



## Brevard County Public Schools

### FMLA Information



Benefits Office  
2700 Judge Fran Jamieson Way  
Viera, Florida 32940  
Phone: 321-633-1000  
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# EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT

## **Basic Leave Entitlement**

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

## **Military Family Leave Entitlements**

Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the service member medically unfit to perform his or her duties for which the service member is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

## **Benefits and Protections**

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

## **Eligibility Requirements**

Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

## **Definition of Serious Health Condition**

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

## **Use of Leave**

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

## **Substitution of Paid Leave for Unpaid Leave**

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

## **Employee Responsibilities**

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 day's notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

## **Employer Responsibilities**

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

## **Unlawful Acts by Employers**

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

## **Enforcement**

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

**FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.**



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# Hours Worked Report FMLA Eligibility

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## **FMLA Hours Worked Report - Print Instructions - XP Production**

**Sign on to the XP Production System for Schools and Department Sites**

**Go To Screen Z603**

Select Option 1

**Key the Employee Id & Press Enter**

**Press F3 twice**

At the top left of the screen in **the Panel: field key PRT & press Enter**

Displayed at the top of the screen - "Work with All Spooled Files"

**Hold the Shift key and press the F6 key;** this will take you to the bottom of the list.

**At the last spool entry on the page, key a "2" in the Opt filed and press Enter**

Displayed at the top of the screen - "Change Spooled File Attributes"

**Change the Printer field to \*OUTQ**

**Press the F10 key once, and the press the Page down key once**

**In the first field - "Output queue" Key "YOUR PRINTER"**

**In the second field "Library" Key QUSRSYS - Press Enter**

***The report will print on your printer. Please return this report with all leave documents to the Benefits Office.***

# LEAVE OF ABSENCE CHECKLIST

- \* Inform an employee of his/her rights and procedures to follow under the School Board's policies for Leaves of Absence including Family and Medical Leave Act (FMLA).
- \* Review your rights under the Family and Medical Leave Act of 1993.
- \* Complete a Leave of Absence Form: including your benefit continuation election.
- \* Apply to Sick Bank if a member and eligible.
- \* Contact ING at 1-866-228-8742 for disability claim information.
- \* If you elect benefit continuation please contact the School Board for more information, 633-1000 ext. 248.
- \* Complete a Benefit Change Form to cancel or change your benefits on the first day of your unpaid Leave.
- \* Complete a Return to Work Medical Certification that an employee is able to return to work from a Medical Leave of Absence.

**This checklist should be used when an employee requests a leave of absence.**

## Reason for Leave (See Leave of Absence Guidebook for more information)

- |                                                                                                 |                                                                                                                  |
|-------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Employee's serious health/medical condition                            | <input type="checkbox"/> Birth of a child or care of newborn                                                     |
| <input type="checkbox"/> To bond with a child in connection with adoption or foster placement.  | <input type="checkbox"/> Military Caregiver Leave                                                                |
| <input type="checkbox"/> To care for a child, spouse or parent with a serious health condition. | <input type="checkbox"/> Military Qualifying Exigency                                                            |
| <input type="checkbox"/> Injury in the line-of-duty (WC). (See Risk Management)                 |                                                                                                                  |
| <input type="checkbox"/> Personal-Reason _____                                                  | <input type="checkbox"/> Union <input type="checkbox"/> Prof/Educational Study <input type="checkbox"/> Military |

## **Test for Eligibility - FMLA Site Contacts use Crosspointe screen Z603 #1**

Requested Leave Start Date: \_\_\_\_\_

ALL Employee's:  At least 12 months of service.

Support Employee:  Worked at least 1250 hours in the 12 months prior to leave start date. (FMLA Hours Worked Report)

Instructional Employee:  Must have worked at least one full semester in the previous 12 months.

Is employee eligible for FMLA?  Yes  No

Has this employee used FMLA within the last 12 months?  Yes  No

Remaining entitlement: \_\_\_\_\_ weeks \_\_\_\_\_ days \_\_\_\_\_ hours

## **Please Provide to Employee Leave of Absence Information & Application Packet**

- Leave of Absence Information & Application Packet  
 FMLA Information Packet

**Provided By:** \_\_\_\_\_

## **Action Checklist**

- |                                                                              |                                                                     |             |
|------------------------------------------------------------------------------|---------------------------------------------------------------------|-------------|
| <input type="checkbox"/> Received FMLA Certification.                        | <input type="checkbox"/> Received Health Care Provider's Statement. | Date: _____ |
| <input type="checkbox"/> Copy of LOA Request Form given to employee.         |                                                                     | Date: _____ |
| <input type="checkbox"/> Original LOA Request Form sent to Leave Specialist. |                                                                     | Date: _____ |
| <input type="checkbox"/> Received Return to Work Medical Certification.      |                                                                     | Date: _____ |
| <input type="checkbox"/> Copy of Benefits Change Form given to employee.     |                                                                     | Date: _____ |

\_\_\_\_\_  
**Department Signature - Site Contact**

\_\_\_\_\_  
School/Department Number

\_\_\_\_\_  
Date

**Please send signed Leave of Absence Checklist, Leave of Absence Request Form, Health Care Provider's Statement and FMLA Certification to the Leave Specialist at the Benefits Office.**

\_\_\_\_\_  
**Employee Signature**

\_\_\_\_\_  
Date

My signature signifies that I have read the information on this form and understand my rights and responsibilities specifically those under the Family and Medical Leave Act (FMLA). I certify that the information submitted on this request is accurate.