EXTENDED LEAVE OF ABSENCE

This contains the information and forms necessary for requesting an Extended Leave of Absence.

- Important Leave of Absence Information
- Family and Medical Leave Act (FMLA)
- Medical and Optional Insurance Benefits
- Standard Insurance Company-Waiver of Premium
- Instructions for Leave of Absence
- Application for Extended Leave
- Certification of Health Care Provider (Form WH-380-E)
- Fitness for Duty Certification (Medical Release Form)

For any questions, contact:

DUVAL COUNTY PUBLIC SCHOOLS
Extended Leave Office
1701 Prudential Drive
Jacksonville, Florida 32207

Phone: (904) 390-2065
Fax: (904) 858-3570

Revised August 1, 2015
This information covers the major issues involved in the Extended Leave process.

FIRST CONTACT: Contacting the Extended Leave Office at (904) 390-2065 is your first step. They will answer all questions about extended leave, determine what type of leave that you qualify for and provide the necessary paperwork to apply for leave.

EMPLOYEE BENEFITS: Being on Extended Leave will affect your benefits. You will need to call Employee Benefits at (904) 390-2887 to discuss continuing or dropping any current benefits while you are on leave. When you return to work, you will also contact Employee Benefits to reinstate your benefits and discuss any adjustments that may be necessary.

SICK LEAVE/ANNUAL LEAVE: You will be required to use all available leave before starting extended leave. Not all sick leave is available to be used. You can check with your work location or the Payroll Department for your available leave balance.

DIRECT DEPOSIT: Once you have been placed on extended leave, you will be taken off direct deposit. The final check that you receive will be a “paper” check. Reinstating your direct deposit is part of the return from leave process.

EQUALIZATION: If you are on an equalized pay plan, the balance in your equalization account will be adjusted on the final check. When you return from leave, adjustments may also be necessary to get you back on the proper schedule. Contact the Payroll Department for more information.

OPTIONAL PAY: If you are on the optional pay plan (which pays you additional checks during the summer), the balance in the Equalization account at the time you are placed on leave will be paid out to you on your final check. When you return from leave, you will be placed back on the regular pay plan for the remainder of the school year. At the end of the school year, you MUST sign up for the optional pay plan, if you choose, for the next school year.

SHORT TERM DISABILITY: If you purchased a Short Term Disability Income Protection Policy, you will need to call the UNUM Claim Office at 1-888-857-0157 to file your claim.

RETURN FROM LEAVE: Once you have been released by your doctor to return to work, you must come to the Extended Leave Office prior to returning to your work location with the doctor’s release and a voided check to reinstate your direct deposit. Completed paperwork will be sent to HR Staffing for placement.
The Family and Medical Leave Act of 1993 (FMLA) allows eligible employees of a covered employer to take job-protected, unpaid leave for up to a total of 12 workweeks in any 12 months.

**How do I qualify for FMLA?**

To be eligible for FMLA, an employee must meet the following qualifications:
- Has worked for DCPS for at least 12 months at the time the leave is to commence
- Has worked at least 1250 hours during the 12 month period prior to leave start date

**What can FMLA be used for?**

A leave of absence under FMLA can be used for the following reasons:
- Birth of a child and care for the newborn child
- Placement with the employee of a child for adoption or foster care
- Serious health condition of the employee
- Care for employee’s spouse, child or parent with a serious health condition
- Qualifying exigency arising out of the fact that the employee’s spouse, child or parent is a covered military member on active duty (special paperwork is required)

**What rights or protections does FMLA leave offer?**

- You have a right under FMLA for up to 12 weeks of unpaid leave in a 12 month period
- Your basic health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work
- You must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA leave.

**How do I apply for FMLA leave?**

- Complete an extended leave application
- Submit the “Certification of Health Care Provider” form completed by your physician

For more information on the Family and Medical Leave Act, go to [www.dol.gov](http://www.dol.gov)
MEDICAL AND OPTIONAL INSURANCE BENEFITS

PLEASE CONTACT EMPLOYEE BENEFITS AT 390-2887 FOR THE FOLLOWING:

- Employees can continue all benefits while on Leave of Absence (LOA) or terminate some or all benefits while on LOA.
- To add a new dependent or drop your benefit coverage(s) while on LOA, please contact the Employee Benefits Dept. to complete an enrollment form.
- If you are enrolled in Short/Long Term Disability and want to file a claim, you must contact UNUM Insurance Company at 800-633-7479. To file claim using the telephonic claim process call 1-888-857-0157. REMEMBER: SHORT TERM DISABILITY INCOME IS NOT CONSIDERED INCOME FROM DCPS.
- You MUST notify Employee Benefits upon your return to work.

PAYING FOR BENEFITS WHILE ON LOA:

FBMC Benefits Management, Inc. will bill for all benefits while on LOA. Once they are notified of your LOA, they will mail out coupons billing for all current benefits. The coupons will list the amount due and due date.

