ALVIN INDEPENDENT SCHOOL DISTRICT
HUMAN RESOURCES
301 E. House Street Alvin, Texas 77511
Phone-281-245-2331 Fax-281-585-8352

FAMILY & MEDICAL LEAVE (FMLA)

An Alvin Independent School District employee who has been employed by the District for at least 12 months and for 1,250 hours during the preceding 12-month period will be entitled to a total of up to 60 days of leave, without loss of any employment benefits accrued prior to the beginning of the leave.

PLEASE BE ADVISED THAT:

1. The 12-month period within which employees will be eligible for 60 work days of family and medical leave will be defined as a "rolling" 12-month period from the time the Family Leave is requested.
2. The FMLA Year is defined as July 1 – June 30th.
3. A Physician's Statement is required for Medical Leave or Family Illness Leave.
4. Employees are required to use all applicable accumulated sick leave concurrently with family and medical leave.
5. If both spouses are employed by the District, combined family and medical leave for the birth, adoption, or placement of a child may be limited to a combined total of 60 work days as determined by the needs of the District.
6. Certified employees continuing on unpaid leave (Temporary Disability Leave) after exhausting FMLA leave will be given the option to continue any insurance coverage at their expense.
7. A Physician's release to Return to Work (on employee medical absence) is required.

I have read and understand the above provisions on use of FML and district policy and request the following:
Leave requested (30 days advance notice must be provided when the leave is foreseeable):

_____ **Care of a newborn** (Physician's Statement and/or Birth Certificate required) I authorize use of available State Days.

_____ **Foster Care/Adoption of a Child**
Date of adoption/ placement_____
(Document from appropriate agency must be attached.)

_____ **Military Leave**

_____ **Personal Illness (Including Maternity)**
(Physician's Statement Required)

_____ **Family Illness**
(Physician's Statement required indicating employee will be providing care for family member)

_____
(Name & relationship of family member)

Employee Name:_____ **Employee #:** _____

Campus or Dept.:_____ **Position or Title:**_____

Date Leave Begins:_____

Leave From:_____ **To:**_____

Employee Signature:_____ **Date:**_____

PRINCIPAL/SUPERVISOR

This request acknowledged:_____ **Date:**_____
(Principal/Supervisor Signature Required as Acknowledgement of Request)

HUMAN RESOURCES

This request approved/denied:_____ **Date:**_____
(HR Administrator)

Reason for denial of request:_____

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NOTICE OF DETERMINATION FOR FAMILY/MEDICAL LEAVE YOU REQUESTED

(Preliminary Notice)

TO:	**FROM:** Erin Seymour
DEPARTMENT/POSITION:	**DEPARTMENT/POSITION:** Leaves & Absence Specialist
You are ☐ Eligible (Approved) ☐ Ineligible (Not Approved) for FML as requested	

This is an important notice of your rights and responsibilities. Please read it and all enclosures carefully and in its entirety. If you have any questions, contact Erin Seymour, Leaves & Absence Specialist at 281-245-2331.

Alvin Independent School District is making a ***preliminary*** designation of your absence as leave under the Family and Medical Leave Act (FMLA) effective _____ based upon your notification of _____.

Your Rights
An employee who has been employed by the District for at least 12 months and for a minimum of 1,250 hours during the preceding 12-month period shall be entitled to a total of 12 work weeks of leave, for certain qualifying medical conditions which includes work-related injuries or family events without loss of any employment benefits accrued prior to the beginning of the leave. Additionally, you will be reinstated to the same or an equivalent position with the same pay, benefits, and terms and conditions of employment on your return from leave.

Your Responsibilities
Pursuant to policy, you are required to provide documentation from your health care provider at your expense of the medical necessity for your absence. A Certification of Health Care Provider Form is included with this letter. The Certification of Health Care Provider must be returned to the Human Resource Department within 15 days from the date of this letter. Failure to return this form may result in your FMLA being denied. You will be required to submit re-certification from your health care provider of the existence or continued existence of a serious health condition every 30 days. In the event that you do not submit appropriate medical certification when requested this preliminary designation will be withdrawn and your leave will not be protected under FMLA.

Accrued Paid Time-Off
You are required to use all accrued leave available under the particular circumstances as outlined in policy DEC Local. Should you exhaust your accrued leave the remainder of your leave, if any, will be unpaid. Payments for premiums will continue to be deducted from your pay during the paid portions of your leave. Should any portion of your leave be unpaid you will be responsible for making these payments yourself. You have a minimum 30-day grace period in which to make premium payments. Premium payments should be made in the Human resource Department. If payment is not made timely your benefits may be cancelled.

Return to Work
You will be required to present a fitness-for-duty certificate with no restrictions prior to being restored to employment. If such certification is required but not received your return to work may be delayed or denied. While you are on leave, you are required to provide us with periodic reports every 30 days of your status and intent to return to work. If the circumstances for your leave change and you are able to return to work earlier than the date indicated on the request forms you will be required to notify us at least two working days prior to the date you intend to report to work.

_____ _____
Alvin Independent School District Date

I certify that I have received this letter from the Human Resources Department on the date indicated below.

_____ _____
Employee Signature and AISD ID # Date

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FAMILY & MEDICAL LEAVE (FMLA)

Certification of Illness/Injury-Employee
(Physician's Statement)

Section I. To be completed by employee.	
Name of Employee:	**SSN:**
Address:	**City, State, Zip Code**
Employee's Statement of Need (the reason for leave, ex: surgery, pregnancy, etc.)	
I, hereby authorize any organization or individual having medical records and/or personal information pertaining to me to disclose such records to the Alvin Independent School District (AISD). I further authorize AISD to communicate verbally with any organization or individual that may be able to confirm my medical situation. I, on behalf of myself or any other person who may have an interest in the matter, hereby release the organization, individual, and the AISD from all legal responsibility and liability that may arise from the act I have hereby authorized relating to the disclosure of personal information. *The requested information is confidential pursuant to Federal and State Law. The information is protected from further disclosure outside AISD without the written consent of the above individual.*	
Employee Signature	**Date**

Section II. To be completed by physician or licensed practitioner and returned to employee.		
This employee has requested medical leave from AISD. To help determine what this employee will require, please take a few minutes to complete this medical certification.		
Diagnosis/Probable Duration		
Name of Physician/Practitioner	**Type of Practice/Field of Specialization and Telephone #**	
Street Address	**City, State, Zip Code**	
Signature of Physician or Practitioner		**Date**

Employee will be required to submit a Return to Work (fitness for duty certification) from medical provider prior to being restored to employment.