WILLIAMSON COUNTY SCHOOLS
WCS Step By Step Sick Leave Guide

(1.) Once you learn that you need to take a leave of absence you will need to have your sick leave paperwork turned in to the HR Leaves Coordinator at least **30 days** before your expected leave date.

****Please note that your leave will be unpaid, unless you choose to use your accrued time off ****

(2.) Paperwork to complete:
- **Long Term Leave of Absence Application**
- **FMLA Physician's Form (Department of Labor) –** Physician will need to complete
- **Consent to Disclose** (optional)

Once you have completed the leave forms:

(3.) Submit forms to HR Leaves by either:
(a.) Faxing to 615.472.5618
(b.) Scanning and emailing to HRLeaves@wcs.edu
(c.) School Courier to HR Leaves Coordinator

(4.) Confirm your return-to-work date with HR Leaves Coordinator via email HRLeaves@wcs.edu

****ALL CHANGES MUST BE IN WRITING****

(5.) If you are needing to extend or revise your return date you will need to do the following:

- Provide the HR Leaves Coordinator with a note from the doctor reflecting the new dates of your leave.
- Provide the HR Leaves Coordinator with the return-to-work form completed by your physician.

Can I start my leave before the date the doctor listed on my FMLA forms?

- Your sick leave will begin the day the doctor indicates on your form.
- If you take days off prior to your first day of official leave, you will have one of the following options:
  - Provide the HR Leaves Coordinator with a letter from your medical doctor stating it was **"medically necessary"** for you to be off work. Sick days cannot be used unless HR has a note from your medical doctor.
  - Use personal days if this time off is **not** medically necessary.
  - Be unpaid for those days.

Can I work/Attend PD/Training while on leave?

- **No**. If an employee performs work in any position on either a part-time or full-time basis while on approved leave, the employee may be subject to disciplinary action, which could include termination.

Questions? Contact Us!
Human Resources Leaves Coordinator
HRLeaves@wcs.edu
Ph: 615.472.4051
Fax: 615.472.5618

Revised 01.29.2024

WILLIAMSON COUNTY SCHOOLS
MEDICAL LEAVE APPLICATION

(*Employee Name – Print*)	*(Employee #)*	*(School/Department)*

Position:_____ ; Full-Time Employee: ____ ; Part-Time Employee: ____

****Your leave information will be delivered to the primary email address on file with Human Resources. This email address will be how WCS communicates all leave information to you. This designation does not include information from the benefits department.****

Note 1: A LOA Form requesting 10 or more consecutive days (including personal, family, sick, maternity or adoption) and unpaid leave for medical reasons must also include a Family Medical Leave Act (FMLA) Employee Form or FMLA Family Form completed by a physician. These forms can be found on the internet under Staff/Employee Forms. **Regardless of whether an employee is or is not FMLA eligible, a physician's statement describing the condition, date condition commenced, and probable duration of incapacity must also be attached to this application. It is the responsibility of the employee to keep all leave dates current. Any revisions must include a physician's statement and be in writing.**

Note 2: Unpaid leaves may affect all state approved benefits (including experience credits, retirement, career ladder payments, sick, personal, and vacation days) and should be considered carefully before applying.

Note 3: Submit all LOA request, along with related forms and documentation such as physician's note, military orders, and student teaching verification to the HR Leaves Coordinator at least 30 days in advance (90 days is strongly recommended for maternity leave).

Note 4: No advances sick leave shall be allowed. Full-time classified employees earn sick leave at the rate of one (1) day per month for each full calendar month worked.

Leave Dates:_____ - _____ ; FMLA Eligible: ____ ; FMLA Ineligible: ____

Indicate below the number of paid and/or unpaid days/hours being requested:

- ☐ **Sick Leave Days: _____**
- ☐ **Personal Leave Days: _____**
- ☐ **Vacation Leave Days: _____ (12 month employees only)**
- ☐ **Unpaid Leave Days (See Note 2 above):_____**

I PLAN TO RETURN TO WORK ON:_____

Applicant's Signature:_____ ; Date:_____

Principal's/Supervisor's Signature:_____ ; Date:_____ ; Approved ____ ; Denied ____

SUBMIT TO HR LEAVES COORDINATOR FOR FURTHER PROCESSING

EN: _____; LOA Approved:____; LOA Denied: ____

HR Leaves Coordinator: _____ ; Date: _____

Certification of Health Care Provider for Employee's Serious Health Condition under the Family and Medical Leave Act

U.S. Department of Labor
Wage and Hour Division

WAGE AND HOUR DIVISION

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR. RETURN TO THE PATIENT.

