PARAMUS PUBLIC SCHOOLS
Paramus, New Jersey

REQUEST FOR LEAVE OF ABSENCE

(Maternity/Paternity/Child Rearing, Adoption/Foster Care Placement, Medical, Active Duty Exigency, Unpaid Personal Leave)

(Please print or complete on the computer.)

Name: _____ School/Location: _____

Position: _____ Date Submitted: _____

STATUTORY FAMILY LEAVE

Request is to be submitted thirty (30) days in advance in order to obtain approval for a period of leave.

Have you been employed by the district for at least twelve (12) months and have worked at least 1,000 hours (NJFLA) and/or worked 1250 hours if applying for federal leave (FMLA) in the preceding twelve (12) month period?

Yes ☐ No ☐

Have you taken a leave within the last twenty-four (24) months?

Yes ☐ No ☐

REQUEST FOR:

A. Serious health condition of:

☐ **Yourself (FMLA)**
Complete and submit the following form.
https://www.dol.gov/sites/dolgov/files/WHD/legacy/files/WH-380-E.pdf

☐ **Family Member (NJFLA & FMLA)**
Complete and submit the following form.
https://www.dol.gov/sites/dolgov/files/WHD/legacy/files/WH-380-F.pdf

B. If family member, relationship _____

C. Dates: From _____ To_____

D. For a serious health condition, the medical certification should indicate the following:
* Date on which the serious medical condition commenced
* Probable duration of the condition
* Medical facts within the provider's knowledge regarding condition

Is medical certification attached? Yes ☐ No ☐

*****If not, date on which certification is to be submitted** _____

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☐ **I am seeking a leave for the birth of my child or to care for my newborn child.**
Please submit request at least 60 days in advance of expected leave dates.

➢ **Anticipated Date of Delivery (per doctor's note – please attach):** _____

MEDICAL LEAVE (if applicable)**:**

Medical Leave may be paid or unpaid, depending upon accrued sick days (personal and vacation days may also be used if applicable) – ***With Health Insurance Benefits (staff member continues to pay her Employee Benefit Contribution).*** *Medical Leave will only apply during the staff member's work year.*

➢ Medical Leave Start Date (up to 20 **work**days before delivery date): _____

➢ Medical Leave End Date (up to 20 **work**days after, including delivery date): _____

➢ If delivery is Caesarian (up to 30 **work**days after, including delivery date): _____

FAMILY MEDICAL LEAVE ACT – FMLA (if applicable)**:**

FMLA is unpaid leave that may be utilized for a maximum of 12 ***calendar*** *weeks during your work year –* ***With Health Insurance Benefits (staff member continues to pay her Employee Benefit Contribution).*** *Staff members are eligible to take FMLA leave if they have worked for the Paramus Public Schools for at least 12 months (cumulative) and have worked for at least 1,250 hours over the previous 12 months.*

➢ FMLA Start Date: _____ ➢FMLA End Date: _____

UNPAID LEAVE (if applicable)**:**

Unpaid Leave (including Child Rearing Leave) – ***No Health Insurance Benefits; however, if staff member already has benefits, she may elect COBRA coverage.***

➢ Unpaid Leave Start Date: _____ ➢Unpaid Leave End Date: _____

➢ **Anticipated Return-to-Work Date**: _____

1. **For information on your upcoming leave**
    a. Fact Sheet #28 - The Family and Medical Leave Act
    b. Fact Sheet #28A - Employee Protections under the Family and Medical Leave Act
    c. Fact Sheet #28F - Qualifying Reasons for Leave under the Family and Medical Leave Act
    d. Fact Sheet #28G - Certification of a Serious Health Condition under the Family and Medical Leave Act
    e. Fact Sheet #28I - Calculation of Leave under the Family and Medical Leave Act
    f. Division of Temporary Disability and Family Leave Insurance Information
    g. FAQ: Maternity Leave Coverage
    h. Contact your private disability insurance carrier, if applicable, for information.

