



## WILLIAMSON COUNTY SCHOOLS

### WCS Step By Step Sick Leave Guide

- (1.) Once you learn that you are needing to take a leave of absence you will need to have your sick leave paperwork turned in to Employee Relations 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**
  - **Consent to Disclose** (optional)

**Once you have completed the leave forms:**

- (3.) Submit forms to Employee Relations (**Kayla Aaron**) by either:
- (a.) Faxing to: 615.472.5618
  - (b.) Scanning and emailing
  - (c.) School Courier
- (4.) Confirm your return to work date with Employee Relations via email [Kayla.Aaron@wcs.edu](mailto:Kayla.Aaron@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 Employee Relations with a note from the doctor reflecting the new dates of your leave.
  - Provide Employee Relations 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 indicated on your form.
- If you take days off prior to your first day of official leave, you will have one of the following options:
  - o Provide Employee Relations with a letter from your medical doctor stating it was **“medically necessary”** for you to be off work. Sick days cannot be used unless Employee Relations has a note from your medical doctor.
  - o Use personal days if this time off is **not** medically necessary.
  - o 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  
Kayla Aaron, Employee Relations Coordinator  
[Kayla.Aaron@wcs.edu](mailto:Kayla.Aaron@wcs.edu)

Ph: 615.472.4051  
Fx: 615.472.5618



**WILLIAMSON COUNTY SCHOOLS**  
**LONG TERM LEAVE OF ABSENCE**  
**APPLICATION FOR 10 OR MORE DAYS**

**MEDICAL LEAVE**

\_\_\_\_\_  
*(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.\*\***

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|----------------|---|
| <b>Note 1:</b> | 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. <b>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.</b> |
| <b>Note 2:</b> | Unpaid leaves may affect all state approved benefits (including experience credits; retirement; Career Ladder payments; sick; personal and vacations days) and should be considered carefully before applying.  |
| <b>Note 3:</b> | To apply for Sick Bank days a Sick Bank Application must be submitted with the LOA and FMLA Forms. An employee can only request 20 days per application. For additional information regarding Sick Bank, see School Board Policy 5.3021 for teachers. It is the responsibility of the employee to request additional Sick Bank Days.  |
| <b>Note 4:</b> | Under Tennessee law, if a teacher has not yet attained tenure status, any time spent on leave of absence, except accumulated sick leave days described in T.C.A. 49-5-710, shall not be credited towards the time of service required to attain tenure status. For example, use of Sick Bank days, any unpaid family medical leave, and other leaves of absence are not credited for tenure purposes.   |
| <b>Note 5:</b> | Submit all LOA request, along with related forms and documentation such as physician’s note, military orders, and student teaching verification to Employee Relations at least 30 days in advance (90 days is strongly recommended for maternity leave).  |

**LEAVE DATES (see NOTE 1 above):**

**Leave Dates:** \_\_\_\_\_ - \_\_\_\_\_ ; **FMLA Eligible:** \_\_\_\_\_ ; **FMLA Ineligible:** \_\_\_\_\_

<p><b>Indicate below the number of paid and/or unpaid days/hours being requested:</b></p> <p><b>Sick Leave Days/Hours:</b> _____</p> <p><b>Personal Leave Days/Hours:</b> _____</p> <p><b>Local Leave Days/Hours:</b> _____ (Teachers only)</p> <p><b>Vacation Leave Days/Hours:</b> _____ (12 month employees only)</p> <p><b>Unpaid Leave Days/Hours (See Note 2 above):</b> _____</p> <p><b>Sick Bank Days/Hours (See Note 3 above):</b> _____</p>
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**I PLAN TO RETURN TO WORK ON:** \_\_\_\_\_

Substitute required: \_\_\_\_\_ Yes; \_\_\_\_\_ No; Applicant’s Signature: \_\_\_\_\_ ; Date: \_\_\_\_\_

Principal’s/Supervisor’s Signature: \_\_\_\_\_ ; Date: \_\_\_\_\_ ; Approved \_\_\_\_\_ ; Denied \_\_\_\_\_

**SUBMIT TO EMPLOYEE RELATIONS FOR FURTHER PROCESSING**

Employee Relations Coordinator: \_\_\_\_\_ ; Date: \_\_\_\_\_ ; Approved \_\_\_\_\_ ; Denied \_\_\_\_\_

**Williamson County Schools**  
**Certification of Health Care Provider for**  
**Employee's Serious Health Condition**  
**(FMLA Ineligible)**

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RETURN TO THE PATIENT.

**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.

Employers must generally maintain records and documents relating to medical information, medical certifications, recertifications, or medical histories of employees as confidential medical records in separate files/records from the usual personnel files.

(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 below. Your patient has requested a leave of absence from work. For leave 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*.

You 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.

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 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 leave 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.

Employee Name: \_\_\_\_\_

(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.

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 a leave of absence.

(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): \_\_\_\_\_

Employee Name: \_\_\_\_\_

- (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.

### **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)



**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 COBRA

My records pertaining to my retirement

My records regarding payroll

My records pertaining to FMLA or leave of absence

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 received 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  
[Kayla.Aaron@wcs.edu](mailto:Kayla.Aaron@wcs.edu)

**\*\*IMPORTANT\*\*** If you chose 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**  
**Kayla Aaron, Employee Relations Coordinator**  
[Kayla.Aaron@wcs.edu](mailto:Kayla.Aaron@wcs.edu)

615.472.4051