POLICY 403.5

TERMS OF EMPLOYMENT 403.5

Family and Medical Leave Policy

Family and medical leaves shall be allowed under the terms and conditions of the Family and Medical Leave Act of 1993 (FMLA).

The "leave year" for purposes of the FMLA shall be a "rolling" twelve-month period, measured backward from the date an employee uses any FMLA leave.

Substitution of accrued paid leaves for otherwise unpaid FMLA leaves may be required in the discretion of the Superintendent or the Board.

Employees shall be required to submit medical certifications to support a request for FMLA leave because of a serious health condition, or a sick leave, when such leave is for a duration in excess of five (5) successive days, and in such other cases as deemed appropriate by the Superintendent or the Board based on the nature of the illness or other circumstances surrounding the leave. Second and third medical opinions may, in the Superintendent or the Board's discretion, be required. Employees shall be required to report periodically, at such times as requested by the Superintendent or the Board, on their intent to return to work from FMLA leaves and other leaves. Employees shall be required to submit a fitness-for-duty certification from their health care provider as a condition of returning to work from a FMLA leave taken because of the employee's serious health condition, or from a sick leave taken by reason of the employee's illness, when such leave was of a duration in excess of five (5) successive days, and upon request of the Superintendent or the Board when such is deemed appropriate by the Superintendent or the Board based upon the nature of the illness or other circumstances surrounding the leave.

An "equivalent position" for FMLA restoration purposes shall, in the case of certificated employees, be any administrative, teaching, or instruction related position for which the employee is qualified by reason of endorsement, college preparation, or experience, or other indicia; in the case of coaching or other similar extracurricular duty assignments, be any extracurricular duty assignment, and in the case of other employees or positions, be in a position with or at equivalent pay, benefits, and working conditions, involving similar or related duties, as determined by the Superintendent or the Board.

Adopted: April 11, 2005
Reviewed: October 14, 2013

LEAVES AND ABSENCES

APPLICATION FOR LEAVE UNDER THE FAMILY AND MEDICAL LEAVE ACT

EMPLOYEE _____ POSITION _____

LEAVE REQUESTED From _____

To _____

If leave is requested on an intermittent or reduced leave schedule, describe the requested leave schedule:_____.

REASON FOR LEAVE (check and complete as appropriate):

___ A. Because of the birth of a son or daughter of mine and in order to care for such son or daughter.

___ B. Because of the placement of a son or daughter with me for adoption or child care.

___ C. In order to care for my spouse, son, daughter, or parent, who has a serious health care condition (name ill family member and briefly describe condition): _____.

__D. Because of a serious health care condition that makes me unable to perform the functions of my position (briefly describe condition): _____ _____.

LEAVE DEDUCTION

Your leave will be counted against your annual FMLA leave entitlement. The "leave year" is a "rolling" twelve-month period, measured backward from the date an employee last used an FMLA leave.

MEDICAL CERTIFICATION

If you checked Reasons C or D, you are requested to submit a written certificate from a health care provider (your ill family member's, for Reason C; your own for Reason D). The certification must be: (1) completed in substantial compliance with the Employer's "FMLA Certification of Physician or Practitioner" form, and (2) be submitted within 15 calendar days of your Application for Leave, or if such is not practicable under your

circumstances, within the earliest time possible using diligent, good faith efforts. Failure to submit a sufficient timely certification may result in your leave request being denied until or unless the certificate is submitted, and if you have commenced leave before the certificate was due, in the denial of continuation of your leave and in your absence being deemed unexcused.

REPORTS DURING LEAVE

During your leave, you will be required, upon employer's request, to provide: (1) subsequent recertifications of medical certifications and (2) reports on your status and your intent to return to work.

SUBSTITUTION OF PAID LEAVE

If you checked Reasons A, B, or C, you have the right to substitute your accrued paid vacation leave, personal leave, or family leave, if any, for the unpaid FMLA leave. If you checked Reasons C or D, you have the right to substitute your accrued paid vacation leave, personal leave, or medical or sick leave, if any, for the unpaid FMLA leave, provided, in the case of medical or sick leave, the employer would normally provide such paid leave in your situation. The employer will generally require the substitution of paid leave under circumstances where you could substitute paid leave.

HEALTH INSURANCE BENEFITS

Group health insurance benefits will be maintained during your leave, provided you pay the share of health plan premiums you paid prior to your leave, as may be adjusted due to changes in premium rates. To the extent substituted paid leave is used, your share of premiums will be paid by payroll deduction. To the extent the leave is unpaid, you must pay your share of premiums to the employer. Your payment must be received by the employer prior to the first day of each month during your leave.

If you fail to return to work after your FMLA leave entitlement is exhausted or expires, you will owe the employer's share of health insurance premiums, to the extent permitted by the FMLA, and the employer may deduct any sums otherwise due you to recover such debt, and use other legal means to collect such debt.

FITNESS-FOR-DUTY CERTIFICATE

If you checked Reason D, you will be required, prior to returning to work, to provide a certificate from your health care provider stating, in connection with the condition that caused your leave, that you are able to return to work.