- **Coupons are due on the 1st and 16th of each month.** Coupons are set up like DCPS payroll deductions and amounts coincide with those deductions.
- Based on what day of the month you go on LOA determines the date of your first coupon. Pay close attention to that date due.
- If payment is not made by the 5th day after the coupon due date, benefits will be termed back to the last day of the prior month.
- Employees on FMLA but enrolled in the Contributory Medical Plan must pay the employee portion of the premium to keep the medical coverage effective. If the employee portion is not paid, the medical coverage will be terminated at the end of the prior month payment was not made.
- If you request to term your benefits or they are termed due to non-payment while on LOA, you must contact Employee Benefits Dept. on your return to work to have those benefits reinstated. They will not automatically be restarted.
- Employees who do not notify the Benefits department upon their return to work and benefits were termed due to non-payment will be enrolled in the same medical plan before LOA began but at the employee only coverage level; Basic life coverage ($10,000) and Flex dollars added to paycheck.
- Employees with Voluntary Individual benefit plans* that are terminated due to non payment, will not have these benefits restarted by DCPS. Employees must pay the provider company directly to have that benefit reinstated and must make a request to the provider company to restart their premium through payroll deduction.

- Trustmark Cancer
- Trustmark Universal Life
- AHL Critical Illness (all plans)
- Trustmark Premier Select
- Trustmark Accident Plan
- UNUM Whole Life

- FBMC will not bill for TSA Deductions, Union Dues, Garnishments and Student Loans.
- FBMC customer service number is 1-855-569-3262
- Payments will be made directly to: Drop Box 24
  FRINGE BENEFITS MANAGEMENT COMPANY
  PO Box 1878, Tallahassee, FL 32302
Standard Insurance Company – Waiver of Premium for Life Insurance

Effective January 1, 2015, DCPS changed the insurance company for their group life insurance. Standard Insurance Company is the new carrier.

The Group Life Insurance provides a benefit that waives further payment of Group Life Insurance premiums for eligible members who are unable to work at all reasonable occupations for which they are suited by reason of education, training and experience.

There is a 180 consecutive day waiting period beginning on the date you become Totally Disabled. Waiver of Premium begins when you complete the Waiting Period.

All employees covered under the Group Life Insurance and are not able to work (Totally Disabled) may qualify for the Waiver of Premiums. There is a Waiver of Premium packet that consists of four (4) separate forms that must be completed by the employee, employer and doctor. The Employer Statement is completed by your immediate Principal/Administrator. All completed forms can be submitted to:

Standard Insurance Company  
Employee Benefits – Waiver of Premium  
PO Box 2800  
Portland, OR 97208

Employees may obtain this packet at the DCPS website www.duvalschools.org under the Employee Benefits department site and by clicking on the Forms link.

If you have questions regarding the Waiver of Premium process and eligibility, please call Standard Insurance Company at 1-800-628-8600.
DUVAL COUNTY PUBLIC SCHOOLS
Instructions for Leave of Absence

STEP ONE: Who to Contact

- **Contact Extended Leave Office** (904) 390-2065
  To answer all questions about Extended Leave, to determine what type of leave that you will qualify for and to receive the necessary paperwork for applying for leave

- **Contact Employee Benefits** (904) 390-2887
  To maintain and continue any necessary benefits while you are on extended leave

- **Contact Payroll Department** (904) 390-2022 or Payroll Contact at work location for leave balances. You will be required to use all available sick and annual leave before any medical leave of absence.

- **Contact UNUM Claims at 1-888-857-0157** if you purchased a Short Term Disability policy and need to file a claim.

STEP TWO: Complete Paperwork

- Complete Extended Leave Application and have signed by Principal or Supervisor

- Medical documentation is required for all medical extended leave
  - **FMLA** requires Certification of Health Care Provider (WH-380) completed by physician
  - **Personal Health/OJI** requires a doctor’s statement which covers the reason for leave, start date and approximate duration of leave

- Other types of leave may require additional documentation

STEP THREE: Submit Paperwork

Return completed application and required documentation to:

**US Mail:**
Duval County Public Schools
Extended Leave 1st Floor
1701 Prudential Drive
Jacksonville, FL 32207

**SCHOOL MAIL:**
Bldg #3001
1st Floor Extended Leave

**Fax:** (904) 858-3570
DUVAL COUNTY PUBLIC SCHOOLS
APPLICATION FOR EXTENDED LEAVE

PLEASE PRINT:

Name ___________________________ Personnel # ___________ Date ___________

Position ___________________________ Principal/Supervisor ___________________________ School/Department Name ___________________________

Home Address ___________________________ New ___________ Temporary ___________ Home ___________

City ___________________________ State ___________ Zip ___________ Home Phone ___________________________ Cell Phone ___________________________

TYPE OF LEAVE: FOR ALL MEDICAL LEAVE, A DOCTOR’S STATEMENT MUST BE INCLUDED

☐ FAMILY & MEDICAL LEAVE ACT (FMLA) ☐ PERSONAL HEALTH
☐ Illness of Employee ☐ MILITARY (include a copy of official orders)
☐ Illness of Family Member ☐ ON THE JOB INJURY (OJI) Date of Injury: ___________
☐ Maternity/due date

READ EACH STATEMENT BELOW AND INITIAL:

☐ All Extended leave will be subject to rules of the DCPS, Civil Service Board and/or employee bargaining agreements in effect the date leave is approved.

