ALBERTVILLE CITY BOARD OF EDUCATION
LEAVE OF ABSENCE
CHECK LIST

- Leave of Absence Request form completed and signed by Principal

- FMLA form WH-380E (for employee) or WH-380F (for family) has been completed and submitted to the Central Office (see FMLA Fact Sheet)

- Medical Release form completed and submitted prior to returning to work. *Pursuant to Board Policy 5.9.3(e-4) , persons absent from work due to surgery, contagious disease or illness serious enough for extended physician's care must present a release from their physician upon return to the job*
  Medical Release not required for Normal Pregnancy and Delivery.

Employee Signature Date

Albertville City Board of Education

107 West Main Street
Albertville, Alabama 35950
Fax: (256) 891-6322
Phone: (256) 891-1183

LEAVE OF ABSENCE REQUEST FORM

Employee Name: _____ School: _____

Beginning Date of Leave: _____ Ending Date of Leave: _____

I will use the following days: (Please indicate the number of days)

_____ Sick _____ Sick Bank _____ Personal _____Unpaid _____Vacation

☐ Please check box if requesting FMLA Leave

_____ _____
(Employee's Signature) (Date)

_____ _____
(Principal's Signature) (Date)

FMLA FACT SHEET

The Family and Medical Leave Act of 1993 requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to "eligible" employees for certain family and medical reasons. Employees are eligible if they have worked for the Board of Education for at least 12 months, and for 1,250 hours over the previous 12-months.

Reasons for Taking Leave:

- To care for the employee's child after birth, or placement for adoption or foster care;[1]
- To care for the employee's spouse, son or daughter[1], or parent who has a serious health condition; or
- For a serious health condition[2] that makes the employee unable to perform his or her job
- At the employee's or employer's option, certain kinds of *paid* leave may be substituted for unpaid leave

Advance Notice and Medical Certification

- Employees seeking to use FMLA leave are required to provide 30-day advance notice of the need to take FMLA leave when the need is foreseeable and such notice is practicable.
- The Board requires that a request for leave based on the serious health condition of the employee, the employee's son, daughter, spouse or parent be supported by a certification issued by the appropriate health care provider, and may require second or third opinions at the Board's expense.
- Form WH-380-E or WH-380-F must be completed for FMLA leave
- The Board may require the employee to provide certification by the employee's health care provider that the employee is able to resume work.

Job Benefits and Protection

- For the duration of FMLA leave, the Board maintains the employee's health benefits under the same conditions these benefits would have been provided if no leave had been taken. If applicable, arrangements will need to be made for employees to pay their share of health insurance premiums while on leave.
- Upon return from FMLA leave, most employees are entitled to restoration to an equivalent position with equivalent pay, benefits, and conditions of employment.

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[1] Spouses employed by the Board are jointly entitled to a combined total of 12 work-weeks of family leave for the birth and care of the newborn child, placement of a child for adoption or foster care, and to care for a parent who has a serious health condition. The entitlement to leave for childcare expires at the end of the 12 month period beginning on the date of birth or placement.

[1] Entitlement for leave associated with illness of a child occurs only where the child is under 18 years of age or incapable of self-care due to mental or physical disability.

[2] A "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves (1) inpatient care in a hospital, hospice or residential medical care facility or (2) continuing treatment by a health care provider.

Albertville City Board of Education

Intent to Return to Work
and
Medical Release Form

_____
(Employee's Name)

Pursuant to my approved Leave of Absence Request, I affirm my intent to return to work on _____, as specified in my approved Leave of Absence Request Form.

_____ _____
(Employee's Signature) (Date)

If your absence was due to extended physician's care, please have your health care provider complete the following:

- ❑ The above named employee is fully released to return to work, without restrictions, on _____(date)
- ❑ The employee is released to work on _____ (date), but with the following restrictions: _____ until _____(date).

_____ _____
(Print name of Health Care Provider) (Type of Practice)

_____ _____
(Address) (Telephone)

_____ _____

_____ _____
(Signature of Health Care Provider) (Date)