Bridgeport Public Schools Board of Education
Human Resources Department
45 Lyon Terrace, Room 310, Bridgeport, CT 06604
hrdept@bridgeportedu.net
203-275-1042
203-337-0145 (fax)

Family Medical Leave Act
Employee Application Packet ~ Contents and Instructions

Family Medical Leave Act (FMLA) Policy – Employees are expected and advised to read and understand the City of Bridgeport's FMLA policy.

Application for a Family Medical of Absence (FMLA):

- Complete, sign, and date.
- Have your Department Head sign and date the Application page. This will provide notification to the Department Head that you are requesting FMLA leave. It is **not** FMLA leave approval.
- Return completed forms to:

  Bridgeport Public Schools Board of Education
  Human Resources Department
  hrdept@bridgeportedu.net
  45 Lyon Terrace, Room 324
  Bridgeport, CT 06604

Acknowledgement and Authorization to Release:

- Print your full name, sign, and date the top half of this form indicating that you have read and understand the FMLA policy.
- On the lower portion of this form, print your full name, and the full name of your attending healthcare provider in each of the designated spaces; sign and date the form.
- Return with the above noted forms to Human Resources – to the office and address listed above.

Medical Certification of Health Care Provider:

- Complete Section 1 with your full name (print legibly). If the FMLA request if for dependent care - please complete Section 2 on page 1 and the bottom of page 3 of the medical certification form.
- Have your attending healthcare provider complete this form and return it to you.
- Return the completed medical certification form along with the Acknowledgment and Authorization to Release, and FMLA Application page to Human Resources – to the contact and address listed above.

As with other important documents, our office recommends that you retain a copy of these completed documents for your own records. If you have any questions or concerns related to your FMLA request, please contact, Human Resources via email: hrdept@bridgeportedu.net or (203) 275-1042.

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APPLICATION FOR FMLA

(Family and Medical Leave Act)

Employee Name: _____

Title & _____

Department: _____

Current Address: _____

Contact Telephone (_____) _____

Reason for Leave (check one only):

☐ A) Birth/Adoption of a Child

☐ B) Serious Health Condition (self)

☐ C) Serious Health Condition (parent, spouse, child)

☐ D) Military related ☐ Qualifying Exigency
☐ Military Caregiver leave

When submitting this leave request to Human Resources/FMLA Administrator, please attach the appropriate certification form supporting this leave request.

Please indicate the anticipated start and end date of the leave: _____ — _____

I understand that a failure to return to work at the end of my leave period will be deemed as a voluntary resignation from employment, unless an extension has been granted and approved in writing by the Bridgeport Public Schools Board of Education, prior to the expiration of the leave. _____
Initial

_____ _____
Employee Signature Date

_____ _____
Supervisor Notified Date

_____ _____
Approval - Human Resources Date

A copy of this completed form will be sent to you confirming your FMLA approval.

ACKNOWLEDGEMENT AND MEDICAL RELEASE

(Family and Medical Leave)

Bridgeport Public Schools

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I _____ acknowledge that I have received and reviewed the City of Bridgeport's policy on Family and Medical Leave (FMLA). I have also received an application to apply for FMLA and the medical certification forms to be completed by a qualified health care provider. I understand that I am responsible to follow the guidelines in the City's FMLA policy including but not limited to;

- Properly notifying my supervisor of an FMLA absence,
- Scheduling intermittent FMLA appointments/treatments in a manner not to unduly disrupt school operations,
- Providing to my supervisor, if requested, an acceptable doctor's note following an intermittent FMLA absence,
- Making timely payments to maintain group health insurance coverage, if necessary,
- Notifying my supervisor *and* Human Resources prior to my return from an FMLA leave of thirty days or more, and,
- Returning to work at the end of my granted leave period.

_____ _____

Employee Signature Date

Authorization for Release of Health Information

I _____ hereby authorize the use/disclosure of my health information needed to process the above FMLA request. I authorize my physician _____ to disclose my health information to the Bridgeport Public Schools Board of Education by completing the medical certification forms provided by the Human Resources Department. I understand that the medical information being disclosed will be used by the Bridgeport Public Schools Board of Education for the purpose of determining if I have a qualifying serious health condition under the Family & Medical Leave Act. I understand that I have a right to revoke this authorization at any time by notifying the Bridgeport Public Schools Board of Education Human Resources Department in writing. I understand that the revocation is only effective after it is received and recorded and that a revocation of this authorization does not disqualify this FMLA leave once it is approved. However, I further understand that the Bridgeport Public Schools Board of Education may deny or discontinue this FMLA leave if I have revoked this authorization and they require the disclosure of more medical information. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation. I understand that I am entitled to receive a copy of this authorization.

_____ _____

Patient Signature Date

MEDICAL CERTIFICATION OF HEALTH CARE PROVIDER

(Family and Medical Leave Act of 1993)

Bridgeport Public Schools

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Sections 1 & 2. Employee/Patient/Dependent information. ***When completed, this form goes to back to the employee.***

1. Employee's Name	2a. Patient/Dependent Name	2b. Relationship to Patient	Date of Birth

If this FMLA request is for one's own serious health condition, the qualifying health care provider should complete Sections 3, 4, 5, 6 & 7 below. If it is to care for a parent, spouse or child, please complete Sections 3, 4, 5, 6 & 8.