OMB Control Number: 1235-0003
Expires: 6/30/2026

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. 29 U.S.C. §§ 2613, 2614(c)(3); 29 C.F.R. § 825.305. The employer must give the employee at least 15 calendar days to provide the certification. If the employee fails to provide complete and sufficient medical certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

SECTION I - EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, this form asks the health care provider for the information necessary for a complete and sufficient medical certification, which is set out at 29 C.F.R. § 825.306. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308.** Additionally, you **may not** request a certification for FMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care.

Employers must generally maintain records and documents relating to medical information, medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

(1) Employee name: _____
First Middle Last

(2) Employer name: WCS BOE Fax: 615-472-5618 Date: _____ (mm/dd/yyyy)
(List date certification requested)

(3) The medical certification must be returned by _____ (mm/dd/yyyy)
(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee's diligent, good faith efforts.)

(4) Employee's job title: _____ Job description ☐ is / ☐ is not attached.

Employee's regular work schedule: _____

Statement of the employee's essential job functions:

_____

(The essential functions of the employee's position are determined with reference to the position the employee held at the time the employee notified the employer of the need for leave or the leave started, whichever is earlier.)

SECTION II - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form. Your patient has requested leave under the FMLA. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of the employee. For FMLA purposes, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves **inpatient care** or **continuing treatment by a health care provider**. For more information about the definitions of a serious health condition under the FMLA, see the chart on page 4.

You also may, but are **not required** to, provide other appropriate medical facts including symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment. Please note that some state or local laws may not allow disclosure of private medical information about the patient's serious health condition, such as providing the diagnosis and/or course of treatment.

Employee Name: _____

Health Care Provider's name: (Print) _____

Health Care Provider's business address: _____

Type of practice / Medical specialty: _____

Telephone: _____ Fax: _____ E-mail: _____

PART A: Medical Information

Limit your response to the medical condition(s) for which the employee is seeking FMLA leave. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. **After completing Part A, complete Part B to provide information about the amount of leave needed.** Note: For FMLA purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

(1) State the approximate date the condition started or will start: _____ (mm/dd/yyyy)

(2) Provide your **best estimate** of how long the condition lasted or will last: _____

(3) Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

☐ **Inpatient Care**: The patient (☐ has been / ☐ is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): _____

☐ **Incapacity plus Treatment**: (e.g. outpatient surgery, strep throat)

Due to the condition, the patient (☐ has been / ☐ is expected to be) incapacitated for **more than** three consecutive, full calendar days from: _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy).

The patient (☐ was / ☐ will be) seen on the following date(s): _____

_____

The condition (☐ has / ☐ has not) also resulted in a course of continuing treatment under the supervision of a health care provider (e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment).

☐ **Pregnancy**: The condition is pregnancy. List the expected delivery date: _____ (mm/dd/yyyy).

☐ **Chronic Conditions**: (e.g. asthma, migraine headaches) Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

☐ **Permanent or Long Term Conditions**: (e.g. Alzheimer's, terminal stages of cancer) Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

☐ **Conditions requiring Multiple Treatments**: (e.g. chemotherapy treatments, restorative surgery) Due to the condition, it is medically necessary for the patient to receive multiple treatments.

☐ **None of the above**: If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed. Go to page 4 to sign and date the form.

Employee Name: _____

(4) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. (e.g., use of nebulizer, dialysis)

_____

_____

PART B: Amount of Leave Needed

For the medical condition(s) checked in Part A, complete all that apply. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. 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.

(5) Due to the condition, the patient (☐ had / ☐ will have) **planned medical treatment(s)** (scheduled medical visits) (e.g.psychotherapy, prenatal appointments) on the following date(s): _____

_____

(6) Due to the condition, the patient (☐ was / ☐ will be) **referred to other health care provider(s)** for evaluation or treatment(s).

State the nature of such treatments: (e.g. cardiologist, physical therapy) _____

Provide your **best estimate** of the beginning date _____ (mm/dd/yyyy) and end date _____ (mm/dd/yyyy). for the treatment(s).

Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery (e.g. 3 days/week)

_____

_____

(7) Due to the condition, it is medically necessary for the employee to work a **reduced schedule**.

Provide your **best estimate** of the reduced schedule the employee is able to work. From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy) the employee is able to work: (e.g., 5 hours/day, up to 25 hours a week)

_____

(8) Due to the condition, the patient (☐ was / ☐ will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.

Provide your **best estimate** of the beginning date _____ (mm/dd/yyyy) and end date _____ (mm/dd/yyyy). for the period of incapacity.

