THE SCHOOL BOARD OF SARASOTA COUNTY, FLORIDA
HUMAN RESOURCES
1960 LANDINGS BOULEVARD, SARASOTA, FLORIDA 34231
PHONE (941) 927-9000 FAX (941) 927-4087

REQUEST FOR FAMILY AND MEDICAL LEAVE (FMLA)

Instructions: Complete this form and submit it with appropriate attachments as outlined below to Human Resources.

I, _____, am requesting leave under the Family and
Employee Name (Print)

Medical Leave Act (FMLA) for _____ for the following reason:
(weeks/days)

Check one:

☐ Medical Employee – Attach Certificate of Health Care Provider Form WH-380-E (190-11-HMR)

☐ Medical Family Member – Attach Certificate of Health Care Provider Form WH-380-F (191-11-HMR)

☐ Birth of a child/child care/adoption/foster care
- Birth of child - Attach Certificate of Health Care Provider Form WH-380-E (190-11-HMR)
- Child care – (Child under one year of age) Attach copy of child's birth certificate
- Adoption/Foster care – Attach letter from attorney or agency verifying adoption/foster care

☐ Qualifying military exigency – Call Human Resources for information

My first day out of work was/will be _____
(Date)

I anticipate returning to work on _____
(Date)

Employee ID No. (A#) _____ SSN XXX-XX- _____

School/Dept _____

NOTE: By signing this document, I agree to the following: I have read and understand page 2 of 2 of this FMLA request; twelve weeks (60 days) is the maximum duration of FMLA leave, even though the total duration of the requested leave may be greater; all accrued sick days must be used concurrently at the start of FMLA leave; it is my responsibility to extend my leave (FMLA or otherwise) if the duration of my leave extends beyond what my physician indicates in questions 5, 6, or 7 on Form WH380E; I must get a release to return to work from my physician before returning to duty.

_____ _____
Employee Signature Date

HR Use Only			
Hire date		Total FMLA	
Hours worked		FMLA dates	
Notes:			

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REQUEST FOR FAMILY AND MEDICAL LEAVE (FMLA)

FMLA ELIGIBILITY

Requesting employee must have been employed by The School Board of Sarasota County for a total of 12 months, have worked at least 1,250 hours over the previous 12 months, and have not exceeded maximum FMLA eligibility within the previous 12 months.

FMLA QUALIFIED LEAVE REASONS

FMLA leave will be granted to eligible employees for the following reasons:

- the employee's own serious health condition
- the birth of a son or daughter and care of a newborn child (under one year of age)
- the adoption or foster care placement of a child (within the first 12 months following the event)
- to care for the employee's spouse, son, daughter, or parent with a serious health condition
- for qualifying exigencies arising out of the fact that the employee's spouse, son, daughter, or parent is on federal active duty or called to federal active duty status as a member of the regular armed forces or the National Guard or Reserve

  Definitions - "Parent": The biological, adoptive, step-, or foster care mother or father or someone who stands or stood *in loco parentis* to the employee when the employee was under the age of 18 or incapable of self-care. "Son" or "Daughter": A biological, adopted, or foster child, a stepchild, a legal ward, or a child of a person standing *in loco parentis*, under 18 years of age, or 18 years of age or older and incapable of self-care because of a mental or physical disability as defined by the ADA

  FMLA leave is available to both male and female employees who request leave for the birth or placement and care of a child as outlined above

FMLA SERIOUS HEALTH CONDITIONS

An illness, injury, impairment, or physical or mental condition (for more than three days) that involves either:

- inpatient care in a hospital, hospice or residential medical care facility, or;
- continuing treatment by a health care provider

Continuing treatment, In broad terms, means the following:

- A period of incapacity (i.e., inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment thereof, or recovery there from) of more than three consecutive calendar days (and any subsequent treatment or period of incapacity involving the same condition) involving treatment two or more times by a health care provider or treatment by a health care provider on at least one occasion that results in a regimen of continuing treatment under the health care provider's supervision.
- Any period of incapacity due to pregnancy or prenatal care.
- Any period of incapacity or treatment for such incapacity due to a chronic serious health condition that requires periodic visits for treatment by a health care provider; continues over an extended period of time; and may cause episodic rather than continuing incapacity (asthma, diabetes, epilepsy, etc.).
- A period of incapacity that is permanent or long-term due to a condition for which treatment may not be effective (Alzheimer's, severe stroke, terminal stages of a disease).
- Any period of absence to receive multiple treatments by a health care provider either for restorative surgery after an accident or 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 (chemotherapy for cancer, physical therapy for severe arthritis, or dialysis for kidney disease).

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CERTIFICATION OF HEALTH CARE PROVIDER FOR FAMILY MEMBER'S SERIOUS HEALTH CONDITION (FAMILY AND MEDICAL LEAVE ACT) FORM WH-380-F

For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Complete this section 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.

Employee Name _____

Employee ID No. (A#) _____ SSN XXX-XX- _____ School/Cost Center _____

Name of family member for whom you will provide care _____

Relationship of family member to you _____

If family member is your son or daughter, date of birth _____

Describe the care you will provide to your family member and estimate leave needed to provide care:

_____

_____

_____

_____

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. Your answer should be your best estimate 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 employee is seeking leave. Do not provide information about genetic tests [29 CFR 1635.3 (f)], genetic services [29 CFR 1635.3 (e)], or the manifestation of disease or disorder in the employee's family members [29 CRF 1635.3 (b)]. **Be sure to sign the form.**

Provider name and business address _____

Type of practice/medical specialty _____

Phone _____ Fax _____

_____ _____

Health Care Provider Signature Date

1. Is the medical condition pregnancy?
   - ☐ No (skip to question 4)
   - ☐ Yes (complete questions 2-3)
2. Expected delivery date _____
3. Estimate the beginning date of the period of incapacity _____. If date specified is one other than delivery date, explain the care needed by the patient and why such care (by the employee) is medically necessary:

_____

_____

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CERTIFICATION OF HEALTH CARE PROVIDER FOR FAMILY MEMBER'S SERIOUS HEALTH CONDITION
(FAMILY AND MEDICAL LEAVE ACT) FORM WH-380-F

Employee Name _____

The following questions are for medical conditions other than pregnancy.

4. Approximate date condition commenced _____

5. Probable duration of condition _____

6. Describe the relevant medical facts for which the patient needs care (such facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment). **This description will determine if this is a serious health condition FMLA qualifying event. If the answer is blank, this form will be returned to the employee and may cause interruption of insurance coverage.**

_____

_____

_____

_____

When answering this question, 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.

7. The patient will be incapacitated for a single **continuous** period of time due to his/her medical condition, including any time for treatment and recovery and will need care from _____ through _____.

Explain the continuous care needed by the patient and why such care (by the employee) is medically necessary:

_____

_____

_____

_____

The patient will be incapacitated on an **intermittent** basis due to his/her medical condition and will need intermittent care from _____ through _____.

Explain the intermittent care needed by the patient and why such care (by the employee) is medically necessary:

_____

_____

_____

_____