WILLIAMSON COUNTY SCHOOLS

WCS Step By Step Paternity Leave Guide

(1.) Once you learn that your spouse/partner is pregnant, you will need to have your Paternity leave paperwork turned in to Human Resources **3 months** before their expected due 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** (leave start date is their expected delivery date…Yes, this date may change)
- **FMLA Family Physician's Form**
- **Consent to Disclose Form** (optional)

Once baby has arrived:

(3.) Submit proof of birth to Emploee Relations **(Kayla Aaron)** by submitting either:

(a.) Copy of the baby's birth certificate (hospital issued copy is fine)

(b.) Note from their physician confirming the baby's date of birth.

(4.) Confirm your return to work date with the Employee Relations Coordinator via email Kayla.Aaron@wcs.edu

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

(5.) If you are wanting to add your baby to your health insurance you will need to do the following:

- Provide the Benefits Department with a copy of the baby's birth certificate.
- Turn in a **"Life Changing Event Form"**
- Turn both of the above documents in to wcs.loa@wcs.edu in the Benefits Department **no later than 31 days** after the baby is born.

Can I start my leave before the baby is born?

- Your Paternity leave will begin the day your baby is born.
- If you take days off prior to the birth of your child that is **not** medically necessary, you will have one of the following options:
  - Use personal days.
  - 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.

Will going on leave affect me from receiving an evaluation score?

- ****If an educator is out for a total of 61 or more days, their full evaluation will not be recorded in TN Compass. Per state statute you can earn a level of effectiveness.** http://team-tn.org/wp-content/uploads/2013/10/Partial-Year-Exemptions_2017.pdf

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
LONG TERM LEAVE OF ABSENCE
APPLICATION FOR 10 OR MORE DAYS

PATERNITY 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.****

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 vacations days) and should be considered carefully before applying.
Note 3:	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.
Note 4:	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:____

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

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

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
Family Member's Serious Health Condition
(FMLA Ineligible)

RETURN TO THE PATIENT. Expires: 6/30/2023

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 FMLA 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 FMLA 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 FMLA 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)*.

Employee Name: _____

- ☐ **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.

(6) 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.

(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)*

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 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

****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