3. The last page in this packet describes what is meant by a **"serious health condition"** under the Family and Medical Leave Act. Does the patient's condition qualify under any of the categories described? If so, please check the applicable category.

(1) ☐ (2) ☐ (3) ☐ (4) ☐ (5) ☐ (6) ☐ or None of the above. ☐ above

4. Describe the **medical facts** which support your certification, including a brief statement as to how the medical facts meet the criteria of one of the categories above:

5. a. State the approximate **date** the serious health condition commenced, and the probable duration of the serious health condition (and also the probable duration of the patient's present **incapacity** if different):

b. Will it be necessary for the employee to **work only intermittently or to work on a less than full schedule** as the result of the serious health condition (including for treatment described in Item 6 below)? If yes, please state the reason for this restriction, its nature, and probable duration:

c. If the condition is a chronic condition or pregnancy, state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity.

6. a. If additional **treatments** will be required for the serious health condition, provide an estimate of the probable number of such treatments.

If the patient will be absent from work because of **treatment** on an **intermittent** or **part-time basis**, also provide an estimate of the probable number of and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any:

b. If any of these treatments will be provided by **another provider of health services** (e.g. physical therapist), please state the nature of the treatments:

c. If a **regimen of continuing treatment** by the patient is required under your supervision, provide a general description of such regimen (e.g. prescription drugs, physical therapy requiring special equipment) and the duration of continuing treatment:

7. a. If a medical leave is required for the employee's own serious health condition (including absences due to pregnancy or a chronic condition), is the employee **unable to perform work of any kind**?

b. If able to perform some work, is the employee **unable to perform any one or more of the essential functions of the employee's job** (the employer will supply you with a job description containing the essential job functions)?

If yes, please list the essential functions the employee is unable to perform:

c. If neither a. nor b. applies, is it necessary for the employee to be **absent from work for treatment**?

8. a. If leave is required to **care for a family member (parent, spouse, or child)** of the employee with a serious health condition, **does the patient require assistance** for basic medical or personal needs or safety, or for transportation? Please explain:

b. If the patient will need care only **intermittently** or on a **part-time basis**, please indicate the probable **duration** of the need for this care:

Signature of Qualified Health Care Provider

Type of Practice

Address

Telephone Number

City, State, Zip

Date

To be completed by the employee requesting leave to care for a family member:

Describe the type of care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full work schedule:

Employee Signature

Date

Failure to accurately and completely fill out the FMLA application and health care certification may result in a delay in processing and/or approval of an employee's FMLA request. A leave request is not fully processed unless and until it has been approved in writing by the Chief Human Resource Officer or their designee.

A **"Serious Health Condition"** means an illness, injury, impairment, or physical or mental condition that involves one of the following which would prevent an employee from performing the essential functions of his/her position:

1. Hospital Care

   Inpatient care (i.e. overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

   A period of incapacity of **more than three (3) consecutive calendar days** (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:

   (a) **Treatment two or more times** by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g. physical therapy) under orders of, or on referral by a health care provider; or

   (b) **Treatment** by a health care provider on **at least one occasion** which results in a **regimen of continuing treatment** under the supervision of the health care provider.

3. Pregnancy

   Any period of incapacity due to **pregnancy**, or for **prenatal care**.

4. Chronic Conditions Requiring Treatments

   A **chronic condition** which:

   (a) Requires **periodic visits** for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision or a health care provider;

   (b) Continues over an **extended period of time** (including recurring episodes of a single underlying condition); and

   (c) May cause **episodic** rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.)

5. Permanent/Long-term Conditions Requiring Supervision

   A period of **incapacity** which is **permanent or long-term** due to a condition for which treatment may not be effective. The employee or family member must be **under the continuing supervision of, but need not be receiving active treatment** by a health care provider (e.g., Alzheimer's, severe stroke, terminal stages of a disease).

6. Multiple Treatments (Non-Chronic Conditions)

   Any period of absence to receive **multiple treatments** (including any period of recovery there from) by a health care provider or by a provider of health care services under orders of, or on referral by a health care provider, either for **restorative surgery** after an accident or other injury, or for a condition that **would likely result in a period of incapacity or more than three (3) consecutive calendar days in the absence of medical intervention or treatment**.

Serious Health Condition—the information sought relates only to the condition for which the employee is applying for FMLA leave.
Incapacity—for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to and directly related to the serious health condition, treatment thereof, or recovery there from.
Treatments—include examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, dental examinations, or other examinations not directly related to the serious health condition for which the employee is seeking FMLA.
Regimen of continuing treatment—includes, for example, a course of prescription medication or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

DO NOT SEND THE COMPLETED FORM TO THE EMPLOYER (BRIDGEPORT PUBLIC SCHOOLS); IT GOES TO THE EMPLOYEE.