☐ Employee will need to contact Employee Benefits at (904) 390-2887 to continue existing insurance plans.

☐ Any employee on the optional pay plan (12 mth) will automatically be placed on regular pay plan (10 mth) for the remainder of the school year upon returning from leave. You MUST reapply for the optional pay plan for the next school year.

☐ Employee must report to the Extended Leave Office to complete necessary paperwork PRIOR to returning to work location.

☐ Employee will need to contact Employee Benefits with return to work date and to discuss any adjustments to benefits.

☐ Failure to return from leave will be considered a resignation.

DATES ABSENT:

Start Date: ___________ End Date: ___________ (IF DATES ARE UNKNOWN, LEAVE BLANK)

REASON FOR REQUEST: __________________________________________________________

Employee Signature ___________________________ Date ___________ Principal/Supervisor Signature ___________________________ Date ___________

OFFICE USE ONLY:

Staffing Supervisor: ___________ Certification: ___________ Date Received: ___________ Position Code: ___________

DCPS – Extended Leave Office – 1st Floor – 1701 Prudential Drive – Jacksonville, FL 32207
Phone: (904) 390-2065 Fax: (904) 858-3570
SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: 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. Employers must generally maintain records and documents relating to 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.

Employer and Contact:  DUVAL COUNTY PUBLIC SCHOOLS, Extended Leave Office

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your Name: ________________________________

First                          Middle                          Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. 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 coverage. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Provider’s name: ________________________________

Business address: ________________________________

Type of practice / Medical specialty: ________________________________

Telephone: (_________) ___________________________ Fax: (_________) ___________________________
PART A: MEDICAL FACTS

1. Approximate date condition commenced: _________________________________________

   Probable duration of condition: _________________________________________________

   **Mark below as applicable:**

   Was the patient admitted for an overnight stay in a hospital, hospice or residential medical care facility? ______ No ______ Yes. If so, dates of admission:
   ____________________________________________________________________________

   Date(s) you treated the patient for condition:
   ____________________________________________________________________________

   Will the patient need to have treatment visits at least twice per year due to the condition? ______ No ______ Yes.

   Was medication, other than over-the-counter medication, prescribed? ______ No ______ Yes.

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? ______ No ______ Yes.

   If so, state the nature of such treatments and expected duration of treatment:
   ____________________________________________________________________________

2. Is the medical condition pregnancy? ______ No ______ Yes

   If so, expected delivery date: ______________________

3. Answer these questions based upon the employee’s own description of his/her job functions.

   Is the employee **unable** to perform any of his/her job functions due to the condition? ______ No ______ Yes.

   If so, identify the job functions the employee is unable to perform:
   ____________________________________________________________________________

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):
   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________
PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery?  ____ No  ____ Yes.

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

_____________________________________________________________________________

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee’s medical condition?  ____ No  ____ Yes.

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

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

_____________________________________________________________________________

Estimate the part-time or reduced work schedule the employee needs, if any:

____ hour(s) per day; ____ days per week from ____ through ____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions?  ____ No  ____ Yes.

Is it medically necessary for the employee to be absent from work during the flare-ups?  ____ No  ____ Yes. If so, explain:

_____________________________________________________________________________

Based upon the patient’s medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months last 1-2 days):

Frequency: _____ times per _____ week(s) month(s) _____

Duration: _____ hours or ___ day(s) per episode

ADDITIONAL INFORMATION:
IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____________________________________________________________________________

_____________________________________________________________________________

Signature of Health Care Provider ___________________________ Date ___________________________
FITNESS FOR DUTY CERTIFICATION
(Physician’s medical release form)

PLEASE PRINT

Employee Name: ________________________________________________

________________________  ________________________________  ________________________________
Personnel #  Work Location #  School Name or Department

You have my permission to contact the health care provider indicated on this form for purposes of certification and authentication.

Employee Signature  ________________________________  Date  ________________________________

BELOW FOR PHYSICIAN’S USE ONLY

• The above patient is certified as fit to resume full time work duties on _____________.
  (mm/dd/yy)

• The above patient is certified as fit to resume work duties on _____________ with the
  following restrictions (Be as specific as possible):
  ______________________________________________________________
  ______________________________________________________________
  ______________________________________________________________

and is certified as fit with all restrictions lifted on _________________.
  (mm/dd/yy)

• Additional comments: ______________________________________________________________

Health Care Provider: ______________________________________________

Practice/Specialty: ________________________________________________

Address: ________________________________________________________  Telephone: ________________________________

Signature: ________________________________  Date: ________________________________

SUBMIT COMPLETED FORM PRIOR TO RETURNING TO WORK LOCATION TO:
Duval County Public Schools, Extended Leave Office
1701 Prudential Drive, Jacksonville, Florida 32207