DURHAM PUBLIC SCHOOLS

Office of Human Resource Services
511 Cleveland Street / Durham, North Carolina 27701
919-560-2000

Leave of Absence Packet
2023-2024 School Year

All submissions and questions can be directed to hrleaves@dpsnc.net or your Leave Analyst:

Andrea Lomuscio (A-K)
Andrea_lomuscio@dpsnc.net
(919) 560-9120 Ext. 21050
(919) 237-7246 Fax#

Lisa Daniel (L-Z)
Lisa_daniel@dpsnc.net
(919) 560-2618 Ext. 21818
(919) 237-7246 Fax #

IMPORTANT INFORMATION

If you are on Parental leave and need to add your newborn to the State Health Insurance Plan please call the Eligibility and Enrollment Center at 1-855-859-0966 for information and contact your Benefits Analyst, **Tori Royster (A-K)** or **Jeannie Edwards (L-Z).**

In order for timely processing of leaves, packets should be submitted 30 days in advance (when possible) of the expected leave date, in its entirety.

Packets should consist of:

1) **Request for Leave of Absence Form-** Employee completes and Supervisors sign

2) **Certification of Health Care Provider Forms (WH-380E for Employee or WH-380F for Immediate Family Member**)- Physician completes

3) **Voluntary Shared Leave Forms should be submitted with initial requests for Leave of Absence if applicable.**

Return to work notices must be submitted to your leave analyst at least 5 days prior to your expected return to work date.

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Office of Human Resource Services
P.O. Box 30002
Durham, North Carolina 27702

REQUEST FOR LEAVE OF ABSENCE

To be used when an employee is out for more than 3 consecutive days due to medical reasons OR for intermittent or ongoing conditions. The employee must submit this completed form and appropriate documentation for the type of leave requested to hrleaves@dpsnc.net so that Human Resources can properly process the leave.

Name:			
Home Address:	**City:**	**State:**	**Zip Code:**
Personal Email Address:			
DPS Email Address:			
Social Security #:	**Date of Request:**		
Phone (Home/Cell):	**Phone (Work):**		
Position:	**School/Department:**		
Date Leave Should Begin:	**Date Leave Should End:**		

Type of Leave Requested:

☐ Parental Leave (*Birth or Adoption*) Expected Delivery Date: _____
☐ Medical Leave ☐ Intermittent ☐ Self ☐ Family Member
☐ Military Leave _____
☐ Education Leave (Reason for Request) _____
☐ Voluntary Shared Leave Only

During this leave of absence, I would like to use the following benefits in accordance with State Board of Education Guidelines:

☐ Sick Leave
☐ Annual Leave
☐ Any and all available leave *(note: available comp time will be used first)*
☐ Personal Leave (Classroom teachers only)
☐ Extended Sick Leave (Classroom Teachers only)

Special requests can be made for the donation of Voluntary Shared Leave if the employee, as a result of a serious medical condition of self or his/her immediate family, faces a prolonged absence or frequent absences from work, resulting in a potential financial hardship for the employee.

***** A return to work should be submitted at least 5 days prior to your expected return to work date. *****

_____ _____
Employee's Printed Name **Principal/ Supervisor's Printed Name**

_____ _____
Signature **Date** **Signature** **Date**

According to the "Family and Medical Leave Act," employees who are taking sick leave, or leave without pay because of personal illness, birth of a child, or placement of an adopted or foster child, or caregiver of an ill child, spouse, or parent are eligible for up to 12 workweeks of leave. During those 12 work weeks, the employee's hospitalization insurance premium will be paid by Durham Public Schools. The employee must have been employed by the Durham Public School System for at least one year full time and have worked at least 1250 hours during the previous 12 months. The employee must also return to work at the end of his/her approved leave. The employee is still responsible for any amount of insurance premium that is normally deducted from his/her check for spouse's and/or children's hospitalization insurance. Once an employee's FMLA entitlement exhausts, the employee will also be responsible for the employer's matching insurance premium, if the employee is out continuously on leave without pay.

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APPLICATION TO RECEIVE VOLUNTARY SHARED LEAVE

The purpose of voluntary shared (donated) leave is to provide economic relief for employees, who by reason of prolonged absence caused by serious medical conditions of self or immediate family, are likely to suffer financial hardship.