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2. **Documents to be completed by you and/or your physician for your leave**
   a. Certification of Health Care Provider for Employee's Serious Health Condition (FMLA) – Form WH-380-E
      Form WH-380-E is to be completed by your physician upon determination of your expected delivery date
   b. Notice of Eligibility and Rights & Responsibilities (FMLA) – Form WH-381
      Form WH-381 is to be completed by Human Resources and will be sent by Ruth Smith.
   c. Designation Notice (Family & Medical Leave Act) – Form WH-382
      Form WH-382 is to be completed by Human Resources and will be sent by Ruth Smith.
   d. NJ Temporary Disability for Pregnancy – Start an Application
      i. Employee completes Parts A and B
      ii. Employee will need to provide a medical certification to confirm the period she is unable to work
   e. Family Leave for Newborn Bonding – Application (after getting state disability insurance (FL2)
      i. After receiving state temporary disability benefits: you will receive an FL2 (new mother bonding notice) in the mail from the Division. The FL2 has a unique Online Form ID Number on it. Upon receiving the form, you will enter that number online when asked.
      ii. If you received private plan temporary disability benefits, or no disability benefits: you will need to submit a new application for Family Leave Insurance benefits for bonding with your baby.
   f. Health Benefits Enrollment and/or Change Form (add newborn); Dental Enrollment Form (add newborn); Vision Form (add newborn)
      i. Ruth Smith will send forms through Frontline Central. You will need to submit a birth certificate and social security number.

3. **Purchasing Service Credit**
   Please see this link for further guidance.

☐ **I am seeking leave for the placement of a child with me for adoption or foster care.**
Complete and submit the following form.
https://www.dol.gov/sites/dolgov/files/WHD/legacy/files/WH-380-F.pdf

Dates: From _____ To_____

Is certification attached stating date of birth or date of placement of child, whichever is appropriate?

Yes ☐ No ☐

*****If not, date on which certification is to be submitted**_____

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☐ **I am seeking leave a medical leave for myself.**

Dates: From _____ To_____

Please attach a physician's note indicating the following:
(1) Date on which the medical condition commenced;
(2) Probable duration of the condition;
(3) Medical facts indicating applicant's inability to perform contractual duties: Yes☐ No☐
*****If not, date on which physician's note is to be submitted** _____

*****Upon return to work, the employee must submit a physician's note indicating the ability to perform his or her job responsibilities.**

☐ **I am seeking leave a personal (non-medical) leave for myself.**

Dates: From _____ To_____

Reason: _____

Is a separate request letter attached? Yes☐ No☐

☐ **I am seeking a leave due to a qualifying exigency because a family member is on or has been called to covered active duty or to care for a family member who is a current member of the Armed Forces who is undergoing medical treatment. Relationship of family member to you:**

Complete and submit the following form.
https://www.dol.gov/sites/dolgov/files/WHD/legacy/files/WH-380-F.pdf

_____ _____
Staff Member's Signature & Date Signature of Director of HR & Date

Human Resources will submit a copy of this request form to the Superintendent.

If you desire to use family and medical leave (FMLA), please review, complete, and return the linked documents no later than fifteen (15) calendar days from your receipt of this letter.

If it is not practicable under the circumstances to return these documents within the time frame, please contact me as soon as possible. Failure to return the enclosed documents in a timely manner may result in the delay, or denial of your rights under the Federal Family and Medical Leave Act.

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BELOW FOR HUMAN RESOURCES USE ONLY

FMLA Information Sent: _____

FMLA Information Received: _____

USE OF ACCRUED DISTRICT PAID LEAVE:

Sick days*:	From _____	To _____	_____ Total # of Days
Personal days:	From _____	To _____	_____ Total # of Days
Vacation days:	From _____	To _____	_____ Total # of Days
Statutory Days	From _____	To _____	_____ Total # of Days