WILLIAMSON COUNTY SCHOOLS

WCS Step By Step Family Leave Guide

(1.) Once you learn that you need to take a leave of absence for a family member, you will need to have your Family 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 Family Physician's Form (Department of Labor)** – Physician will need to complete

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

****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 your family member's doctor reflecting the new dates of your family leave.
- Email Employee Relations Coordinator **(Kayla Aaron)** with your new anticipated return to work date if returning earlier than anticipated return date.

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

- Your family leave will begin the day the doctor indicated on the FMLA family form.
- If you take days off prior to your first day of family leave, you will have one of the following options:
  - Provide Employee Relations with a letter from your family member's medical doctor stating you needed to be off to care for your family member. Sick days cannot be used unless Employee Relations has a note from your family member's 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
Kayla Aaron, Employee Relations Coordinator
Kayla.Aaron@wcs.edu
Ph: 615.472.4051
Fx: 615.472.5618

WILLIAMSON COUNTY SCHOOLS
FAMILY 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: To apply for Sick Bank days a Sick Bank Application must be submitted with LOA and FMLA Forms. An employee can only request 20 days per application. For additional information regarding Sick Bank, see School Board Policy 5.3201 for teachers. It is the responsibility of the employee to request additional Sick Bank Days.

Note 4: Under Tennessee law, if a teacher has not yet attained tenure status, any time spent on a 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.

Note 5: 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:_____ - _____ **; FMLA Eligible: ____ ; FMLA Ineligible: ____**

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

- ☐ **Sick Leave Days:** _____
- ☐ **Personal Leave Days:** _____
- ☐ **Local Leave Days:** _____
- ☐ **Vacation Leave Days:** _____ **(12 month employees only)**
- ☐ **Unpaid Leave Days (See Note 2 above):**_____
- ☐ **Sick Bank Leave Days (See Note 3 above):**_____

I PLAN TO RETURN TO WORK ON:_____

Applicant's Signature:_____ ; Date:_____

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

SUBMIT TO EMPLOYEE RELATIONS FOR FURTHER PROCESSING

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

Employee Relations Coordinator:_____ ; Date: _____

Williamson County Schools

Certification of Health Care Provider for Family Member's Serious Health Condition (FMLA Ineligible)

RETURN TO THE PATIENT. Expires: 6/30/2026

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 or employees' family members 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.)

SECTION II - EMPLOYEE

Please complete and sign Section II before providing this form to your family member or your family member's health care provider. **You are responsible for making sure the medical certification is provided to your employer within the time frame requested, which must be at least 15 calendar days.**

(1) Name of the family member for whom you will provide care: _____

(2) Select the relationship of the family member to you. The family member is your:

☐ Spouse ☐ Parent ☐ Child, under age 18

☐ Child, age 18 or older and incapable of self-care because of a mental or physical disability

Spouse means a husband or wife as defined or recognized in the state where the individual was married, including in a common law marriage or same-sex marriage. The terms "child" and "parent" include in loco parentis relationships in which a person assumes the obligations of a parent to a child. An employee may take leave to care for an individual who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take leave to care for a child for whom the employee has assumed the obligations of a parent. No legal or biological relationship is necessary.

(3) Briefly describe the care you will provide to your family member: (**Check all that apply**)

☐ Assistance with basic medical, hygienic, nutritional, or safety needs ☐ Transportation

☐ Physical Care ☐ Psychological Comfort ☐ Other: _____

(4) Give your **best estimate** of the amount of leave needed to provide the care described: _____

(5) If a **reduced work schedule** is necessary to provide the care described, give your **best estimate** of the reduced schedule you are able to work. From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy), I am able to work _____ (hours per day) _____ (days per week)

Employee Signature _____ **Date** _____ (mm/dd/yyyy)

Employee Name: _____

SECTION III - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form below. A family member of your patient has requested a leave from work to care for your patient. 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 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.

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 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.

(1) Patient's Name: _____

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

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

(4) For leave to apply, care of the patient must be medically necessary. Briefly describe the type of care needed by the patient (e.g., assistance with basic medical, hygienic, nutritional, safety, transportation needs, physical care, or psychological comfort).

_____

_____

(5) 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: _____

(6) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks 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.

(7) 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): _____

_____

(8) 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)

_____

(9) 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.

(10) Due to the condition, it (☐ was / ☐ is / ☐ will be) medically necessary for the employee to be absent from work to

provide care for the patient 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.

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