like to begin such leave is: _____ (MMDDYY)

The date on which I expect to resume my regular duties is _____ (MMDDYY)

Conditions for use of Accrued Leave Days: For the birth of a child, adoption of a child, care of a sick spouse, child, or parent, or serious health conditions of the employee, an employee may use accrued sick leave, personal leave, or vacation days as part of FMLA Leave.

I would like to use the following accumulated leave as a part of my approved Family and Medical Leave:

- ☐ Sick Leave — Number of days to be used _____.
- ☐ Personal Leave — Number of days to be used _____.
- ☐ Vacation Leave — Number of days to be used _____.
- ☐ Leave Without Pay — Number of days to be used _____.

Total Days 0.00.

Note: Use of accrued leave days must be approved in advance of beginning Family and Medical Leave.

I have forwarded post-dated check to payroll for the employee paid portion of the PEEHIP group health and / or supplemental premium. ☐ Yes ☐ No

I have read the Family and Medical Leave Policy and I am making this request being fully aware of its terms and conditions.

Signature: _____ Date: _____
Employee

Approved: _____ Date: _____
Superintendent