An employee may complete an application for shared leave at such time as medical evidence is available to support the need for leave beyond the employee's available accumulated leave. Application may also be made by a third person acting on the employee's behalf, if the employee is unable to complete an application.

Only full-time and part-time permanent employees who have exhausted all available accumulated paid leave (comp time, sick leave, annual vacation leave, and bonus leave, if applicable) are eligible to receive donated leave. An employee need not exhaust personal leave and the 20 days of extended sick leave to be eligible for voluntary shared leave.

Approved LEA employees may receive sick leave from both family members and non-family in LEAs. The combined total of sick leave received from non-family members shall not exceed 20 days per year. Approved LEA employees may receive sick leave only from immediate family members in community college institutions and state agencies. Donated sick leave shall not be used for retirement purposes. Approved LEA employees may receive vacation/bonus leave from employees of their own or other LEAs and from immediate family and their coworkers in community college institutions and state agencies.

For the purposes of voluntary shared leave, all leave donated will be credited to the recipient's sick leave account.

An employee should not solicit or coerce donated leave days from co-workers or give or receive compensation for donated leave days. Upon receipt of a completed voluntary shared leave application, the Leave Analysts will notify the worksite supervisor that an email to the staff at the workplace may be sent requesting donated leave. The supervisor or designee can send this email: *"[NAME] has requested donated leave days for a medical situation. If you are interested in donating days, please fill out a voluntary shared leave donation form and submit to hrleaves@dpsnc.net within two business days*." Please put "VSL for [Donee's Name]" in the subject line of the email to HR.

If an employee receives donated leave after being placed on direct billing as a result of being out of work on non-paid leave, the donated leave may be applied for pay purposes only, not for benefits. It is imperative that any donated leave be sent to HR as soon as possible.

Individual Applying to Receive Voluntary Shared Leave

Name:	
Last 4 of SS#:	
DPS Worksite:	

Attestation: I understand that I will not solicit or coerce donated leave days from co-workers or give or receive compensation for donated leave days. I understand that the donation of leave days is a confidential process, and I will not seek to learn who has or has not donated leave days.

Employee signature: _____ Date:_____

Certification of Health Care Provider for Family Member's Serious Health Condition under the Family and Medical Leave Act

U.S. Department of Labor
Wage and Hour Division

WAGE AND HOUR DIVISION

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR. RETURN TO THE PATIENT.

OMB Control Number: 1235-0003
Expires: 6/30/2026

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave to care for a family member with a serious health condition to submit a medical certification issued by the family member's health care provider. 29 U.S.C. §§ 2613, 2614(c)(3); 29 C.F.R. § 825.305. The employer must give the employee **at least 15 calendar days** to provide the certification. If the employee fails to provide complete and sufficient medical certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

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, which is set out at 29 C.F.R. § 825.306. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308.** Additionally, you **may not** request a certification for FMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care.

Employers must generally maintain records and documents relating to medical information, medical certifications, recertifications, or medical histories of employees or employees' family members 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, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

(1) Employee name: _____
First Middle Last

(2) Employer name: _____ 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. The FMLA allows an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of your family member. If requested by your employer, your response is required to obtain or retain the benefit of the FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). **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.** 29 C.F.R. §§ 825.305-825.306. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA leave request. 29 C.F.R. § 825.313.

(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.

Employee Name: _____

(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)

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 leave under the FMLA to care for your patient. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a family member with a serious health condition. For FMLA 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. For more information about the definitions of a serious health condition under the FMLA, see the chart at the end of the form.

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 FMLA 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 FMLA 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. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

(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).

_____

Employee Name: _____

(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.

(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 if the benefits and protections of the FMLA apply.

(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)

_____

Employee Name: _____

(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)

Definitions of a Serious Health Condition (See 29 C.F.R. §§ 825.113-.115)
Inpatient Care
• An overnight stay in a hospital, hospice, or residential medical care facility. • Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.
Continuing Treatment by a Health Care Provider (any one or more of the following)
Incapacity Plus Treatment: A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either: o Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or, o At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.
Pregnancy: Any period of incapacity due to pregnancy or for prenatal care.
Chronic Conditions: Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.
Permanent or Long-term Conditions: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.
Conditions Requiring Multiple Treatments: Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 15 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

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