SUMMARY OF THE FAMILY MEDICAL LEAVE

Up to **12 weeks of unpaid**, job protected leave provided to eligible employees.

ELIGIBILITY:
Employee must:
*Have worked for the District for 12 months; and
*Have worked 1250 hours during the 12 month period.

CALCULATION PERIOD:
*12 month **Rolling** year

REASONS FOR LEAVE:
*Employee's own serious health condition
*Birth of child
*Placement of adopted or foster child
*Care of child, spouse, or parent who has a serious health condition

NOTICE AND CERTIFICATION
*Provide at least 30 days notice when practicable.
*Provide medical certification (Form WH-380-E or WH-380-F) to support your request. Submitted to HR prior to leave when practicable.

JOB BENEFITS AND PROTECTION
*Continued health coverage under same conditions as previously provided
*Restored to original position upon return to work
*No loss in accrued employment benefits

SUBSTITUTION OF ACCRUED PAID LEAVE

ALL ACCRUED PAID VACATION, SICK, AND/OR PERSONAL LEAVE MUST BE USED TO SUBSTITUTE FOR UNPAID FAMLY MEDICAL LEAVE, AND WILL BE CONSIDERED AS PART OF THE CALCULATION OF THE 12 WEEKS LEAVE.

ANY EMPLOYEE THAT IS GOING TO USE THREE (3) OR MORE CONSECUTIVE DAYS OF SICK TIME NEEDS TO FILL OUT THE APPLICATION FOR FMLA. CONTACT HUMAN RESOURCES IF YOU HAVE ANY QUESTIONS.

Phone: 989-775-2300
Fax: 989-775-2309

Physicians can fax the medical certification forms to Human Resources for processing.

MT.PLEASANT PUBLIC SCHOOLS
APPLICATION FOR FAMILY MEDICAL LEAVE

______________________________ ______________________________
EMPLOYEE NAME **BUILDING/POSITION**

CURRENT ADDRESS: ____

____

LEAVE DATES FROM ____________________ **TO**____________________

RETURN TO WORK DATE (ANTICIPATED): ____________________

REASON FOR LEAVE (EXPLAIN): ______________________________________

____

A leave request based on an employee's serious health condition or the serious health condition of an employee's spouse, child, or parent **must** be accompanied by a verifying medical certification from a physician.

I hereby authorize a health care provider representing the Mt. Pleasant Public School District to contact my physician to verify the reason for my requested Family Medical Leave.

I understand that failure to return to work at the end of my leave period may be treated as a resignation unless an extension has been agreed upon and approved in writing by the Assistant Superintendent of Human Resources or the Board of Education. Further, I understand that I must have documentation from my physician if I am going to extend my FML or when I am ready and able to return to work.

I understand that if my leave is approved, it will be counted towards my annual entitlement under the FMLA: and I am required to use accumulated paid leave during this time including vacation, sick, and personal days before using unpaid leave.

Further, while under the FMLA entitlement, I understand that if I currently receive health care benefits, as a condition of employment, I would pay the same insurance premium (if applicable) as I would if I were not on FML. Should I fail to return to work on my own volition, I shall be responsible to repay the Mt. Pleasant Public School District for any premium cost upon request.

I understand that if I am no longer qualified for FML that I shall immediately report this in writing to the Assistant Superintendent of Human Resources.

______________________________ ______________________________
EMPLOYEE SIGNATURE DATE

______________________________ ______________________________
SUPERVISOR SIGNATURE DATE

______________________________ ______________________________
ASSISTANT SUPERINTENDENT OF HR DATE

APPROVED______________ DENIED____________________

PAYROLL NOTIFIED BY HR___YES_____NO ______________________________
DATE