PASSAIC VALLEY REGIONAL HIGH SCHOOL

100 EAST MAIN STREET, LITTLE FALLS, NEW JERSEY 07424

Complete all forms (Medical Leave Request and Certification for Health Care Provider) to begin the leave application process. Submit completed forms to the superintendent's office by fax at 973-890-2562 or hand delivery.

Medical Leave Request

Please Print

Employee Name: _____ **Employee Id:** _____

Mailing Address: _____

Phone: _____ **Job Title /Position** _____

Email Address: _____

Requesting Medical Leave for the following reason:

Select one: ☐ Birth/Adoption of Child ☐ Care for Family Member ☐ Self Serious Health Condition ☐ Military Service care

Duration of leave: ☐ Continuous or ☐ Intermittent

Estimated Leave Start Date: **Estimated Return to Work Date:**

Continuation of Benefits

Select one	☐ Continue Benefits	If continue is selected, the employee must establish a payment plan prior to the start of unpaid leave. Contact the business office at 973-890-2510 to speak with the Business Administrator to set up the plan. If the payment plan is not in place prior to the beginning of one's unpaid leave, Passaic Valley Regional High School has the right discontinue benefits regardless of selection.
	☐ Discontinue Benefits	

I understand and agree to the following:

- I have met the requirement of working 12 months and worked at least 1,250 hours in the previous 12 months.
- I understand that Leave is taken concurrently with any other leave pursuant to Board Policy 3431.1.
- I understand that FMLA or NJFLA is an unpaid leave, and I am required to substitute personal leave time as regulations require. I will continue to receive a paycheck until all approved leave time is exhausted.
- My benefits coverage at the time of Leave will remain intact unless I choose to change or discontinue benefits. I am responsible for premium deductions while on leave.
- Contact the superintendent's office if you have eligibility concerns or for more information

Fax Completed Form to the Superintendent's office at 973-890-2562 or hand deliver.

_____

Employee Signature *Date*

Office Use Only

Authorized Signature _____ Date: _____

☐ Approved ☐ Denied Comments:

BOE Approval/Denied _____ Date: _____

Certification for Health Care Provider: Care of Family Member/Self

Please Print

SECTION I: For completion by the EMPLOYEE **Employee ID: _____**

Last Name: _____First Name: _____Middle Initial: __

1. Name of family member for whom you will provide care: _____

2. Relationship of family member to you: _____

a. **If family member is your son or daughter, please indicate date of birth:** _____ /_____ / _____ (MM/DD/YYYY)

Request is for (check one): _____Continuous Leave _____Intermittent Leave

3. Describe care you will provide to your family member and estimate duration of leave needed to provide care:

_____
_____
_____
_____

SECTION II: For completion by the HEALTH CARE PROVIDER

Instructions for the Health Care Provider: Our employee has requested leave under the FMLA/NJFLA. Answer, fully and completely, all applicable parts. 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/NJFLA coverage. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form.

Provider's name *(Print)*_____
Type of practice/medical specialty _____
Provider's business address_____
Telephone ( ) _____ Fax ( ) _____

PART A: AMOUNT OF LEAVE NEEDED When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care.

1. Will the patient be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment/recovery? __ *Yes* __ *No*

a. If so, estimate the beginning and ending dates for the period of incapacity.

_____

b. During this time, will the patient need care? __ Yes __ No

If so, explain the care needed by the patient and why such care is medically necessary.

_____
_____

Employee Signature:_____ Date: _____

Certification for Health Care Provider: Care of Family Member/Self

Please Print

SECTION II: Continued

2. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the patient's medical condition? __ *Yes* __ *No*

a. *If so, are the treatments or the reduced number of hours of work medically necessary? __ Yes __ No*

3. Estimate treatment schedule, if any, including dates of any scheduled appointments and the time required for each appointment, including any recovery period.

_____

_____

PART B: MEDICAL FACTS

1. Approximate patient's date condition commenced ___ /___ /_____ (MM/DD/YYYY)

2. Probable duration of condition _____

Mark below as applicable:

3. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave for care of a family member (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment): _____

_____

a. Estimate treatment schedule, if any, including dates of any scheduled appointments and the time required for each appointment, including any recovery period.

_____

_____

Additional Information

_____

_____

_____

_____ _____

Health Care Provider Signature Date *Date*

Return completed forms to the Superintendent's office or fax: 973-890-2562