RIGHT TO RESTORATION

Upon return from FMLA leave, you are entitled to be restored to the same position you held when the leave started, or to an equivalent position. The "equivalent position" is defined by School District policy. If you qualify as a "key" employee (an employee who is salaried and is among the highest paid 10 percent of employees within 75 miles of your

work site), you may be denied restoration after leave if restoration would cause substantial and grievous economic injury to the operations of the employer.

I certify that the above information given by me is correct and that I have read the foregoing and understand my rights under the FMLA.

DATED this ____ day of _____, 2_____.

BY: _____
Employee

Send notices to me at: _____

ACTION ON FMLA REQUEST

Your leave request dated the ____ day of _____, 200_, is _____ granted _____ denied, subject to your (check if applicable) _____ submitting sufficient medical certification within 15 calendar days of the above date. Substitution of paid leave will be made as follows:

___ days Vacation leave
___ days Personal leave
___ days Medical or Sick leave
___ a determination on substitution is unable to be made at this time; you will be notified when it is made

You _____ do _____ do not qualify as a "key" employee for FMLA restoration limitation purposes.

Comments: _____
_____.

DATED this ____ day of _____, 2008.

BY: _____
Superintendent
Kimball Public Schools
901 S. Nadine
Kimball, NE 69145

KIMBALL PUBLIC SCHOOL DISTRICT
FMLA CERTIFICATION OF HEALTH CARE PROVIDER

1. Employee's Name: _____

2. Patient's Name (If other than employee):_____

3. The attached sheet describes what is meant by a "serious health condition" under the Family and Medical Leave Act. Does the patient's condition[1] qualify under any of the categories described? If so, please check the applicable category.

(1)___ (2)___ (3)___ 4)___ (5)___ (6)___, or ____ None of the above

4. Describe the **medical facts** which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories:_____

5.a. State the approximate **date** the condition commenced, and the probable **duration** of the condition (and also the probable duration of the patient's present incapacity[2] if different): _____
_____

b. Will it be necessary for the employee to take work only **intermittently or to work on a less than full** schedule as a result of the condition (including for treatment described in Item 6 below): _____("yes" or "no")
If yes, give the probable duration: _____

c. If the condition is a **chronic condition** (condition #4) or **pregnancy**, state whether the patient is presently incapacitated[2] and the likely duration and frequency of **episodes of incapacity[2]: _____**
_____

[1] *Here and elsewhere on this form, the information sought relates **only** to the condition for which the employee is taking FMLA leave.*

[2] *"Incapacity," for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom.*

6.a. If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments.

If the patient will be absent from work or other daily activities because of **treatment** on an **intermittent** or **part-time** basis, also provide an estimate of the probable number and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery, if any: _____
_____

b. If any of these treatments will be provided by another **provider of health services** (e.g. physical therapist), please state the nature of the treatments. _____
_____

7.a. If medical leave is required for the employee's **absence from work** because of the **employee's own condition** (including absences due to pregnancy or a chronic condition), is the employee **unable to perform** work of any kind? _____("yes" or "no")

b. If able to perform some work, is the employee **unable to perform any one or more of the essential functions of the employee's job** (the employee or the employer should supply you with information about the essential job functions)? _____ If yes, please list the essential functions the employee is unable to perform:_____
_____

c. If neither a. nor b. applies, is it necessary for the employee to be **absent from work for treatment**?
_____

8.a. If leave is required to **care for a family member** of the employee with a serious health condition, **does the patient require assistance** for basic medical or personal needs or safety, or for transportation?
_____

b. If no, would the employee's presence to provide **psychological comfort** be beneficial to the patient or assist in the patient's recovery? _____

c. If the patient will need care only **intermittently** or on a part-time basis, please indicate the probable duration of this need:_____

_____ _____
(Signature of Health Care Provider) (Type of Practice)

_____ _____
(Address) (Telephone number)

To be completed by the employee needing family leave to care for a family member:
State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule:

_____

_____ _____
(Employee Signature) (Date)

Return upon completion to: Superintendent
Kimball Public Schools
901 S. Nadine
Kimball, NE 69145

ATTACHMENT TO FMLA CERTIFICATION OF HEALTH CARE PROVIDER

A "Serious Health Condition" means an illness, injury, impairment, or physical or mental condition that involves one of the following:

1. Hospital Care Inpatient care (i.e.,an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity[1] or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment (a)A period of incapacity[2] of more than three consecutive calendar days (including any subsequent treatment or period of incapacity[2] relating to the same condition), that also involves:
   (1) Treatment[2] 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
   (2) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment[3] under the supervision of the health care provider.

3. Pregnancy Any period of incapacity[2] due to pregnancy, or for prenatal care.

4. Chronic Conditions Requiring Treatments A chronic condition which:
   (1) 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;
   (2) Continues over an extended period of time (including recurring episodes of a single underlying condition); and
   (3) May cause episodic rather than a continuing period of incapacity[2] (e.g., asthma, diabetes, epilepsy, etc.).

5. Permanent/Long-term Conditions Requiring Supervision A period of incapacity[2] which is permanent or long-term due to a condition for which treatment may not be effective. The employee of 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 serve 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 case provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity[2] 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), kidney disease (dialysis).

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1 "Incapacity," for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom.

2 Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

3 A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.