(9) Due to the condition, it (☐ was / ☐ is / ☐ will be) medically necessary for the employee to be absent from work on an intermittent basis (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, episodes of incapacity are estimated to occur _____ times per (☐ day ☐ week ☐ month) and are likely to last approximately _____ (☐ hours ☐ days) per episode.

Employee Name: _____

PART C: Essential Job Functions

If provided, the information in Section I question #4 may be used to answer this question. If the employer fails to provide a statement of the employee's essential functions or a job description, answer these questions based upon the employee's own description of the essential job functions. An employee who must be absent from work to receive medical treatment(s), such as scheduled medical visits, for a serious health condition is considered to be **not able** to perform the essential job functions of the position during the absence for treatment(s).

(10) Due to the condition, the employee (☐ was not able / ☐ is not able / ☐ will not be able) to perform **one or more** of the essential job function(s). Identify at least one essential job function the employee is not able to perform:

_____

_____

Signature of Health Care Provider _____ Date: _____ (mm/dd/yyyy)

Definitions of a Serious Health Condition (See 29 C.F.R. §§ 825.113-.115)
Inpatient Care
• An overnight stay in a hospital, hospice, or residential medical care facility. • Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.
Continuing Treatment by a Health Care Provider (any one or more of the following)
Incapacity Plus Treatment: A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either: o Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or, o At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.
Pregnancy: Any period of incapacity due to pregnancy or for prenatal care. _____
Chronic Conditions: Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.
Permanent or Long-term Conditions: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.
Conditions Requiring Multiple Treatments: Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 15 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR. RETURN TO THE PATIENT.

WILLIAMSON COUNTY SCHOOLS

Authorization of designation for Release of Medical Information to a Family Member, Friend Or Legal Representative

Williamson County Schools • Human Resources
1320 West Main Street, Suite 202 • Franklin, TN • 37064

Williamson County Government • Benefits Department
1320 West Main Street, Suite 204 B • Franklin, TN • 37064

SECTION A: The employee who is requesting this authorization or appointment

*Name: _____

*Address: _____

Phone: _____ Email: _____

*Social Security Number/ Employee Number: _____

Appointment of Personal Representative (if applicable). I appoint the individual named below to act on my behalf as Personal Representative:

Personal Representative's Name: _____ Relationship: _____

SECTION B: Please read and complete the following statements carefully

***What health information can we disclose? (**Check all that apply)

- ☐ Insurance Records
- ☐ My records pertaining to my retirement
- ☐ My records pertaining to FMLA or leave of absence
- ☐ My records pertaining to COBRA
- ☐ My records regarding payroll
- ☐ Other reason: _____
  (Be specific, we will only share the health information you tell us we can share)

***Expiration:** This authorization will expire. Choose an expiration date or give an expiration event that relates to the purpose of this release (i.e. when I retire, if I am terminated or resign my position, when I return from leave of absence.)

On _____ - _____ - _____

On occurrence of the following event: _____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to Williamson County Schools Human Resources office and Williamson County Government – Benefits Office. I understand that revocation of this authorization WILL NOT affect any action taken in reliance on this authorization before you receive my written notice of revocation. Revocations can be mailed or emailed to:

Williamson County Schools
Human Resources
1320 West Main Street, Suite 202
Franklin, TN 37064
HRLeaves@wcs.edu

****IMPORTANT**** If you choose to use electronic communications there is a risk. Confidentiality of information sent via the internet cannot be guaranteed. You may submit this authorization via email, but you do so assuming this risk.

Redisclosure: I understand that information disclosed by this authorization may be subject to redisclosure by the recipient and may no longer be protected under the Health Insurance Portability and Accountability Act (HIPPA Privacy Rule.)

SECTION C: SIGNATURE – YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

I, _____, have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization that Benefits Administration may release the protected health information described in this form for the purposes stated in this form.

_____ _____
Employee Signature Date

WILLIAMSON COUNTY SCHOOLS

WCS RELEASE TO RETURN TO WORK

The Release to Return to Work Form must be completed when an employee is released to return to work following a leave of absence as a result of an injury or illness.
This form must be completed before the employee can return to work.

Patient Name: _____

Is released to return to work on: _____
Date

☐ No Restrictions

☐ With Restrictions

Restrictions Requested: _____

Dates of restriction(s): _____

_____ _____
Health Care Provider Telephone Number

_____ _____
Physician Signature Date

Questions? Contact Us!
Human Resources Leaves Coordinator
HRLeaves@wcs.edu
Ph: 615.472.4051
Fax: 615.472.5618